KEY PROVISIONS OF 2010 HEALTHCARE REFORM LEGISLATION FOR LARGE (50+) EMPLOYERS

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NOTE: Yesterday, the U.S. Supreme Court upheld the Patient Protection and Affordable Care Act, with the exception that the Federal government's power to terminate Medicaid funding is to be narrowly read. The main focus of the Court was on the individual mandate, which requires most individuals to maintain health coverage or pay a penalty beginning in 2014. The Court found the mandate constitutional as a tax. The individual mandate is not discussed in this memorandum, since it is not an employer responsibility.

NOTHING IN THE COURT'S RULING CHANGED EMPLOYER RESPONSIBILITIES UNDER THE ACT. EMPLOYERS THEREFORE SHOULD CONTINUE TO COMPLY WITH THE PROVISIONS OF THE ACT THAT ARE ALREADY EFFECTIVE AND TO PLAN FOR THOSE THAT ARE TO TAKE EFFECT IN FUTURE YEARS. THE REMAINDER OF THIS MEMORANDUM IS THUS UNCHANGED BY THE RULING.

The sweeping healthcare reform legislation enacted in 2010 is exceedingly complex and raises innumerable issues for employers. To add to the complexity, the new rules have varying effective dates, from 2010 to as late as 2018, and the rules for employers vary depending on the number of employees. The "large employer" threshold may be 25, 50, 100 or 200 employees, depending on the provision, but this memorandum focuses on changes that affect employers with at least 50 employees.

Also, grandfather rules apply to existing plans and may alter or delay the requirements for those plans. A "grandfathered plan" is a group health plan or individual health policy that was in effect on the date of enactment (March 23, 2010.) Grandfathered plans are exempt from some of the new rules and have later effective dates for others. The different rules for such plans are noted where applicable. Interim guidance provides that, in order to maintain grandfathered status, a plan must (1) include a statement in plan materials describing plan benefits and stating that the plan is believed to be grandfathered and (2) provide contact information for questions and complaints. Loss of grandfathered status is triggered by certain reductions in benefits or increases in certain employee costs.

Similarly, health coverage maintained pursuant to a pre March 23, 1010 collective bargaining agreement ("CBA") is exempt from certain provisions of the new law until the termination of the CBA. Those provisions are *not* specifically set out in this

memorandum. Please contact your BrownWinick attorney if you have questions about a collectively bargained health plan.

The effective dates in this memorandum are based on the original effective dates in the legislation. Many of those effective dates have now been delayed, as noted in italics where applicable.

EFFECTIVE 2010

Automatic enrollment.

- Employers who maintain one or more group health plans must automatically enroll new employees in one of the plans (subject to permissible waiting periods).
- Employers must give the affected employees adequate notice and the opportunity to opt out of coverage.
- No specific effective date for this provision was stated in the legislation. *This provision has now been delayed indefinitely, subject to the issuance of regulations.*
- *Applies only to employers of 200+ employees.*

EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER SEPTEMBER 23, 2010

Dependent coverage extended

- Group health plans ("plans") and insurers that offer dependent coverage must allow uninsured children to remain on parent's health insurance until age 26, regardless of student or marital status.
- *For years prior to 2014, this provision applies to grandfathered plans only to extent the "child" is not eligible for another employer-sponsored health plan.*

Lifetime and annual limits

- Plans and insurers cannot impose lifetime limits on coverage of "essential health benefits"
- For plan years beginning prior to January 1, 2014, a plan may impose a "restricted annual limit" on essential health benefits. The restricted annual limits are as follows:
    - 09/23/10 - $750,000
    - 09/23/11 - $1,250,000
    - 09/23/12 - $2,000,000

Essential Health Benefits will be further defined, but must include the categories listed below. The task of further defining essential health benefits has been delegated to the states.

- Ambulatory patient services

- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Preventative health services

- Plans must provide coverage for preventative services and immunizations with no cost-sharing.
- *N/A to grandfathered plans.*

Prohibition on rescissions

- Plans and insurers may not rescind coverage, exception in cases of fraud or misrepresentation.

Pre-existing conditions

- No pre-existing condition limitations for children under age 19

Appeal procedures

- Plans and insurers must implement an appeals process for appeals of both coverage determinations and claims.
    - Must include an internal claims appeal process
    - Must provide notice of the appeals process and of the availability of assistance.
    - Must allow the participant to review his or her file and present testimony.
    - Must allow participant to receive continued coverage while an appeal is pending.
    - *N/A to grandfathered plans.*
    - *This provision was delayed to 2012.*

Nondiscrimination

- Insured group health plans are subject to the nondiscrimination rules of IRC § 105(h)(2), which previously applied only to self-insured plans. Those rules generally prohibit discrimination in favor of the top paid 25% of employees with regard to both eligibility and benefits.

- The penalties for violating the nondiscrimination rules are severe. Discriminatory insured health plans will be subject to excise taxes of $100 per day per participant.

- *N/A to grandfathered plans.*

- *This requirement has been delayed indefinitely, subject to the issuance of regulations. The comment period closed in March, 2011, but regs have not yet been issued.*

EFFECTIVE 2011

Reporting on Form W-2.

- All employers must reflect the value of health insurance provided to an employee on the employee's W-2 Form. (Note: This does not mean that the benefit is taxable. The reporting is informational only.)

- *This requirement has been delayed. Reporting is optional for 2011 and will be mandatory for 2012 for employers issuing 250+ W-2 forms. The delay is indefinite for smaller employers.*

HSA/FSA/HRA Changes

- The definition of qualified medical expense for Health Savings Accounts, Flexible Spending Accounts and Health Reimbursement Arrangement is amended to exclude over-the-counter medicine (except for insulin) unless obtained with a prescription.

- The excise tax on distributions from HSAs not used for qualified medical expense is increased to 20%.

EFFECTIVE 2013

Reduced limit on health FSAs

- The maximum annual contribution to a health FSA under a cafeteria plan is reduced to $2,500 (indexed).

- *The IRS issued guidance on May 30, 2012 providing that the limit will not apply to fiscal-year plans until the plan year beginning in 2013.*

Medicare Part D subsidy

- Employers will no longer be allowed to deduct expenses allocable to Medicare Part D subsidies.

EFFECTIVE 2014

Pre-existing conditions

- Plans and insurers may not impose any pre-existing condition limitations.

Waiting periods

- Plans and insurers cannot impose a waiting period that exceeds 90 days.

- **Wellness programs**

- Wellness program rewards based on satisfaction of health standards may equal as much as 30% of the cost of employee-only coverage. *N/A to grandfathered plans.*

Cost-sharing

- Plans cannot have out-of-pocket limits greater than the limits for high-deductible health plans (which are paired with HSAs) (currently $6,050 for individual coverage and $12,100 for family coverage). *N/A to grandfathered plans.*

Reporting

- Plans must report to the IRS and provide a statement to employees regarding whether the employee was covered under the employer's plan for minimum essential health coverage.

- Deadline is the same as for Form W-2. (First deadline is January 31, 2015.)

"Pay or play" penalties

- Large (50+) employers generally must offer "minimum essential coverage" to their employees or pay a penalty.

- Penalty applies if at least one full time employee is a Government Assistance Full-Time Employee ("GAFTE"). That is an employee who:

    - enrolled in a qualified health plan offered through an Exchange *and*
    - received a premium tax credit or cost-sharing reduction *and*
    - did not receive a "free choice voucher" from the employer.
    - Amount of the annual penalty is $2,000 (indexed) per full-time employee, except that the number of employees is reduced by 30 in calculating the penalty.

        Example: Employer has 50 full-time employees and does not offer coverage. The penalty is calculated as follows:

        50 – 30 = 20 x $2,000 = $40,000.

EFFECTIVE 2018

"Cadillac tax" on high-cost health plans

- 40% excise tax on insurance companies, based on premiums that exceed certain amounts.

- The tax is not on employers themselves unless they are self-funded. Insurers are expected to pass on this expense to employers sponsoring high-cost plans, however, so those employers will be indirectly affected.

This is merely a brief summary of some of the key benefit provisions of more than 3,000 pages of legislation. Substantial additional guidance from the IRS and other regulatory agencies will be issued over the coming months and years and additional legislation can also be expected. We will keep you informed regarding new developments. Please contact Alice Helle at 515-242-2407 or helle@brownwinick.com or contact your BrownWinick attorney if you have questions or need assistance.

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