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Alerts

Health Care Reform: What Employers Need to Know Now

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Insights for Employers

FIRST IN A SERIES

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). Six days later, the Health Care and Education Reconciliation Act of 2010 was enacted. When fully implemented, these Acts will significantly affect nearly every aspect of health care in the United States, including employer-provided group health plan coverage.

This Alert is the first in a series that will discuss how health care reform legislation will impact employers and employer-provided group health plans. This Alert focuses on those changes under the legislation that are most imminent for employers and their plans. Nearly all of the changes described here will become effective sometime in the next year. Topics covered below include:

- Upcoming changes to the design and operation of group health plans.
- Upcoming changes to individual health care account arrangements, such as flexible spending accounts (FSAs), health savings accounts (HSAs), and health reimbursement accounts (HRAs).
- Changes relating to retiree medical coverage.
- New small employer health insurance tax credit.
- New Form W-2 reporting requirement for health plan premium amounts.

Many significant aspects of the new legislation do not take effect until future years; we will cover those topics, listed at the end of this Alert, in the coming days and weeks.

Managing Reform: Focus on Effective Dates

The health care reform legislation is structured so that the new provisions become effective in stages. Employers must therefore focus on the various effective dates in the legislation in deciding which actions need to be taken — and when — with respect to their current group health plans. The legislation's effective dates range from the date of enactment to 2018. We are advising employers to focus on the more immediate changes and wait for guidance and regulations before attempting to restructure group health plans to comply with requirements becoming effective in subsequent years.

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Employee Benefits
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Grandfathered Plans

The legislation contains special carve-outs for "grandfathered plans," which require employers to carefully examine the new law to determine which provisions apply to their plans. For this purpose, a grandfathered plan is any group health plan, with respect to an individual, in which such individual was enrolled on March 23, 2010, the date PPACA was signed into law. That is, a group health plan that existed at the time of PPACA's enactment is considered a grandfathered plan. Future renewals of coverage under such plans will also retain grandfathered plan status, and this status will apply both to current employees and to new enrollees (and their families). Additional guidance on grandfathered plans rules, such as what changes a plan may implement without losing its grandfathered status, was not provided in the legislation and will likely be addressed in future regulations.

Upcoming Changes to Design and Operation of Employer Group Health Plans

The first set of changes affecting the design of employer group health plans will be effective for plan years beginning on or after September 23, 2010. For calendar year plans, these provisions are effective January 1, 2011. Group health plans that do not currently meet these requirements (including grandfathered plans where applicable) should change plan administration practices to comply with new law and amend plan documents, as necessary, to reflect the new rules.

The principal changes effective for plan years beginning on or after September 23, 2010, that apply to both new and grandfathered plans are as follows:

- **Prohibition of Exclusions for Pre-Existing Conditions for Children Under Age 19.** Employer group health plans will no longer be permitted to exclude coverage of pre-existing conditions for any period of time for children under age 19. (For all other participants, the elimination of pre-existing condition limitations under employer group health plans will take effect for plan years beginning on or after January 1, 2014.)
- **Prohibition of Lifetime Benefit Limits on "Essential Health Benefits."** Lifetime limits on certain "essential health benefits" under employer plans will be prohibited. A definition of "essential health benefits" is not provided in the legislation, but is left to future regulations from the United States Department of Health and Human Services. These regulations are to be informed by a survey to be conducted by the U.S. Department of Labor as to what is typically offered under employer-sponsored plans, including collectively-bargained plans.
- **Restriction on Annual Benefit Limits.** Between 2010 and 2014, employer group health plans may only establish a "restricted annual limit"—to be determined in subsequent guidance—on the scope of benefits that are "essential health benefits." After January 1, 2014, those limits will be prohibited. Annual limits on what will eventually be determined to be nonessential health benefits will not be affected.
- **Expanded Availability Coverage for Adult Children.** For new group health plans that cover dependent children, all children under the age of 26 must be offered coverage under the plan. This coverage will be available to an adult child regardless of the adult child's income, marital status, or lack of status as a dependent for federal tax purposes. For plan years beginning prior to January 1, 2014, grandfathered plans are required to offer coverage to such adult children only if they are not eligible for coverage under another employer's group health plan. The Internal Revenue Code was also amended to provide for an exclusion from income related to the cost of such coverage provided to the adult child. This tax fix is effective as of March 23, 2010.
- **Prohibition on Rescinding Coverage.** Group health plans will be prohibited from rescinding coverage with respect to an enrollee once that enrollee becomes covered under the plan, except in the case of fraud or intentional misrepresentation of material fact as stated in plan document.

The principal changes effective for plan years beginning on or after September 23, 2010, that apply only to new group health plans and NOT to grandfathered plans are as follows:

- **Required Coverage of Preventive Care Without Cost-Sharing.** A new group health plan will be required to cover — and without cost-sharing — certain preventive care benefits, including but not limited to: recommended immunizations, preventive care for children, and additional preventive care and screening for women.
- **Prohibition of Preauthorization for Emergency Services.** A new group health plan may not require prior authorization for emergency services, regardless of whether such services are provided in-network or out-of-network.

- **Prohibition of Certain Preauthorization or Referrals.** A new group health plan will be prohibited from requiring preauthorization or referral by the plan for a patient who seeks certain coverage, including coverage for obstetrical or gynecological care, regardless of whether such services are provided in-network or out-of-network.
- **Expanded Prohibition on Discrimination in Favor of Highly Compensated Employees.** Insured group health plans will be prohibited from discriminating in favor of highly compensated individuals. This requirement previously applied only to self-insured group health plans. Thus, the ability of employers to offer new insured executive-only group health plan coverages that benefit highly compensated executives will be severely restricted.
- **Improvement of Appeals Procedures.** A new group health plan will be required to have a new effective appeals process for appeals of coverage determinations and claims, with clear and easily understood processes and notice requirements.

Upcoming Changes to FSAs, HSAs, and HRAs.

- **New Restrictions on What Expenses Are Reimbursable.** Certain expenses will no longer be eligible for reimbursement under health flexible spending accounts, health savings accounts or health reimbursement accounts. Among these new disallowed expenses will be over-the-counter medications purchased without a prescription. Thus, for example, employees will not be able to spend down the remaining balances of their health flexible spending accounts to purchase common pain relievers or cold medicines at the end of the year. Plan sponsors should notify employees of this change before they make their elections for the 2011 taxable year.
- **Increased Penalties for Non-Medical Distributions.** Distributions from health savings accounts and Archer medical savings accounts that are not used for qualified medical expenses will be subject to a 20 percent excise tax, up from 10 percent under current law. These increased penalties apply to distributions made after December 31, 2010.

Changes Relating to Retiree Medical Coverage

- **New Government Subsidy for Early Retiree Coverage.** A new temporary reinsurance program will provide reimbursement for a portion of the cost of providing health insurance coverage to early retirees (and their dependents). Under the program, the government will cover 80 percent of claims made by covered individuals between $15,000 and $90,000. Individuals who are age 55 and older but who are not eligible for Medicare and who are not active employees covered under an employment-based plan would be eligible for this reinsurance coverage. The new subsidy comes with a catch, however — amounts received by employers must be used to lower the costs under the retiree plan. This new government subsidy program will be effective June 21, 2010 and extend through December 31, 2013.
- **No Deduction Related to Prescription Drug Subsidies for Retirees.** A significant deduction previously available to employers who offered retiree prescription drug coverage to their former employees will be eliminated. For taxable years beginning on or after January 1, 2011, employers who offer prescription drug programs to retirees and receive government subsidies under those programs will no longer be able to deduct payments of the amounts (up to the subsidy) that are made for such coverage.

Small Employer Health Insurance Tax Credit

"Eligible small employers" may apply for a new subsidy in the form of a tax credit to provide health insurance coverage, effective for taxable years beginning on or after January 1, 2010. Tax credits are available for employers with 25 or fewer full-time equivalent employees and average annual wages of no more than $50,000 per employee. The maximum amount of the credit would be between 25 percent and 50 percent of the cost of offering coverage. Complex eligibility and phase out rules apply to this credit.

Form W-2 Reporting Requirement for Health Plan Premium Amounts.

Beginning with the 2011 tax year (i.e., for Forms W-2 issued in 2012), employers will be required to report the cost of applicable employer-sponsored coverage that is provided to an employee on such employee's Form W-2. This cost of coverage will be determined using the same methods that are used to determine Consolidated Omnibus Budget Reconciliation Act (COBRA) premiums. The reported benefits are not currently includible in the recipient's income, but rather will simply need to be reported for informational purposes.

Effects on Costs of Coverage
Perhaps the biggest question facing employers is what will happen to the costs of providing group health coverage? The consensus view is that premiums will rise. A report by the Congressional Budget Office and the Joint Committee on Taxation project that the average premium per person covered (including dependents) in the nongroup market would be about 10 percent to 13 percent higher in 2016 than the average premium would have been under prior law. Comparable increases may or may not apply to employer group health plans. Similar comprehensive coverage requirements in Massachusetts, for example, have led to significant premium increases in the individual and group markets. Such future rate increases under PPACA could face government regulation. On April 20, 2010, the U.S. Senate Committee on Health, Education, Labor & Pensions held hearings on new legislation that would give the Secretary of Health and Human Services the power to review premiums and block "any rate increase found to be unreasonable."

More Significant Changes to Come and the Limited Scope of This Alert

In future years, more significant provisions affecting employer group health plans will become effective. Primary among these changes are new mandates to require employers to offer coverage to employees, and, in the case of individuals, to obtain coverage.

Future Alerts in this series will cover the following topics:

- Changes to Design and Operation of Employer Group Health Plans Effective for Plan Years Beginning on or after January 1, 2014
- New Mandate on Large and Mid-Sized Employers to Provide Coverage
- Automatic Enrollment of Employees of Large Employers
- New Mandate on Individuals to Purchase Minimum Essential Coverage
- Government Subsidies for Low- and Middle-Income Individuals
- Guaranteed Renewal of Group Health Insurance
- Limits on Factors That May Be Used in Premium Ratings
- New Long-Term Care Insurance Program
- Increased Medicare Tax on High-Income Individuals

In addition, the Hinshaw & Culbertson LLP's Health Care Practice Group has issued a series of Alerts on how the new legislation affects health care providers. These Alerts can be viewed on our website at:http://www.hinshawlaw.com/newsroom-publications.html

Upcoming Breakfast Briefing and Additional Information
Hinshaw's Labor and Employment Practice Group will host a breakfast briefing on how health care reform affects employers on Wednesday, April 28, 2010 at 8:30 AM. If you are interested in attending, please contact Renee Odom by email at rodom@hinshawlaw.com or by telephone at 312-704-3050.

For additional information, please contact James D. Harbert, Anthony E. Antognoli, Lisa M. Burman, or your regular Hinshaw attorney.

This alert has been prepared by Hinshaw & Culbertson LLP to provide information on recent legal developments of interest to our readers. It is not intended to provide legal advice for a specific situation or to create an attorney-client relationship.