



Health Reform-Impact on Employer-Sponsored Health Plans

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, followed by the Health Care and Education Reconciliation Act of 2010 on March 30, 2010 (collectively, "PPACA"). The passage of these healthcare reform laws will have a far-reaching impact on a number of areas. The purpose of this Client Advisory is to highlight the effect of the PPACA on employer-sponsored benefit plans, with particular focus on the changes that will occur during the next year and a half.

The underlying purpose of the PPACA is to require all individuals to be covered by either an employer-sponsored group health plan or by an individual health insurance policy providing "minimum essential coverage." Key elements of the PPACA include incentives and penalties that are designed to encourage large employers to offer health care coverage to their employees, coupled with incentives and penalties to encourage individuals to obtain health care coverage.

Effective Dates

For the most part, much of the PPACA is not effective until 2013-2014. That is welcome news, meaning that there is plenty of time to review the new laws and required changes. It also means that the government will provide us with regulations, technical corrections, and other guidance in the future as the rules for employers are refined.

Immediate Changes

The PPACA does, however, contain provisions that require immediate attention.

Retiree Drug Subsidy Taxation. The PPACA eliminates the federal subsidy that employers receive for their Medicare Part D prescription drug coverage. The deduction is disallowed starting in 2013, but accounting rules require employers to recognize the tax liability of the effects of the future deduction disallowance on current company financial statements.

Retiree Medical Reinsurance Program. Effective June 21, 2010, the PPACA establishes a temporary reinsurance program to help employers with the cost of certain early retiree medical claims. Employers will be reimbursed for 80% of the claims between \$15,000 and \$90,000 for retirees aged 55 through 64. The program will expire at the end of 2013 or, earlier, when the \$5 billion in funding is exhausted.

Small Employer Tax Credit. Beginning in 2010, employers with fewer than 25 employees and average annual wages of less than \$50,000 will be eligible to apply for a sliding scale tax credit if they offer health insurance to employees and subsidize, on a uniform basis, at least 50% of the cost of coverage.

Changes for the Next Plan Year

The PPACA contains provisions that become effective for the first plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans).

Coverage of Adult Dependent Children Until Age 26. The PPACA requires health plans to cover dependent children (married or unmarried) until they reach age 26.



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Until the first plan year beginning on or after September 23, 2013 (January 1, 2014 for calendar year plans), group health plans are required to provide coverage for children up to age 26 only if they are not eligible to enroll in another employer-sponsored group health plan. Coverage for adult children will be exempt from federal income tax. An "Adult Child" is a son, daughter, step-child, or legally adopted or eligible foster child of the employee.

No Lifetime Maximum. Health plans may not establish lifetime limits on the amount of plan benefits that are essential health benefits (the scope of which is to be determined by the Secretary of Health and Human Services).

Annual Maximum. Health plans may not impose annual limits on essential health benefits, effective for plan years beginning after December 31, 2013. Until 2014, employers may apply some limits to essential benefits as long as those limits will not violate other federal or state laws.

Pre-existing Condition Exclusions. The PPACA prohibits the application of pre-existing condition exclusions for plan years beginning on or after January 1, 2014. Note, however, that for children who are under age 19, this prohibition applies to plan years beginning after September 23, 2010.

Prohibition on Rescissions. Health plans are prevented from rescinding health coverage once an individual is covered under the plan, unless the individual acted fraudulently or made an intentional misrepresentation of a material fact.

60-Day Prior Notice of Material Modification. The PPACA now requires health plans to provide 60 days prior notice of a material modification. This will create timing and notification issues for changes associated with the annual enrollment process and, for the first

time, prevent employers from immediately changing the plan terms during a plan year.

Expansion of Nondiscrimination Testing. The nondiscrimination rules (presently only applicable to self-insured medical programs under Internal Revenue Code Section 105(h)) will now extend to insured health/medical plans, such that insured medical programs will no longer be allowed to favor high paid/owner employees in areas of eligibility for participation and available benefits. See "Grandfather Rules" below for the application of this rule to grandfathered plans.

Appeals and Reviews of Claims. The PPACA requires health plans to adopt ERISA-like claims and appeals processes but goes further than current ERISA rules by guaranteeing the receipt of benefits during the appeals process and also requiring an external review process. See "Grandfather Rules" below for the application of this rule to grandfathered plans.

Preventive Services. The PPACA requires health plans to cover certain preventive services such as immunizations and infant preventive care and screenings without cost to the employee. See "Grandfather Rules" below for the application of this rule to grandfathered plans.

Primary Care Physicians. Health plans that require the designation of a primary care provider must permit the designation of any participating primary care provider, with special rules for emergency services, pediatric care, and ob-gyn care. See "Grandfather Rules" below for the application of this rule to grandfathered plans.

Grandfather Rules. The PPACA contains limited provisions that exempt parts of existing health plans from the application of some of the new law's provisions. PPACA defines a "grandfathered health plan" as a group health plan



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or health insurance coverage in which an individual was enrolled on March 23, 2010. Future guidance is expected that will clarify the grandfather requirements and what changes made to a plan can cause the plan to lose grandfather status.

Changes Effective January 1, 2011

The following provisions of the PPACA are effective January 1, 2011, regardless of the plan year of an employer-sponsored group health plan.

Form W-2 Reporting. The PPACA requires employers to report the aggregate cost of an employee's employer-sponsored group health plan coverage for 2011 on the Form W-2 issued in January 2012. The aggregate cost is to be determined under rules similar to the rules used for calculating COBRA costs.

Over-the-Counter Drugs Ineligible for Pre-Tax Reimbursement. Flexible spending accounts (FSAs), health savings accounts (HSAs), and health reimbursement accounts (HRAs) may not reimburse the cost of over-the-counter drugs other than insulin or those prescribed by a doctor.

Higher Penalties for HSA and Archer MSA. The excise tax for withdrawals of amounts from an HSA or Archer MSA for non-medical expenses prior to age 65 increases from 10 percent to 20 percent.

Small Employer "Simple" Cafeteria Plans. Small employers (i.e., employers with an average of 100 or fewer employees in either of the two prior calendar years) may avoid the cafeteria plan nondiscrimination requirements by adopting a "simple" cafeteria plan and making an employer contribution on behalf of each eligible employee. Certain eligibility, participation, and contribution requirements apply.

CLASS Act Program Established. The PPACA creates a new national employee-funded long-term care

benefit known as the Community Living Assistance Services and Supports Act. The program provides benefits to participants who have a qualifying disability after the participant has contributed to the program for at least five years. While involvement is voluntary, the government is encouraging employers to participate in the CLASS Act and to adopt automatic enrollment rules that default employees into the CLASS Act.

Unclear Effective Date

At some point after enactment, employers are required under the Fair Labor Standards Act to automatically enroll new employees in their health plans, subject to a waiting period. There has been no effective date released for this requirement. From unofficial discussions with Department of Labor representatives, we believe this will begin in 2012 or 2013.

Changes Effective Further into the Future

The PPACA has many provisions that are effective in 2012 and beyond. We note these provisions for you, but we expect many of these provisions to change considerably over the next few years as the government releases future guidance and fine tunes parts of the PPACA.

2012

- All plans must pay a \$2 per participant fee to finance the newly established Patient-Centered Outcomes Research Trust Fund.
- A uniform explanation of coverage document must be distributed to plan participants.

2013

- Contributions to health FSAs are capped at \$2,500 annually.
- Employees (but not their employers) are subject to an additional 0.9% Medicare Hospital Insurance payroll tax (i.e., a total of 2.35%) if their wages exceed \$200,000 for a single taxpayer (or \$250,000 for joint filers).



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- Employers must inform employees about the new state-based Exchanges that will start in 2014, whether the employer subsidizes 60% of any employer-provided coverage, and whether purchasing coverage through an Exchange may result in losing the employer subsidy for the employer-provided coverage.

2014

- Employer must give certain employees the option of enrolling in the group health plan or receiving a voucher with which to purchase insurance from the new state-based Exchanges.
- Employers with 50 or more full-time equivalent (FTE) employees are subject to \$2,000 penalty per FTE employee if it does not offer “qualifying” coverage and it has at least one FTE employee who receives a federal premium tax credit or cost-sharing subsidy.

2018

- High-cost (“Cadillac”) plans with total health coverage costs exceeding specified dollar thresholds are subject to a 40% excise tax, collected from

insurance companies and self-insured employers.

Conclusion

The effects of the PPACA on group health plans will vary according to many factors, including, for example, whether the plan sponsor is large or small, whether the employer purchases insurance or self-insures, whether plan participants qualify for federal assistance, and whether the employer-provided benefits offered can satisfy the “qualifying” standards. Nearly all plans will face numerous challenges in administrative systems and processes, employee communications, and benefit program design changes. Until regulations and future guidance are issued by the various agencies, many of the details about the implementation of the new requirements will not be known.

For more information on the effect PPACA on employer-sponsored benefit plans, employee benefits, or other employment law issues, please contact Kimberly W. Daniel or Ryan Waid at (804) 967-9604 or by email (kdaniel@hdjn.com or rwaid@hdjn.com).

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