ALERT

HEALTH CARE REFORM FOR EMPLOYERS

June 16, 2010

Don't panic! Yes, it's true that Congress has, in fact, enacted a major health care bill called the Patient Protection and Affordable Care Act ("PPACA"). It's also true that this new law is more than 900 pages long, filled with highly complicated (and often deliberately vague) language, and many things will be changing over the next several years.

This is an important and far-reaching law that will affect *every* employer. However, there's no need to rush into making important and long lasting decisions, in part because there is still an awful lot about the PPACA that is unknown.

Although you might expect a 900-page law to contain some fairly detailed provisions, this law does not, at least when it comes to employers. The PPACA is full of concepts and broad generalities, but Congress left the all-important details to various government agencies to work out. Until these agencies issue detailed regulations that translate concepts into actual rules, there is really no way to say exactly how employers will be affected by the new law – at least not without engaging in some combination of conjecture and speculation.

A few regulations have been issued, including regulations addressing the requirement that coverage be made available to participants' children until they attain age 26 and regulations defining "grandfathered plans." However, many of the key regulations have not yet been released. As the summer progresses, we expect the government agencies that are preparing this guidance to continue issuing regulations. By summer's end, we should all know a lot more than we do now.

As mentioned above, we don't see much to be gained by jumping the gun. There are definitely things that employers will need to do before the end of 2010, particularly as they begin planning for open enrollment. But there is still time to approach this methodically. We think that it makes sense to wait to act until the bulk of government guidance has actually been issued, although it is never too soon to begin thinking about all of this.

In the past, we have presented workshops explaining other significant new laws in plain English, including GUST, EGTRRA, COBRA, and HIPAA Medical Privacy. **We will also be presenting workshops at no cost regarding the PPACA, beginning later this summer. Because your time is valuable, we are intentionally waiting until more regulations are issued so that we can provide you with the information you need to make good decisions.** We anticipate that, by late summer, enough regulations will have been issued to allow us to outline the proper steps you will need to take by the end of 2010. We also intend to send out a series of Alerts regarding the PPACA as additional guidance is issued.

HINKLE ELKOURI
LAW FIRM L.L.C.

Downtown Office 2000 Epic Center • 301 North Main Street, Wichita, KS 67202
East Office 8621 East 21st Street North, Suite 200, Wichita, KS 67206
(316) 267-2000 • www.hinklaw.com

Having said that, we know that some employers may use a fiscal year for their group health plans. If your new plan year begins between September 23 and December 31, 2010, you could potentially face earlier deadlines than other employers. If you are in this situation and we prepared your group health plan documents, please contact us to discuss the steps you might need to take. If we do not currently prepare your plan documents but you have questions, we would be happy to answer them also.

In the meantime, to help you begin thinking about the impact that health care reform will have on your business, we have put together the following partial list of things that you will need to do before the end of this year:

(1) Review and amend "dependent" eligibility conditions to reflect changes made by the "age 26" coverage mandate, including changes relating to "dependents" who are no longer a tax-dependent of an employee;

(2) Develop a notice to be provided to all benefits-eligible employees before the end of this year informing them of the changes made as a result of the new "age 26" coverage mandate;

(3) If you have a health flexible spending account plan, be prepared to amend your document and explain to participants that, beginning next year, they will no longer be able to seek reimbursement for over-the-counter drugs unless they have a prescription for that over-the-counter drug; and

(4) Be aware that, starting next year, you may no longer be able to offer insured plans solely to your executives and/or highly compensated individuals. There are nondiscrimination rules that will become applicable to those types of plans.

Please note that this is only a partial list and, as we have said above, it is difficult to answer detailed questions about these steps until the federal agencies issue more regulatory guidance.

Finally, to help give you an idea about what you will need to be focusing on, we are enclosing a list of the major aspects of the PPACA, organized by when they are effective. Again, many of these requirements exist more as concepts than anything else and, until detailed rules are issued, it is difficult to know exactly how they will end up affecting employers. We hope the attached list is a helpful beginning for you.

If you have any questions regarding the impact of health care reform on employers, please feel free, as always, to call Eric Namee, Steven Smith, Ruhe Wadud Rutter, or Brad Schlozman at (316) 267-2000.

HINKLE ELKOURI
LAW FIRM L.L.C.
Downtown Office 2000 Epic Center • 301 North Main Street, Wichita, KS 67202
East Office 8621 East 21st Street North, Suite 200, Wichita, KS 67206
(316) 267-2000 • www.hinklaw.com

HINKLE ELKOURI
LAW FIRM L.L.C.

June 16, 2010

SUMMARY OF KEY HEALTH CARE REFORM CHANGES

The following are major features of the Patient Protection and Affordable Care Act ("PPACA") that affects employers. They are categorized below by their effective dates.

I. – PROVISIONS ALREADY EFFECTIVE

- **Early Retiree Reinsurance Program.** The health care bill established a temporary insurance program (which will lapse on 1/1/2014, when Exchanges become available) to provide reimbursement to participating employer health plans for the cost of providing health coverage to early retirees (age 55 or older who are not eligible for Medicare) and their dependents. Employers must apply to participate in the program. Reimbursements are limited to 80% of the cost of benefits that are between $15,000-$90,000, and may only be used to reduce retiree costs (e.g., premiums, co-insurance, or deductibles) and may not be treated as general revenue. Funding for the program is capped at $5 billion. This provision took effect June 1, 2010. [*HHS published regulations applicable to the program on 5/5/2010.*]
- **Small Employer Tax Credit for Employee Health Insurance.** A new tax credit was established for small employers who provide health insurance to their employees. To be eligible, (i) an employer must have fewer than 25 full-time equivalent employees, (ii) the average annual wage of the employer's employees must be less than $50,000, and (iii) the employer must pay a uniform percentage (of at least 50%) of the cost of each of its employees' health care premiums under the employer's plan. This provision was made effective for the 2010 tax year. [*IRS issued guidance applicable to this issue on 6/1/2010.*]

II. – PROVISIONS EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER SEPTEMBER 23, 2010

A. – Provisions Affecting Insured or Self-Funded Coverage

- **Annual Benefits Limit.** Group health plans may not establish "unreasonable" annual limits on the "essential health benefits" of a participant or beneficiary. "Reasonable" annual limits will be permitted until 1/1/2014. [*HHS must issue regulations on what annual limits are "unreasonable" as well as the scope of "essential health benefits."*]
- **Coverage of Preventive Services.** Group health plans must provide certain preventive services and may not impose any cost-sharing requirements (e.g., co-payment or deductible) on these benefits. "Grandfathered plans" are not subject to this requirement until January 1, 2014. [*A determination of what preventive services must be covered will be determined by a newly created federal advisory board – the "Preventive Services Task Force" – which has yet to be convened; HHS/DOL/IRS jointly issued regulations on what constitutes a "grandfathered plan" on 6/14/2010.*]

- **Emergency Room Services Coverage.** If group health plans offer coverage for emergency services, coverage (i) cannot be limited to in-network providers, (ii) cannot include higher cost-sharing for out-of-network providers, and (iii) cannot require pre-authorization. "Grandfathered plans" are not subject to this requirement.

- **Lifetime Benefits Limit.** Group health plans may not impose any lifetime limits on the "essential health benefits" of a participant or beneficiary. [*HHS must issue regulations on the scope of "essential health benefits."*]

- **OB/GYN Services.** Group health plan may not require preauthorization or referral for OB/GYN services. "Grandfathered plans" are not subject to this requirement.

- **Pre-Existing Condition Exclusion.** Group health plans may not impose any pre-existing conditions on individuals under age 19. This prohibition applies to individuals of all ages – not just those under age 19 -- beginning 1/1/2014. [*HHS must issue regulations to clarify whether the prohibition applies to individuals seeking to enroll in addition to individuals who are already enrolled in the plan.*]

- **Primary Care Physician.** Group health plans that require or provide for a primary care physician designation must allow participants to designate any participating primary care doctor (or pediatrician) who is available. "Grandfathered plans" are not subject to this requirement.

- **Prohibition on Rescissions.** Group health plans may not rescind the health coverage of a participant or beneficiary once he/she is covered under the plan (absent fraud or material misrepresentations).

B. – Provisions Affecting an Employer's Plan Design or Plan Administration Process

- **Appeals Process.** Group health plans must implement an appeals procedure to be used for challenging coverage and claims denials. This procedure must include binding external review, the parameters of which are determined either by state law or HHS regulations. [*HHS must issue regulations detailing exactly what is required under the new appeals process.*]

- **Automatic Enrollment for Plans Sponsored by Employers With More Than 200 Employees.** Group health plans that are sponsored by employers with more than 200 full-time employees must automatically enroll all full-time employees in the plan (with opt-out rights). [*DOL must issue regulations on the effective date of this requirement as well as guidance on how to determine if an employer has more than 200 full-time employees.*]

- **Dependent Care Coverage.** Group health plans must offer dependent coverage up to age 26 for a covered employee's "child" who lacks access to employer-sponsored coverage (other than the employer of either of the child's parents). Coverage must be provided regardless of whether the child is a tax dependent, student, married, or residing with the employee. The exception applicable to a "child" with access to other employer coverage applies only to "grandfathered plans," and the exception goes away effective 1/1/2014. [*IRS published regulations applicable to this issue on 5/13/2010.*]

- **New Disclosure Requirements on Claims Practices.** All group health plans (even self-insured plans) must disclose to HHS and the state insurance commissioner (and make available to the public) certain data on claims denials, rating practices, and cost sharing for out-of-network coverage. [*HHS must issue regulations on what type of information must be disclosed and when the disclosure must be made.*]

- **Non-Discrimination Requirements (Based on Salary) Extended to Insured Plans.** Group health plans utilizing insurance products can no longer discriminate in favor of highly compensated employees. (This prohibition already applies to most self-insured plans, but is now extended to fully insured plans as well.) "Grandfathered plans" are not subject to this requirement.

- **Non-Prescription Drugs Not Eligible for Reimbursement Under HSA and HFSA.**
  - Funds in a Health Savings Account or a Health Flexible Spending Account may be used for reimbursements of medicines and drugs only if the medicine or drug is (i) insulin or (ii) purchased pursuant to a prescription. [*IRS will likely issue guidance on this new requirement*.]
  - In addition, the penalty for nonqualified distributions from Health Savings Accounts increases from 10% to 20%.
  - These new restrictions are effective for expenses incurred on or after January 1, 2011.
- **Reporting of Value of Employer-Provided Coverage on W-2.** Employers providing group health plans must report the aggregate cost of the employer-provided health coverage on each employee's W-2. The reporting requirement does not apply to employee contributions under a Health Savings Account or Health Flexible Spending Account.
- **"Simple" Cafeteria Plans.** Employers with fewer than 100 employees (on average for the preceding two years) may offer a new type of "simple cafeteria plan" that is not subject to the nondiscrimination rules applicable to traditional cafeteria plans. The employer generally must make a uniform contribution (of at least 2%) to each employee who worked at least 1,000 hours during the preceding year. Employers taking advantage of this provision may be able to provide discriminatory benefits for highly compensated employees and enjoy significant tax savings. [*IRS will likely issue guidance on this new arrangement.*]
- **Voluntary Long Term Care Program (the "CLASS Act").** The health care bill established a voluntary federal program for long-term care insurance that will be funded with participant contributions. Employers may (but are not required to) permit employees to purchase coverage via employer-administered payroll deduction. [*HHS must issue regulations on the details of this program.*]

C. – Provisions Affecting Medicare

- **Medicare Advantage – Frozen and Reduced Benefits.** Medicare Advantage payments for 2011 will be frozen at 2010 levels. Further reductions in benchmark payments will be phased in beginning in 2012.
- **Medicare Part D Premiums.** Medicare beneficiaries with high incomes face higher Medicare Part D premiums.

D. – Other Provisions

- **Premium Rebates.** Health insurance companies will be required to pay rebates to their customers if their medical loss ratios fall below a certain percentage. This will affect employers with fully insured plans (although not self-insured plans) because, although it's not clear whether the rebates will be paid to employers or individual participants in the plan, the rebates likely will be plan assets and thus must be distributed to the participants. [*HHS must issue guidance on the proper handling of these rebates.*]
- **Temporary Insurance Program for High-Risk Individuals.** The health care bill established a temporary insurance program (which will lapse on 1/1/2014 and the funding for which is capped at $5 billion) to provide coverage for individuals with preexisting conditions who have not had group health plan coverage for at least six months. If an employer discourages an employee from remaining enrolled on the employer's health care plan and encourages that the employee sign up for the federal insurance program instead, the employer may be required to reimburse the government for the cost of the individual's coverage under the federal insurance program. [*Some of these programs are being administered by the States (including Kansas) and these States must issue guidance on how the programs will be implemented. In addition, HHS also must issue guidance or regulations on its own program.*]

III. – PROVISIONS EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER JANUARY 1, 2012

- **New Fee Imposed on All Health Care Plans.** All group health plans (including self-insured plans) must pay a fee to the government of $1 for each participant in the plan. (The fee doubles to $2 beginning in 2013.) The funds raised from this fee will go to a newly established "Patient-Centered Outcomes Research Trust Fund." This fee sunsets in 2019.

IV. – PROVISIONS EFFECTIVE MARCH 23, 2012

- **Increased Plan Summary Information and Advance Notice of Material Modifications.** Group health plans must distribute a plan summary to all participants that is no greater than 4 pages, contains certain specified information, follows a uniform format, and is written in plain English. This new summary will be *in addition to* the Summary Plan Description that plans already are required to distribute. Moreover, material modifications to the plan that impact the information required in the summary must now be distributed to participants 60 days before they take effect. A $1,000 fine (per participant) will be imposed for willful failures to provide this summary document. [*HHS must issue regulations on the required format and content of the new summary. Although the statute provides that these requirements will go into effect on 3/23/2012, it is conceivable that HHS regulations will postpone the effective date until the first plan year after 3/23/2012*.]

V. – PROVISIONS EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER JANUARY 1, 2013

- **Reduced Maximum Salary Contribution to Health Flexible Spending Account.** Employees may contribute a maximum of $2,500 per year to their Health Flexible Spending Account. This $2,500 limit must be prorated for periods of participation of less than one year. (Under current law, there is no maximum limit on contributions, although many employers voluntarily impose a limit under their plans.) [*IRS will likely issue guidance on this new requirement.*]
- **New Reporting Requirements on Wellness Programs.** Group health plans must submit an annual report to HHS on the wellness and prevention programs offered under the plan and how effective (or ineffective) such programs have been. [*HHS must issue regulations by 3/23/2012 on the reporting requirements. Presumably this reporting obligation will not commence until plan years beginning on or after 01/01/2013.*]
- **Required Notice Regarding Health Insurance Exchange.**
  - Employers must notify all employees about health insurance Exchanges and the employees' potential eligibility for a federal subsidy towards the cost of insurance under the Exchange.
    - Employees may be eligible for a subsidy to buy Exchange-based coverage if their employer's plan pays less than 60% of covered benefits.
  - This notice requirement takes effect 3/1/2013. The notice must be provided to current employees no later than 3/1/2013. Notice must be provided to individuals hired on or after 3/1/2013 at the time of hire. *[HHS will need to issue guidance on the requirements of this notice.]*

- **Increased Medicare Taxes for High-Income Individuals.**
  - An additional 0.9% Medicare tax (increasing the current tax from 1.45% to 2.35%) will be imposed on taxpayers with wages over $200,000/individual or $250,000/joint return. This additional tax will apply only to the employee and not to the employer's share of the tax.
  - In addition, a new annual tax of 3.8% will also be assessed on the "net investment income" (i.e., interest, dividends, annuities, royalties, etc.,) of these same individuals. The new tax will not apply to qualified plan distributions. The tax will apply to the lesser of the "net investment income" or the individual's/family's income in excess of $200,000/individual or $250,000/joint return.
- **Elimination of Employer's Deduction for Medicare Part D Subsidy.**
  - Under current law, employers who provide prescription coverage to retirees receive a subsidy for such coverage under Medicare Part D. The subsidy is in addition to any tax deduction the employer receives, and is designed to discourage employers from dropping the prescription coverage and having retirees rely solely on Medicare Part D for prescription benefits. Beginning 1/1/2013, the employer's deduction will be eliminated. Thus, no more "double dipping."
  - This change may force many companies to make a reduction in their deferred tax assets, resulting in an immediate (i.e., 2010) accounting charge.
- **Tax on Medical Devices.** A 2.9% tax will apply to all sales of medical devices (excluding eyeglasses, contact lenses, hearing aids, and any other device that HHS determines is of a type generally purchased by the public at retail for individual use). [*HHS must issue regulations on what types of medical devices are not subject to the additional tax.*]

VI. – PROVISIONS EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER JANUARY 1, 2014

- **Certain "Grandfathered Plan" Exceptions and Other Transition Rules Expire.**
  - Group health plans must offer coverage to participant's dependent "child" until age 26, *regardless of whether the "child" has access to other employer coverage.*
  - Group health plans may not impose any preexisting condition exclusions.
  - Group health plans may not impose any annual dollar limits on "essential benefits".
- **Mandatory Coverage of Clinical Trials.** Group health plans may not deny "qualifying individuals" from participating in certain clinical trials, may not deny coverage of routine patient costs for items and services furnished in connection with the clinical trials, and may not discriminate against individuals who participate in the clinical trials. "Grandfathered plans" are not subject to this requirement. [*HHS likely will issue additional guidance and/or regulations on this issue.*]
- **Restricted Waiting Periods.** Group health plans may not impose any waiting periods exceeding 90 days.
- **Maximum Cost Sharing (i.e., co-payments and deductibles).**
  - Group health plans may not impose an annual deductible in excess of $2,000 (for self-only coverage) or $4,000 (for family coverage). These figures will be adjusted for inflation.
  - Group health plans may not impose total annual out-of-pocket expenses of more than the maximum out-of-pocket expenses applicable to a high-deductible health plan for self-only or family coverage (as applicable).
  - "Grandfathered plans" are not subject to these requirements.

- **HIPAA Wellness Incentive Limit Increased By 30%.**
  - HIPAA's limit on the premium discount incentives that group health plans may offer to participants for participation in a wellness program is increased to 30% (up from 20%). Thus, plans may now offer up to a 30% discount off the total cost of coverage for participation in a wellness program.
  - Secretaries of HHS, Labor, and Treasury have authority to further raise the limit to 50%.
- **Individual coverage mandate.**
  - All individuals must obtain "minimum essential coverage" for their health care or else pay a penalty to the federal government. [*HHS must issue regulations defining the scope of "minimum essential coverage."*]
    - Penalties will not apply to (i) an individual whose lowest cost plan option – either employer-sponsored plan or plan purchased on individual market – exceeds 8% of his/her adjusted gross income, (ii) an individual whose income is below the tax filing threshold, or (iii) gaps in coverage of less than 3 months.
  - Penalty would be the *greater of* a flat dollar amount ($95 in 2010, rising to $325 in 2015, $695 in 2016, and indexed for inflation thereafter) or a percentage of the individual's income (1% in 2014, rising to 2% in 2015, and to 2.5% in 2016).
- **Health Insurance Exchanges.**
  - Each state must establish an Exchange through which individuals and employers may purchase health coverage under qualified plans participating in the Exchange. (Multi-state Exchanges and geographically-based Exchanges will also be permitted.) The federal government will fund the creation of the Exchanges. (If a state fails to establish an Exchange, HHS will establish and maintain one (directly or through some non-profit entity). [*HHS, as well as the various States, must issue guidance and/or regulations on the details of these Exchanges.*]
  - Employers with 50 or fewer employees (threshold increases to 100 in 2016) may rely on a plan in the Exchange to provide its employees with health coverage, and thus offer the Exchange plan through the employer's cafeteria plan.
  - The federal government will provide income-based assistance for the purchase of coverage under the Exchange for individuals or families with incomes below 400% of the federal poverty level.
- **Employer Penalties for Not Providing Adequate Health Care Coverage to Employees.**
  - If an employer with at least 50 full-time equivalent employees (FTEs) (defined as employees working at least 30 hours/week, with part-time employees converted into FTEs by dividing their average monthly hours by 120) fails to offer "minimum essential" health coverage to all its FTEs, and at least one of those full-time employees enrolls in and receives an income-based tax credit to participate in a health care plan under the Exchange in any month, the employer must pay a penalty to the federal government for that month.
    - The penalty is roughly $167 (1/12 of $2,000) for every FTE in the employer's workforce (disregarding the first 30 employees) per month. For example, if an employer with 51 FTEs does not offer minimum essential coverage, and 1 employee enrolls in and receives an income-based tax credit to participate in a health care plan under the Exchange, the employer must pay a monthly penalty of 21 times the FTE penalty for the month (i.e., $167 x 21 = $3,507). These penalties will be indexed for inflation after 2014.
  - Even if an employer with at least 50 FTEs does offer "minimum essential" health coverage to all its FTEs, if one or more of those full-time employees opt out of the employer's plan and receives an income-based tax credit to participate in a health care plan under the Exchange in a given month, the employer still must pay a penalty to the federal government for that month.

        - The penalty is $250 (1/12 of $3,000) per month for each FTE in the employer's workforce who opts out of the employer's plan and receives an income-based tax credit to participate in a health care plan under the Exchange during that month. (The total potential penalty is capped at the penalty figure applicable to an employer who fails to provide minimum essential coverage to its employees, as described above.) These penalties will be indexed for inflation after 2014.
    - [*IRS will likely issue additional regulations and/or guidance on this new penalty.*]

- **"Free Choice" Vouchers for Certain Employees.**
    - Employers offering health care plans must offer "free choice" vouchers to any employee with household income at or below 400% of the federal poverty level if the employee's cost of premiums under the employer's plan would be between 8% and 9.8% of the employee's household income. The amount of the voucher must be equal to the highest contribution that the employer would make to the plan on the employee's behalf.
    - The vouchers must be used to purchase coverage from a health insurance Exchange.
    - If the cost of coverage on the Exchange is less than the amount of the voucher, the employee can pocket the difference.
    - The voucher is tax deductible to the employer and not taxable to the employee.
    - [*HHS must issue regulations and/or guidance on this new requirement.*]
- **Reporting Requirement for Employers Providing Minimal Essential Coverage to Employees.**
    - Employers providing "minimum essential coverage" to employees under a company health plan must file a return with the IRS containing information about each covered person in the plan. This requirement applies to both fully-insured and self-insured plans. (If the plan is fully insured, the reporting obligation falls upon the insurer; if the plan is self-insured, the reporting obligation falls upon the employer.) [*IRS must issue regulations and/or guidance on this new requirement.*]
    - The IRS will notify each taxpayer who files a return but is not enrolled in minimum essential coverage (either through an employer or on the individual insurance market).

VII. – PROVISIONS EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER JANUARY 1, 2018

- **Excise Tax on "Cadillac Plans."**
    - A nondeductible 40% excise tax will be imposed on employers offering self-insured health care plans in which the cost of coverage exceeds $10,200 (in the case of individual coverage) or $27,500 (in the case of family coverage). In the case of fully-insured plans, the excise tax technically falls upon the insurer, but this tax will likely be passed on to the employer and/or participants. The tax applies to the value of the coverage exceeding the aforementioned levels, and will be adjusted for inflation in subsequent years.
    - The tax is <u>not</u> applicable to stand-alone dental and vision plans.
    - [*HHS will need to issue guidance on how to calculate the cost of coverage and what amounts are subject to the legal limits.*]