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An Employers Perspective on Health Care Reform Summary Timeline and Recent Guidance on Grandfathered Health Plans

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Introduction

Health care reform at the federal level—the result of the Patient Protection and Affordable Care Act (signed into law on March 23, 2010), as amended by the Health Care and Education Reconciliation Act (signed into law on March 30, 2010)—will affect U.S. employers and their health plans (whether insured or self-insured) in a phased manner through 2018. The coverage mandates of the new law ("PPACA") become effective at various dates, the earliest of which is the first plan year beginning six months after the March 23, 2010 date of enactment. For a calendar year plan, this will be January 1, 2011.

Grandfathered plans

PPACA contains a critical distinction between "grandfathered" and "non-grandfathered" plans, since the former category will be permanently exempt from some, but not all, coverage mandates, but will not escape the new law's taxes and reporting requirements. A grandfathered plan is generally one that was in effect on March 23, 2010. Such a plan's grandfathered status extends not only to employees and their family members enrolled on that date, but also to later added family members of already enrolled employees and to new employees (whether newly hired or newly enrolled) and their family members.

Under interim final regulations jointly issued by the Department of Labor ("DOL"), the Department of Health and Human Services ("HHS") and the Department of the Treasury ("Treasury") on June 14, 2010, a plan's grandfathered status can be lost in the following ways:

- Eliminating all or substantially all benefits to diagnose or treat a particular condition;
- Increasing a percentage cost-sharing requirement (such as coinsurance) above the level where it was on March 23, 2010;
- Increasing a fixed-amount cost-sharing requirement (other than a copayment) by a total percentage measured from March 23, 2010 that is greater than the sum of medical inflation[1] plus 15%;
- Increasing a fixed-amount copayment by an amount that exceeds the greater of (1) $5 increased by medical inflation measured from March 23, 2010 or (2) the sum of medical inflation plus 15%;
- Decreasing the employer's or employee organization's contribution toward the cost of coverage by more than 5% below the contribution rate on March 23, 2010;
- Adding an annual limit, adding an annual limit lower than the dollar value of the lifetime limit on March 23, 2010, or decreasing the dollar value of an annual limit in effect on March 23, 2010; or
- Transferring employees into a health plan or health insurance coverage from a plan or coverage under which they were covered on March 23, 2010 if the change in terms, when treated as an amendment of the original plan or coverage, would cause a loss of grandfathered status for the reasons outlined immediately above and there was no bona fide employment-based reason to transfer the employees.

In addition, preservation of a health plan's grandfathered status requires that an employer include in any materials provided to plan

participants that describe the plan's benefits, a disclosure that the plan is believed to be a grandfathered health plan under PPACA and contact information for questions or complaints. The newly released interim final regulations contain **model language** that can be customized to satisfy this disclosure requirement.

Finally, the interim regulations contain a transition rule for a health plan amendment made after March 23, 2010 and adopted prior to June 14, 2010 that would cause the plan to lose its grandfathered status. If such amendment is reversed as of the first day of the first plan year beginning on or after September 23, 2010, the plan will not lose its grandfathered status.

Summary timeline

Rather than an extensive discussion of the new law's application to employers—which would be subject to subsequent regulations and other guidance—we present here a timeline summary of key provisions and their effective dates, with a particular focus on provisions that become effective over the next two years.[2] Where grandfathered plans are accorded special treatment or exemption from a particular provision, that will be noted. In addition, the timeline will note distinctions between requirements that may or may not apply to an employer due to the number of individuals employed.

Summary Timeline

Tax Years Beginning On or After December 31, 2009

Small Employer Tax Credit: Under new Section 45R of the Internal Revenue Code (the "Code"), employers with 25 or fewer full-time equivalent employees ("FTEs")[3] and average annual wages of $50,000 or less are eligible for a tax credit based on the premiums paid by the employer for tax years beginning after 2009 so long as the employer pays at least 50% of the premium cost. The amount of the credit depends on the number of employees and average annual wages.

Date of Enactment (But Pending Regulatory Guidance)

Automatic Enrollment: Once regulations are issued by the DOL, employers with more than 200 full-time employees that offer health plan coverage must automatically enroll new full-time employees, subject to notice and opportunity to opt out. This mandate applies to grandfathered and non-grandfathered plans.

Plan Years Beginning On or After September 23, 2010

Grandfathered and Non-Grandfathered Plans:

- **Lifetime Limits:** No lifetime limits on dollar value of "essential health benefits" (to be defined in regulations) allowed for any participant or beneficiary.
- **Annual Limits:** Annual limits on the dollar value of "essential health benefits" allowed on a restricted basis only, with annual limits completely prohibited in 2014.
- **Pre-Existing Conditions for Children:** No excluding children under age 19 based on pre-existing condition and no refusal to pay expenses for pre-existing condition of a child under age 19.
- **Coverage of Adult Children:** Plan offering dependent child coverage must make coverage available for adult children, regardless of marital status, until age 26; coverage need not be extended to children of the adult child or the spouse of the adult child. For grandfathered plans, coverage must be made available only if the child does not have other employer-provided coverage; in 2014, grandfathered plans must make coverage available in all cases, even if child has other employer-provided coverage. Interim final regulations issued on May 10, 2010 indicate that a child under age 26 who previously lost dependent

coverage (or who was previously denied dependent coverage) due to aging out of eligibility for such coverage must be given a new opportunity to enroll in coverage.[4]

- **Prohibition on Rescission:** Plan prohibited from rescinding enrollee's coverage except in the case of fraud or intentional misrepresentation of material fact as stated in the plan document.

Non-Grandfathered Plans:

- **Preventive Care:** Certain screenings and preventive care, including specified immunizations, must be provided without cost-sharing.
- **Emergency Services**: Plan offering emergency services must cover emergency services without prior authorization, regardless of whether the provider is in network and using same cost-sharing as in-network provider.
- **Designation of Primary Care Provider:** Participant must be allowed to select any primary care provider in the plan's network, including a pediatrician for a child. Female participant or beneficiary must be able to obtain ob/gyn services without a referral from a primary care provider.
- **Claims and Appeals Process:** Plans must establish internal claims and appeals procedures that satisfy existing ERISA requirements (employer-provided plans in private sector already subject to such requirements) and external appeals procedures that comply with state law (insured plans) or DOL regulations (self-funded plans). Must provide notification of such procedures in a "culturally and linguistically appropriate manner" and must identify the ombudsman's office created under the PPACA to assist with appeals.
- **Nondiscrimination Rules for Insured Group Health Plans:** Insured plans will be subject to the nondiscrimination rules of Section 105(h)(2) of the Code, which are intended to prevent discrimination in favor of highly compensated individuals as to health benefits. However, non-compliance results in a penalty of $100 per day per highly-compensated individual imposed on the employer (not an ordinary income tax on the highly-compensated individual's medical reimbursement, as is the case with discriminatory self-funded health plans). Such penalty is capped at the lesser of $500,000 or 10% of the employer's health plan costs. This provision effectively prohibits "executive only" insured health plans and might be interpreted to apply to the practice of paying a departing executive's health insurance/COBRA premiums as part of a separation package.

Tax Years Beginning After December 31, 2010

Over-the-Counter Drugs: Payments for such drugs from a health savings account (an "HSA"), a health reimbursement arrangement (an "HRA"), a health flexible spending account (an "FSA") or an Archer medical savings account (an "Archer MSA") are no longer eligible for nontaxable treatment unless for insulin and over-the-counter drugs prescribed by a physician.

Tax on Nonqualifying Withdrawals: Additional tax on withdrawals for non-medical expenses from an HSA or an Archer MSA is increased to 20% of the amount of the distribution included in gross income.

Annual W-2 Reporting: Aggregate cost of employer-sponsored health coverage (including any dental or vision coverage), whether paid by the employer or the employee, must be reported, for informational purposes only, beginning with the 2011 Form W-2 (issued in January 2012). Such "cost" excludes contributions to an HSA and an Archer MSA, as well as salary reduction contributions to an FSA.

Simple Cafeteria Plans for Small Employers: "Eligible employers" (those employing an average of 100 or fewer employees during either of the two preceding years) will be able to establish a cafeteria plan to provide a menu of benefits (including cash) from which participating employees may select. Such a plan, if it satisfies minimum employer contributions, eligibility and participation requirements, will be exempt from meeting applicable nondiscrimination requirements, which might reduce significantly the cost of plan administration.

On or Before March 23, 2012

Summary of Coverage: In addition to the summary plan description (SPD) required by ERISA, a short (four pages or less) summary of plan benefits must be provided to all participants and applicants in a format to be developed by HHS. In addition, any material modification to the terms or coverage of a group health plan that is not addressed in the most recent summary must be described in a notice to enrollees provided at least 60 days before the effective date of such modification.

Tax Years Beginning After December 31, 2012

Cap on Health FSAs: Cafeteria plan must provide for an annual cap of $2,500 on salary reduction contributions to a health FSA thereunder. If plan terms do not prohibit salary reduction contributions in excess of $2,500, employee will be subject to tax on distributions from the health FSA.

On or Before March 1, 2013

Notice to Employees about Insurance Exchange, Premium Credits and Vouchers: Employers must provide to current employees (and to new employees at hiring) a written notice about (1) the existence of an insurance exchange, including services and contact information; (2) the employee's potential eligibility for premium credits and cost-sharing subsidies if the employer plan's share of covered health care expenses is less than 60%, and (3) the employee's potential loss of any employer contribution if the employee purchases a plan through an exchange that is not eligible for a free choice voucher.

Plan Years Beginning After December 31, 2013

Employer Mandates:

- **Play or Pay:** Employers with 50 or more FTEs[5] with at least one full-time employee receiving a premium credit or cost-sharing reduction for coverage through a state health insurance exchange (rather than through the employer's health plan) will be:
  - Subject to a penalty of $2000 per full-time employee (excluding first 30) if employer does not offer "minimum essential coverage"[6]
  - Subject to a penalty of $3,000 per full-time employee receiving a premium credit or, if less, $2,000 per full-time employee (excluding first 30 employees) if employer does offer minimum essential coverage but either such coverage is not affordable[7] or such coverage consists of a plan that pays for less than 60%, on average, of covered health expenses
- **Employer Free Choice Vouchers:** Employer that offers (and pays any part of the cost of) minimum essential coverage is required to provide free choice vouchers to qualified employees.[8] A qualified employee is an employee whose share of the cost of minimum essential coverage exceeds 8% (but is less than or equal to 9.8%) of the employee's household income, whose household income is not greater than 400% of the federal poverty level and who does not participate in the employer-sponsored plan. Amount of voucher is the largest amount the employer pays toward the monthly premium cost of health coverage under the employer's health plan(s) and is deductible by the employer as a compensation expense. Amount of voucher is not taxable to the qualified employee to the extent used to pay for health coverage through an insurance exchange, but any excess is taxable.

Insurance Market Reforms:

- **Prohibition Against Any Pre-Existing Condition:** Both grandfathered and non-grandfathered plans are prohibited from denying health coverage for a pre-existing condition.
- **No Enrollment Waiting Period Greater than 90 Days:** Both grandfathered and non-grandfathered plans are prohibited from imposing an enrollment waiting period longer than 90 days.
- **Guaranteed Availability:** Insurance carriers must accept every employer and individual in the state who applies for coverage.
- **Guaranteed Renewability:** Insurance carriers must renew every employer's and every individual's coverage upon request.

Cost-sharing Limits: Non-grandfathered plan is prohibited from imposing cost-sharing with respect to an essential health benefits

package[9] in excess of the out-of-pocket limits applicable to high-deductible health plans (currently $5,950 for individual coverage and $11,900 for family coverage). In addition, a non-grandfathered plan in the small employer market[10] is prohibited from imposing a maximum deductible in excess of $2,000 for individual coverage and $4,000 for family coverage.

Employer Health Coverage Reporting: Employers must annually report to the Secretary of the Treasury and to each covered individual (1) whether they offer minimum essential coverage to full-time employees and dependents, (2) the length of any applicable waiting period, (3) monthly premium for the lowest-cost option in each enrollment category under the plan, (4) the plan's share of covered health care expenses, and (5) the total number, names, addresses and tax identification numbers of full-time employees receiving health coverage, as well as the number of months covered under the plan.

Wellness Program Incentives: Financial incentive for participating in wellness program that is part of a group health plan can equal up to 30%[11] of the cost of such coverage (based on the COBRA cost of coverage).

Tax Years Beginning after December 31, 2017

Excise Tax on High Cost Health Plans: A 40% excise tax applies to the excess of the aggregate cost of employer-sponsored health coverage for an employee (including any former employee or surviving spouse) over a threshold of $10,200 (single coverage) and $27,500 (family coverage).[12] Cost of employer-sponsored health coverage includes both the employer's cost and the employee's cost of any group health coverage (insured and/or self-insured) offered to an employee plus reimbursements under an FSA or an HRA, contributions to an HSA or an Archer MSA but excludes stand-alone dental and/or vision coverage.

The excise tax is imposed on the insurance carrier in the case of insured health benefits and on the employer in the case of self-insured/self-funded health benefits. Employers must calculate the aggregate cost of the coverage and the amount of the excise tax and then allocate the excise tax between the carrier(s) and itself.

Employer action steps

The recommended action plan for employers begins with documenting the terms of any health plan or health insurance policy in place on March 23, 2010. This will establish a baseline against which any proposed changes can be evaluated to determine whether grandfathered status would be lost. An employer that believes that its health plan is a "grandfathered health plan" should add the model language contained in the interim final regulations to participant materials describing plan benefits.

In addition, employers should now consult with their broker and/or health insurance carrier about the mandates that will be effective in 2011 (including coverage of adult children, which some carriers are offering immediately). Employers also should identify any health FSA, HSA, FSA plan and Archer MSA plan documents that need to be amended to clarify that over-the-counter drugs are no longer eligible expenses. Finally, employers should consider how to capture the aggregate cost of health coverage provided to each employee so that it can be reported on the 2011 Forms W-2.

PPACA is a far-reaching and somewhat uncoordinated legislative package, for which we expect a continuing stream of published guidance from the various agencies charged with its interpretation and enforcement. We shall keep you informed as guidance that is significant for employers is released.

If you have questions about this *Alert,* please contact one of the attorneys in the Compensation & Benefits Group listed above.

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Notes

1 "Medical inflation" means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) as published by the DOL using the 1982-1984 base of 100.

2 Note that some provisions are effective for "tax years" beginning after a certain date and some are effective for "plan years" beginning after a certain date. Typically the former applies to provisions that mandate requirements for health plans or health insurance and the latter applies to provisions that impose or change certain tax treatment in connection with health benefits.

3 To determine the number of FTEs, each full-time employee working at least 30 hours per week is counted as 1 FTE. A part-time employee (working less than 30 hours per week) is counted as a fraction of an FTE, based on the hours worked by the employee per month divided by 120.

4 On April 27, 2010, the Internal Revenue Service released Notice 2010-38, which provides for a tax exclusion for health coverage and reimbursements for children under age 27, effective March 30, 2010. Note that the tax exclusion applies, for a period of time, to adult children who continue to remain covered beyond the age mandated by PPACA (i.e., until age 26). This was intentional so that coverage beyond that date (for example, where coverage extends to the end of the month in which the child attains age 26) would not result in imputed income on account of such child's coverage beyond age 26.

5 Employers with fewer than 50 FTEs are exempt from the "play or pay" employer mandate. Seasonal workers (those who work up to 120 days per year) are excluded when determining the number of FTEs.

6 Under Section 5000A of the Code, "minimum essential coverage" is defined to include coverage under either a grandfathered or a non-grandfathered employer-sponsored plan.

7 Employer coverage is not affordable if the employee's required contribution toward the premium for self-only coverage exceeds 9.5% of the employee's household income.

8 Employees who qualify for free choice vouchers are not eligible for premium credits.

9 An essential health benefits package must offer coverage for, at a minimum, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and pediatric services.

10 Employers in the small group market are those with 100 or fewer employees.

11 The Secretaries of the DOL, HHS and Treasury may raise the incentive limit to 50%.

12 Thresholds are higher for certain retirees and for others engaged in high-risk professions.

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