SOLUTIONS

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HEALTH CARE REFORM

On March 23, 2010, President Obama signed in to Law the Patient Protection & Affordable Care Act (H.R. 3590), commonly referred to as the "Senate Bill". This was approved by the House of Representatives on Sunday, March 21, 2010. In addition to passing the Senate Bill, the House passed the Health Care & Education Affordability Reconciliation Bill of 2010 (H.R. 4872), also referred to as the "Reconciliation Bill" signed by the President on March 31, 2010. This changed some of the provisions in the Law signed by President Obama on March 23rd.

The Patient Protection and Affordable Care Act and the Reconciliation Act of 2010 (commonly referred to as Health Care Reform) contain complex and far-reaching provisions that are aimed at changing the health care industry and the insurance coverage available to United States citizens and legal residents. They address the providers of health services, individual citizen's rights and obligations, as well as what health care plans (both individual and group) must do to comply. These requirements are stretched out over nearly a ten-year period of time.

The future of these Laws is clouded by many factors which could change the requirements proscribed by their provisions. Several government agencies, most notably, the Department of Health and Human Services (DHHS), the Treasury Department via the Internal Revenue Service (IRS), and the Department of Labor (DOL) are charged with providing regulations and guidance that will add both clarity and detail to the requirements contained within this sweeping legislation. This also means that there is a strong possibility there will be changes prior to some of the implementation dates discussed later in this newsletter. Future legislative leaders may change some of these provisions as well.

What follows is based upon our understanding of the current legislation. We will continue to monitor this new law and the ensuing guidance and legislation.

Our focus on the changes dictated by the Laws for the years 2010 to 2013 generally are directed at specific changes for coverage and eligibility in health care plans – both individual and group-based programs. Due to the impending implementation time frames, it appears unlikely that these will be drastically altered. Because implementation timelines are short, we have reviewed the actions that should be addressed for years up to 2013, these items are listed below.

In 2014 and beyond, the Laws direct states to establish state health insurance exchanges where people can purchase health care insurance under several plan designs. The Laws also direct insurance plans, including self-funded medical plans, to implement features that relate to the availability of these state exchanges:

- Employers with more than 50 full-time equivalent employees (FTEs) begin to be penalized for not offering coverage to FTEs. This penalty is $2,000/ FTE after the first 30 employees. Full-time employee is defined as working 30 or more hours per week. This application could be implemented sooner than 2014.
- Annual limits on the dollar value of benefits covered will be eliminated. This is also vague since the legislation does not explain how this may be applied to specific benefit levels, such as for chiropractic care.
- Plans must eliminate pre-existing limits for adults (employees, spouses and other dependent children age 19 or older).
- Plan waiting periods for coverage cannot exceed 90 days. Employers with longer waiting periods will be subject to penalties. There is no information on

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Health Care Changes and when they are scheduled to go into effect

exceptions for industries that may have turnover issues. There is also no information on how plans that use the first of the month following a certain period of time as the starting point for counting the waiting period will be affected by this change.

- Individuals who do not choose to be covered either with an individual or employer-sponsored group plan will be assessed an annual amount starting at $95 or 1% of taxable income, indexed annually thereafter. There are some exceptions to the penalty based on seven criteria, including but not limited to financial hardship, religious objection, incarceration, etc.

In 2018, "high value" plans, those at $10,200 or more for individual coverage and $27,500 for family coverage will be taxed at 40% of the value of the plan in excess of the threshold amounts. Increases in the value are allowed for individuals over age 55 who are not eligible for Medicare and for employees engaged in high risk professions (as yet to be determined).

This is not a comprehensive list of the changes in the Laws but highlights some of the more important changes.

While it is important to understand that these last seven items are contained in the Laws, these are the provisions causing much of the public concern. There will be more information as 2014 approaches.

Complicating how changes should be done is the "grandfather clause" in the original Health Reform Act and revised by the Reconciliation Act. The "grandfather clause" generally allows that individuals covered by individual insurance plans and group-based programs on March 23, 2010 cannot be terminated or limited by those plans/programs for any health-related condition.

In addition, the plans providing coverage are saved from some of the acts provisions as long as the plan does not make changes to the plan. The laws do not indicate what kinds of changes that will cause a plan to lose its grandfathered status. The Reconciliation Act amended this somewhat by eliminating the "grandfather" exemption from some of the more immediate changes. Changes other than those not covered by the exceptions to the "grandfather rules" may be deemed new plans and make the plan subject to all aspects of Health Care Reform Laws. However, what the "grandfather clause" actually does is unclear and regulations will be needed to explain how this affects all types of insurance plans.

Following is a listing of the major changes that occur within the next two to three years.

Effective Immediately:

- A temporary reinsurance program for group insurance programs that cover retirees ages 55 to 65 who are not eligible for Medicare. In 90 days from passage of the Law the program will go into effect and will be in place until 2014. This program will reimburse plans for claims between $15,000 and $90,000.

- Small businesses (25 or less employees) who contribute 50% or more of the cost of coverage for participating employees will qualify for a tax credit of up to 35% of the company's contributions toward the coverage. This extends from calendar year 2010 to calendar year 2013. These businesses must have average annual wages for each employee of no more than $50,000. Smaller businesses (10 or fewer employees) with average annual salaries below $25,000 may be eligible for a higher tax credit. An Internal Revenue Service website for this is available at http://www.irs.gov/newsroom/article/0,,id=220848,00.html

- Fully-insured group plans become subject to the same non-discrimination rules as are currently in effect for self-funded plans.

- Individuals covered by Medicare Part D prescription plans who have reached the "donut hole" will receive a $250 rebate from the drug programs.

- HHS Secretary is directed to create, within 90 days of passage of the Law, a temporary high-risk pool for uninsured individuals with pre-existing conditions. This pool will remain in place until 2014 when insurance companies and health plans will no longer be permitted to deny coverage for a pre-existing condition. Applicants must be U.S. citizens and legal immigrants who are not covered by any form of insurance, must have been denied coverage due to the pre-existing condition and have been without health care coverage for at least six (6) months.

- The plan must cover at least 65% of the participants' health costs and must follow limits set by the Law. Participants will need to pay premiums based on "standard rates" which are defined as the average premium charged by private insurers for similar plans.

- The cost of coverage for children covered by a plan who have not attained the age of 27 by the end of the calendar year is not subject to federal taxes. This is complicated by the fact that some states have laws requiring coverage for children beyond age 27. Many states have not enacted laws permitting similar pre-tax treatment for this federal law or similar state laws.

Effective on the next plan anniversary following six months after the President signed the Health Reform Bill (generally, the first day of the next plan year following September 2010):

- Plans must eliminate lifetime maximums for benefits payments.

- Plans must provide coverage for children to age 26, unless the child is eligible for coverage under another employer-sponsored plan. The original Law specified "unmarried" children; this was deleted in the Reconciliation Bill. In 2014, the requirement that the child not be eligible under another employer-sponsored plan will be removed.

- Plans must not have a pre-existing limitation on children under age 19.

- All emergency services, Network or Out-of-Network providers, must be covered at the Network level of benefits. Grandfathered plans are exempted from this provision until 2014.

- Mandates coverage of specific preventive services with no cost sharing. The services that must be covered at minimum include:

  ⇒ Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

  ⇒ For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

  ⇒ For women, additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

  ⇒ For women, the recommendations issued by the United States Preventive Service Task Force regarding breast cancer screening, and mammography. Grandfathered plans are exempted from this requirement until 2014.

- Employers with more than 200 employees will be required to automatically enroll all eligible employees in the health plan offered by the employer. Employees may choose to opt out. It is not explained how this will work with employers with more than one plan. Nor does it require the employee who opts out to do so on account of other coverage. **NOTE:** the actual required implementation date is subject to regulations that are yet to be published. It is possible this requirement will be applicable in a later year.

Effective for 2011 plan/tax years:

- Healthcare Flexible Spending Account programs (FSAs or Section 125 plans), Health Savings Accounts (HSAs), Medical Savings Accounts (MSAs) and Health Reimbursement Arrangements (HRAs) may no longer reimburse participants for over-the-counter (OTC) drugs unless they are prescribed by a physician. As the Law stands this restriction appears to apply to the tax year of 2011. This would mean that reimbursements for December 2010 could be used for OTC drugs and those in January 2011 could not. This will cause problems for plans whose enrollment dates are other than January.

- Penalties for non-qualified distributions from HSAs are increased from 10% to 20%.

- Employers must include on employees' W-2 forms for tax year 2011 the value of benefits provided for each employee's health insurance coverage. "Value" appears to be designed as the total premium/premium equivalent cost (including both

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employee and employer contributions) and includes medical, dental, vision and applicable HRA payments.

- The government will establish a national, voluntary long term care insurance program for purchasing community living assistance services and supports (CLASS program). For the first five years, all participating employees will not receive benefits but will pay the premium. After this five-year period, individuals with functional limitations will be provided a cash benefit of not less than an average of $50 per day to purchase non-medical services and support necessary to maintain community residence. The program will be financed through voluntary payroll deductions. All working adults will be automatically enrolled unless they elect to opt-out.

- Within twelve (12) months of enactment of the Law, the DHHS is required to develop a short form description of benefits all employers must use in addition to the current description materials used. This summary must meet certain uniform standards developed by the Secretary of HHS. Plans must begin using this standardized form with 24 months of the Law's enactment.

Effective 2012

- Plans renewing on/after October 1, 2012 will pay a levy of $1 per participant per year to fund Comparative Effectiveness Research. This increases to $2 for years 2013 through 2019. No details are yet available.

- Plans must begin using the standardized description of benefits form developed by the HHS within two months of the Law's enactment.

Effective for 2013 plan/tax years

- Health Care Flexible Spending Accounts will be limited to a calendar/taxable year maximum of $2,500, indexed annually for inflation.

- Medicare Part D tax deductions for plans receiving the Medicare Part D retiree drug subsidies are eliminated.

Benefit programs subject to Collective Bargaining Agreements (CBAs) ratified before March 23, 2010 will not have to comply until the date the last CBA relating to such coverage terminates. Any coverage amendment made pursuant to a CBA relating to coverage being amended solely to conform to the new Laws will not be treated as a termination of such CBA. Employers with negotiations in process on/after March 23, 2010 are urged to discuss this with their labor attorneys.

The material contained in this article is not intended to be a summary of all the parts of the Health Care Reform Laws. As indicated earlier, these Laws are complex and some of the possible effects are just becoming apparent. Not all aspects of the Laws are fully understood and there will be further clarification.

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