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CLIENT ALERT

What Employers, Employees and Health Plans Need to Know Right Now About Health Care Reform

May.12.2010

Health care reform has been the subject of much public debate and, in many cases, misinformation both about the actual content of the new laws and the ways in which the laws are to be applied and interpreted. Regardless of your point of view, it is clear that health care reform will have a significant impact, not only on the health insurance industry but also on employment and employee benefit issues generally.

The Patient Protection and Affordable Care Act ("PPACA"), signed into law by President Obama on March 23, 2010, was then supplemented and modified, less than one week later, by the Health Care and Education Tax Credit Reconciliation Act ("HCERA"). This Alert will refer to these two laws collectively as "Health Care Reform" or "Health Reform Laws."

Despite their length and extraordinary depth of detail, the Health Reform Laws leave open a host of issues that will have to be resolved either through agency regulations or further action by Congress (including possible technical and conforming amendments to the Health Reform Laws). As such, definitive guidance is simply not possible at this time on many of the provisions of Health Care Reform. However, we are now in a position to begin helping employers, employee benefit plans and plan sponsors to start exploring the contours of Health Care Reform in order to be better prepared for the numerous health care changes that will soon be upon us.

Despite the multiple and often confusing effective dates of the various provisions of the Health Reform Laws (discussed in more detail below), it is important to remember that none of the major provisions of the Health Reform Laws is effective any earlier than the first plan year beginning after September 23, 2010 (i.e., six months after March 23, 2010, the date of enactment of PPACA). For a calendar-year plan, the result is that none of the new coverage mandates would apply any earlier than January 1, 2011.

Health Care Reform will have distinct impacts on employers, employees and health plans and will have other impacts that will stretch across these groups and the public at large. As a result, we have divided our discussion of the Health Reform Laws by focusing on the different groups most affected by the various provisions of the Laws. Set forth below are links to discussions of the Health Care Reform provisions as they affect employers, employees and health plans. We also include links to a discussion of several over-arching Health Care Reform issues, and to a timeline to help you plan out your compliance activities. This structure will allow you quick access to analyses of issues of most importance to you and your organization. If, instead, you need a thorough discussion of the individual sections of the Health Reform Laws, please see our "**Summary of Health Reform Legislation 2010**."

This section addresses the impact of Health Care Reform on Employers. Some of these new provisions require action in the near term, while others are more relevant to long-term planning (for example, in setting strategy for dealing with health benefits in future collective bargaining). The topics addressed in this section include discussions of automatic enrollment, mandatory coverage, breaks for nursing mothers, new IRS Reporting obligations, new notice requirements under the Fair Labor Standards Act, and several other topics: **Health Care Reform: Impact on Employers**

II. Employees

The Health Care Reform Laws directly affect the ways in which employees relate to and choose health benefit coverage. Employers will likely need to be aware of these provisions as well, since they may impact future benefit design. This section addresses these employee-related areas, including discussions of new employee responsibilities under the Health Reform Laws, as well as the new taxes applicable and the new benefits available to employees: **Health Care Reform: Impact on Employees**

III. Employee Health Benefit Plans

The most significant impact of Health Care Reform will be felt by employee health benefit plans. This section addresses the impact of Health Care Reform on those plans (and, unless otherwise noted, these provisions apply to both insured and self-funded plans), including discussions of the coverage requirements for non-dependent adult children, bans on pre-existing conditions exclusions, bans on lifetime and annual limits, new disclosure requirements, the Cadillac Tax, and a new per-participant fee under the Internal Revenue Code, among other topics: **Health Care Reform: Impact on Health Plans**

IV. General Issues

This section addresses several over-arching Health Care Reform issues, including both the issue of grandfathered plans and enforcement and penalties under the Health Reform Laws: **Health Care Reform: Other Issues**

V. Timeline

This section provides a timeline that includes all statutory deadlines from 2010 through 2018: **Health Care Reform: Implementation Timeline**

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This is just the first installment of what will likely be numerous additional alerts in this area. Health Care Reform will be an on-going process, and we expect that compliance requirements will develop over time. Indeed, in just the past few days the Department of Health and Human Services ("HHS") has issued an interim final regulation on the Early Retiree Reinsurance Program, and HHS, jointly with the Departments of the Treasury and Labor, has issued interim final regulations implementing the Health Reform Laws' mandatory expansion of dependent coverage of children to age 26. Both of these interim final rules will be discussed in a soon to be forthcoming Alert. We will, of course, keep you apprised of these and any other important developments over the coming weeks, months and years as they occur.

If you have any questions about this Alert, Health Care Reform generally, or about any other employee benefits matter, please contact the attorneys listed at the bottom or your usual Crowell & Moring contact.

Health Care Reform: Impact on Employers

1. ***Automatic Enrollment***

PPACA amended the FLSA to require that an employer with more than 200 full-time employees (1) must automatically enroll new full-time employees -- subject to permitted waiting periods -- and re-enroll current employees; (2) must provide new employees with a notice regarding such automatic enrollment; and (3) must provide new employees with an opportunity to opt-out of automatic enrollment. Furthermore, PPACA also provides that state payroll laws are preempted as necessary to permit this automatic enrollment. It is not known when this provision will be effective; PPACA states that it is effective "in accordance with regulations," but no specific date is set for the issuance of such regulations.

2. ***Mandatory Coverage***

The Health Reform Laws provide that, effective January 1, 2014, employers with 50 or more full-time equivalent employees must offer minimum essential plan coverage or pay a penalty, with penalties of either $2,000 or $3,000 per year per participant, depending, respectively, on whether no coverage is offered or "unaffordable" coverage is offered. The penalty amount (which is not tax deductible) is indexed to the rate of premium growth after 2014, and there is an exception to the "unaffordable" coverage penalties for situations covered by "free choice vouchers."

3. ***Free Choice Vouchers***

The Health Reform Laws provide that employers, of any size, that offer health coverage and pay a portion of the premium must, effective January 1, 2014, provide free choice vouchers to "qualified employees" (employees who do not participate in the employer's health plan and meet certain financial requirements). Failure to offer the voucher does not cause tax or penalty, but the voucher relieves the employer of the $3,000 unaffordable-coverage tax (discussed in paragraph 2, above) for each employee receiving the voucher. The voucher is deductible to the employer and tax-excludable to the employee. The amount of the voucher is the dollar value of the employer's contribution to the health plan, or, if multiple plans are offered, the dollar value of the plan with the largest percentage of employer-paid cost. A "qualified employee" can use the voucher as a credit against premiums required for Exchange-provided coverage, and the employee may retain the excess amount if the premium is less than the voucher. (For more information about the Exchanges, please see paragraph 15, below.)

4. ***Breaks for Nursing Mothers***

The Health Reform Act amended the FLSA to require employers, effective March 23, 2010, to provide reasonable break time and a private place -- other than a bathroom -- for a female employee to express breast milk after giving birth to a child. Specific conditions and exemptions may (depending upon the employer) apply, and, furthermore, if the applicable state law would provide greater protections to employees than the protections provided under these FLSA amendments, then employers in those states must still adhere to state law.

5. ***IRS Reporting***

The Health Reform Laws require employers to report the value of each employee's health coverage on the employee's W-2. Employers will be required to report the aggregate value of all employer-provided health coverage, including any portion paid by

the employee through after-tax premiums but excluding contributions to Archer MSAs, HSAs, and salary reduction contributions to FSAs. Although the provision appears to be effective January 1, 2011, this effective date also appears to be tied to the issuance of implementing regulations.

6. *Simplified Cafeteria Plans*

The Health Reform Laws provide that, beginning January 1, 2011, employers with fewer than 100 employees may establish a "Simplified Cafeteria Plan," with simplified nondiscrimination rules that would apply if certain contribution and eligibility requirements are met.

7. *Loss of Medicare Part D Deduction*

The Health Reform Laws will not allow employers, after 2012, to take a tax deduction for the amount of any Medicare Part D subsidy they receive for providing prescription drug coverage to their retirees. Although the loss of this deduction will not occur until 2013, accounting rules will require employers to immediately write down deferred income-tax assets to reflect this loss.

8. *Medicare Tax*

The Health Reform Laws provide that, effective January 1, 2013, the employee portion of the Medicare tax increases to 2.35% for wages over $200,000 (for single filers) or $250,000 (for married filing jointly). The employer's withholding liability for any employee is based on wages in excess of $200,000 paid by that employer to that employee for the year, without regard to filing status or wages of the employee's spouse.

9. *New Notice to Employees under Fair Labor Standards Act*

The Health Reform Laws amend the FLSA to require employers to provide, effective on March 1, 2013 for existing employees and thereafter on hiring dates for new employees, notice to employees of the following: (a) availability of the Exchanges (even though the exchanges do not become operational until 2014); (b) if the employer's share of health plan costs is less than 60%, eligibility for certain credits and reductions if purchasing coverage through the Exchange; and (c) if the employee purchases Exchange insurance, the employee will lose the employer contribution toward the value of coverage. (For more information about the Exchanges, please see paragraph 15, below.)

10. *Reporting to IRS and Covered Employees*

The Health Reform Laws amended the Code to provide that, effective January 1, 2014, every insurer and every employer providing a health plan (including a grandfathered plan) must report certain health insurance coverage information (including the portion of the premium paid by the employer) to the IRS and to each covered individual on a form to be provided by the IRS. Although PPACA literally requires this additional information only if the plan is insured, there is reason to believe that this requirement will also be imposed on self-insured plans. Under a separate amendment to the Code, certain employers are required to file an additional information return with the IRS, as well as provide the same information to every full-time employee, if for any employee the required employee contribution exceeds 8% of wages paid by the employer to that employee. Although these are two separate reporting requirements, the IRS is allowed to combine the two reports.

11. *Premium Rebates*

The Health Reform Laws amend the Public Health Service Act to require health insurance issuers to pay rebates to their customers if their medical loss ratios fall below 80 percent (or 85 percent in some cases), averaged over three years. States are permitted to increase these percentages, subject to adjustment by HHS. Although this affects employer plans, it does not affect self-insured plans, and it is not clear whether the rebates will be paid to the employer, the plan, or individual plan participants. This provision generally applies to plan years beginning on or after September 23, 2010, but it appears to apply to grandfathered plans (described in more detail under the "Other Issues" Alert) for plan years beginning on or after March 23, 2010, i.e., the date of enactment of PPACA. Because this results in an earlier effective date for grandfathered plans than for non-grandfathered plans, it is possible that this effective date may be altered by further guidance and/or statutory changes.

12. ***Extension of Nondiscrimination Requirements***

The Health Reform Laws extend the same non-discrimination rules currently applicable only to self-insured plans to insured group health plans. These rules prevent plans from providing significantly better coverage to higher-paid employees than to other employees. This provision has a separate $100-per-day penalty per affected participant, and the provision does not apply to grandfathered plans.

13. ***Tax Credit for Small Employers***

Beginning in 2010, a small employer (which, for these purposes, means an employer with 25 or fewer employees with average full-time wages of less than $50,000) is eligible to apply for a tax credit if they offer health insurance and subsidize, on a uniform basis, at least 50 percent (35 percent for tax-exempt employers) of the cost of coverage. The tax credit is paid in full for employers with 10 or fewer full-time equivalent employees (with average wages of $25,000 or more) and phases out as employer size and average wage increases. Furthermore, the credit is available on a reduced basis during the period 2010 to 2013, i.e., before the Exchanges are established. (For more information about the Exchanges, please see paragraph 15, below.)

14. ***CLASS Act***

Beginning in 2011, the Health Reform Laws create a new benefit through the "Community Living Assistance Services and Supports Act" (i.e., the "CLASS Act"), a new national employee-funded long-term care benefit. Although involvement is voluntary, employers are encouraged to participate in the CLASS Act and to adopt automatic enrollment rules that default employees into this benefit.

15. ***Exchanges***

By January 1, 2014, each state must establish an Exchange through which individuals and employers may purchase coverage under qualified health plans. If a state fails to establish an Exchange, HHS must establish and operate an Exchange (either directly or though an agreement with a not-for-profit entity). The Exchanges are open to small employers, which is defined to mean employers who had 100 or fewer employees in the previous year. Before 2016, a state may elect to reduce this threshold to 50 employees. An employer will not lose access to an Exchange just because it grows too large to be a small employer. In 2017, the Exchanges may be opened to large employers, and any state that does so must allow large employers to purchase health insurance for their employees through an Exchange.

16. ***Cadillac Tax***

In 2018, the Cadillac Plan Tax is effective. This tax is a nondeductible 40% excise tax on the aggregate value of coverage per covered employee that exceeds $10,200 for an individual or $27,500 for a family, as adjusted according to specific criteria. The coverage taken into account includes all employer-sponsored health coverage (including after-tax premiums, reimbursements from a Health FSA or an HRA, contributions to an HSA or Archer MSA, and other supplementary health coverage), but does not include certain other types of coverage, such as employer coverage for long-term care and separately-provided dental or vision coverage. The tax is paid by the insurer for insured coverage, by the employer for HSA and MSA contributions, and by the plan administrator for other employer sponsored coverage (presumably including self-funded coverage).

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Health Care Reform: Impact on Employees

1. *Responsibilities*

Beginning in 2014, almost all U.S. citizens and legal residents will be required to obtain health coverage. If they do not obtain health coverage, they will be subject to an annual penalty amount. This penalty amount starts in 2014 at the greater of 1.0% of household income above the tax filing threshold or $95, and then grows in 2015 to the greater of 2.0% of household income above the tax filing threshold or $325, and in 2016 to the greater of 2.5% of household income above the tax filing threshold or $695. After 2016, the penalty amounts will be indexed, and no penalty is assessed for individuals who fail to maintain coverage for three months or less during the year. The penalty amount for a family is capped at 300% of the individual penalty. Finally, individuals whose required contributions for coverage through an Exchange or through an employer plan exceed 8% of income are exempt from the penalty, and certain low-income individuals may be entitled to premium and cost-sharing subsidies from the federal government in connection with coverage obtained through an Exchange. (For more information about the Exchanges, please see paragraph 15 ("Exchanges") under "Health Care Reform: Impact on Employers.")

2. *Taxes*

The Health Reform Laws provide that, effective January 1, 2013, the employee portion of the Medicare tax increases to 2.35% for wages over $200,000 (for single filers) or $250,000 (for married filing jointly).

3. *Benefits*

As discussed in more detail in the "Employers" and "Health Plans" sections of this Alert, in the next few years employees will see many changes to their health plan coverage, including the following:

- Employees will be automatically enrolled and re-enrolled in certain employer plans (but can opt out of such coverage).
- An employee will be allowed to cover a dependent child under an employer's plan until age 26.

- Pre-existing condition limitations will be banned under group health plans, and lifetime and annual benefit limits will be severely limited and may be banned in some situations. Plans will also be prohibited from rescinding coverage except in the cases of fraud or intentional misrepresentation of material facts.
- Group health plans will be required to provide coverage for preventive health services and must provide coverage for emergency services without prior authorization.
- Annual contributions to FSAs will be limited to $2,500 per year, and FSAs, HRAs, Archer MSAs and HSAs will not be allowed to reimburse a participant for most over-the-counter drug expenses.
- Waiting periods under a plan will not be allowed to exceed 90 days.

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Health Care Reform: Impact on Health Plans

1. *Coverage of Non-Dependent Adult Children*

The Health Reform Laws generally require plans, if they offer dependent coverage, to cover a participant's adult children to age 26, even for married children. For most plans, this requirement is effective beginning in 2011; however, prior to 2014, for grandfathered plans (which are described in more detail in the "Other Issues" Alert), this provision only applies to a child not eligible to enroll in another employer-provided plan. In plan years beginning on or after January 1, 2014, however, this limitation for grandfathered plans is lifted, and this coverage expansion will apply equally to both grandfathered and non-grandfathered plans. The Department of Health and Human Services ("HHS") has been instructed to write regulations defining "dependents" to whom coverage must be made available (HHS, jointly with the Departments of Labor and the Treasury, released interim final regulations on this matter on May 10, and these regulations will be discussed in a future Alert). Although that provision is not effective for most plans until 2011, the Health Reform Laws also amended the Code, effective in 2010, to allow (but not require) plans to extend coverage to an employee's children on a more generous basis than had been previously allowed (up to age 27). However, any such coverage expansions are only effective (at least for tax purposes) after the plan has been amended.

2. *Ban on Pre-Existing Conditions Exclusions*

The Health Reform Laws completely ban pre-existing condition limitations under group health plans. This prohibition is in effect for plan years beginning after September 23, 2010 for children under 19 and is in effect for all participants beginning in 2014.

3. *Early Retiree Reinsurance Program*

The Health Reform Laws require HHS to establish a temporary reinsurance program to reimburse participating employer plans for a portion of the cost of providing health insurance to early retirees and their spouses and dependents. For purposes of this program, "early retirees" are individuals age 55 or older who are not active employees and are not eligible for Medicare. Reimbursements may not exceed 80% of the cost of benefits for a year with respect to a retiree (and his or her spouse and

dependents) between $15,000 and $90,000 (adjusted for inflation). The program will be in existence from June 21, 2010 (i.e., 90 days after the date of enactment of PPACA) to January 1, 2014, or when the $5 billion appropriation for this program is exhausted, whichever occurs first. Plans must apply to be a part of this program, and certain limitations apply to how the reimbursement amounts may be used. HHS issued interim final regulations on this program on May 5 (these regulations will be discussed in a future Alert).

4. ***Temporary Insurance Program for High-Risk Individuals***

The Health Reform Laws also require HHS to establish a temporary insurance program that will exist from June 21, 2010 to January 1, 2014 for individuals who have preexisting conditions and have not had group health plan coverage for at least six months. Although this program is not directly applicable to health plans, PPACA directs HHS to establish an anti-abuse rule requiring health insurance issuers or employer health plans (including self-insured plans) to reimburse the program for the cost of coverage for any individual where the insurer or plan has discouraged the individual from remaining enrolled under the insurance policy or employer plan because of the individual's health status.

5. ***Ban on Lifetime & Annual Limits***

Under the Health Reform Laws, maximum lifetime benefit limits are prohibited on the dollar value of "essential health benefits" for any participant or beneficiary. Furthermore, plans are only allowed to place annual limits on "essential health benefits" if specifically permitted in regulations issued by HHS ("essential health benefits" will also be defined in regulations to be issued by HHS).

6. ***Limits on Rescission of Coverage***

Starting in plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan), the Health Reform Laws prohibit group health plans from rescinding coverage except in the cases of fraud or intentional misrepresentation of material facts (provided that the plan contains a specific provision allowing such rescissions and that prior notice has been given).

7. ***Required Preventive Health Services***

Starting in plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan), PPACA requires plans, at a minimum, to provide coverage for preventive health services within specified guidelines without imposing cost-sharing requirements on participants. PPACA lists several preventive health services for which plans are required to provide coverage, and plans may need to be frequently updated in order to keep pace with the most current required preventive health services. However, this provision does not apply to grandfathered plans.

8. ***Emergency Services & Clinical Trials***

Starting in plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan), the Health Reform Laws (a) provide that, if emergency services are otherwise covered, they must be provided without prior authorization, whether or not the provider is a participating provider, and with the same cost-sharing as in-network services (whether or not the provider is in-network); and (b) prohibit plans from denying individuals the right to participate in clinical trials or discriminating

against individuals who have participated in such trials, and further prohibit plans from denying or limiting coverage for routine patient costs for items and services furnished in connection with participation in a clinical trial, if those items and services would otherwise be provided under the plan. These provisions do not apply to grandfathered plans.

9. ***Access***

The Health Reform Laws mandate that plans requiring participants to have a primary care physician/gatekeeper must allow individuals to designate any participating primary care physician who is available to accept that individual, and further must both permit a pediatrician to be designated as a primary care physician for a child and permit direct access (i.e., without the need for referral or prior authorization from a primary care physician) to an obstetrician or gynecologist for a female participant or beneficiary. This provision is effective starting in plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan) and does not apply to grandfathered plans.

10. ***Internal/External Reviews***

The Health Reform Laws provide that (a) plans not already subject to ERISA must establish an internal claims and appeals process satisfying ERISA regulations; (b) all plans must establish an external review process meeting either state law (for insured plans) or regulations (for self-insured plans); (c) all plans must provide notice to employees of internal and external review processes, and the availability of the ombudsman's office (as established under the statute) to assist claimants in the appeals process; and (d) all plans must guarantee the receipt of benefits during an appeals process. These provisions are effective (subject to the issuance of implementing regulations) starting in plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan) and do not apply to grandfathered plans.

11. ***Requirement to Disclose Certain Information***

PPACA requires plans to disclose to HHS and to the relevant state insurance regulator, and to make available to the public, certain plan information including, among other things, data on claims denials, rating practices, and cost-sharing for out-of-network coverage. This requirement appears to apply to self-insured as well as to insured employer plans and does not appear to apply to grandfathered plans (an issue that may or may not be cleared up in future regulations). This provision is effective (subject to implementing regulations) starting in plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan). Plans (apart from grandfathered plans) are separately required to annually provide HHS with reports regarding both health care quality and wellness initiatives, including information on plan designs to improve outcomes, reduce hospital readmissions, reduce medical error, implement wellness programs, etc. This reporting requirement is effective in accordance with regulations to be issued on this provision, presumably by HHS.

12. ***Reimbursements for Over-the-Counter Expenses***

The Health Reform Laws provide that, effective January 1, 2011, FSAs, HRAs, Archer MSAs and HSAs may not reimburse a participant for over-the-counter drug expenses, except for (a) insulin, and (b) any medication prescribed by a physician, even if it is purchased over the counter. It appears that this provision would apply not only to the 2011 plan year, but would also prohibit plans from reimbursing over-the-counter drug expenses incurred during the first 2-1/2 months of 2011 that could have been reimbursed under a FSA grace period under pre-Health Care Reform law.

13. ***Benefits Summary Disclosures***

Under PPACA, any group health plan must distribute to enrollees, upon their enrollment or re-enrollment (as applicable) in the plan, a standardized summary of plan benefits satisfying certain criteria, including using a uniform format (limited to four pages) and plain-English terminology and including certain specified information. HHS is directed to issue standards for drafting the summaries by March 23, 2011, and the first summaries must be distributed by March 23, 2012 (there is some indication that this requirement may apply earlier to grandfathered plans, but this issue may be addressed in further guidance). Furthermore, a notice of any "material modification" of the plan (presumably limited to a modification that impacts the information required to be provided in the summary) must be distributed at least 60 days before the modification becomes effective, unless the modification is reflected in the most recent summary. For self-insured plans, the plan sponsor or designated plan administrator is responsible for distributing these notices. PPACA provides that the penalty for noncompliance with this provision is up to $1,000 per failure per enrollee.

14. ***Per Participant Fee under Internal Revenue Code***

Effective for plan years ending after September 30, 2012 (i.e., December 31, 2012 for calendar year plans), the Health Reform Laws impose a per-participant fee on both insured and self-funded plans in order to fund the new Patient Centered Outcomes Research Trust Fund for the study of comparative effectiveness research. Plans will be assessed a fee of $1 per participant in the first applicable plan year, and $2 per participant in the second applicable plan year. (This fee will be adjusted through a complex formula thereafter.) The fee sunsets in 2019, meaning that plans will not be subject to this fee for plan years ending after September 30, 2019.

15. ***FSA Annual Contribution Limit***

The Health Reform Laws provide that, effective January 1, 2013, an employee's annual contribution to a health care FSA that is part of a salary reduction arrangement under a cafeteria plan will be capped at $2,500, indexed to inflation (rounded to $50) thereafter.

16. ***Waiting Periods***

The Health Reform Laws provide that, effective January 1, 2014, waiting periods under a plan cannot exceed 90 days.

17. ***Cost Sharing***

The Health Reform Laws provide that cost sharing under a plan (1) may not exceed certain limitations specified in the Code (which in 2010 are $5,950 for single coverage and $11,900 for family coverage), and (2) may not charge a deductible in excess of $2,000 (in the case of individual coverage) or $4,000 (in the case of family coverage). After 2014, these dollar limits are indexed to the rate of increase in health insurance premiums. These limits do not apply to grandfathered plans.

18. ***Discrimination Against Providers***

PPACA amends the PHS Act to impose a requirement that, effective January 1, 2014, plans cannot exclude or otherwise discriminate with respect to participation under the plan against any health care provider who is willing to abide by the terms

and conditions for participation established by the plan. However, plans may vary reimbursement rates based on quality or performance measures.

19. ***Low Actuarial Risk Plan Assessment***

Under the Health Reform Laws, each State will assess a charge on "low actuarial risk plans" -- group health plans and health insurance issuers where the actuarial risk of their enrollees is less than the average actuarial risk for all enrollees in plans or coverage in the State (excluding self-insured group health plans). The State will also make a corresponding payment to "high actuarial risk plans" whose enrollees' actuarial risk is higher than the average. This program applies to plans and issuers providing coverage in the individual or small group market in a state, and the effective date of this provision is unclear. This assessment does not apply to grandfathered plans.

20. ***Cadillac Tax***

In 2018, the Cadillac Plan Tax is effective. This tax is a nondeductible 40% excise tax on the aggregate value of coverage per covered employee that exceeds $10,200 for an individual or $27,500 for a family, as adjusted according to specific criteria. The coverage taken into account includes all employer-sponsored health coverage (including after-tax premiums, reimbursements from a Health FSA or an HRA, contributions to an HSA or Archer MSA, and other supplementary health coverage), but does not include certain other types of coverage, such as employer coverage for long-term care and separately-provided dental or vision coverage. The tax is paid by the insurer for insured coverage, by the employer for HSA and MSA contributions, and by the plan administrator for other employer sponsored coverage (presumably including self-funded coverage).

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Health Care Reform: Other Issues

1. ***Grandfathered Plans***

A group health plan in effect on March 23, 2010 (i.e., the date of enactment of PPACA) is considered to be a "grandfathered health plan," meaning that, except as specifically indicated otherwise, the provisions of PPACA that apply to group health plans will not apply to such grandfathered plans. Grandfathering covers all employees enrolled on March 23, 2010, their family members even if not yet enrolled, and all "new employees." It is unclear whether and how a plan (apart from collectively bargained plans which are separately addressed in the statute) could lose its grandfathered status. However, because losing grandfathered status could have significant financial and compliance consequences for employers, until further guidance is issued on this subject, employers and plan sponsors should exercise caution in the near term in operating and/or amending a grandfathered plan.

2. ***Enforcement and Penalties***

The new coverage mandates under the Health Reform Laws will generally be enforced through a new Internal Revenue Code ("Code") section which imposes a penalty of $100 per day for each affected participant for violations of the new coverage mandates. This penalty is measured from the date of failure to the date of correction, does not apply to retiree-only plans, and can be capped if the failure was unintentional. It is important to note that this penalty is a *new* penalty; it does not replace any of the old penalties that could be assessed against employers or health plans and could potentially be assessed *in addition to* such existing penalties.

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Health Care Reform: Implementation Timeline

Effective in 2010

- **Coverage of Non-Dependent Adult Children** -- Effective as of March 23, 2010, plans are allowed (but not required) to cover an employee's child up to age 27.
- **Early Retiree Reinsurance Program** -- Effective no later than June 21, 2010.
- **Temporary Insurance Program for High-Risk Individuals** -- Effective no later than June 21, 2010.
- **Loss of Medicare Part D Deduction** -- Although deduction is not actually lost until 2013, accounting changes take effect immediately.
- **Breaks for Nursing Mothers** -- Effective as of March 23, 2010.
- **Tax Credit for Small Employers** -- Effective beginning in 2010.

Effective in 2010-2011

- **Bans on Pre-Existing Conditions Exclusions** -- Effective for children under age 19 for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan). Ban on all pre-existing condition exclusions is effective for plan years beginning on or after January 1, 2014.
- **Ban on Lifetime Limits** -- Effective for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan).
- **Ban on Annual Limits** -- Limitations on annual limits apply for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan). The ban on all annual limits is effective for plan years beginning on or after January 1, 2014.
- **Requirement to Cover Older Children** -- Effective generally for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan), plans will be required, if they offer dependent coverage, to cover a participant's adult children until age 26 (note that, as described above, plans will be *permitted* (but not required) to cover adult children to age 27 beginning March 23, 2010). Special rules apply for grandfathered plans for the period between 2010 and 2014.

- **Limits on Rescission of Coverage** -- Effective for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan).
- **Extension of Nondiscrimination Requirements** -- Effective for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan).
- **Required Preventive Health Services** -- Effective for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan).
- **Emergency Services without Prior Authorization** -- Effective for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan).
- **Access to Any Participating Primary Physician** -- Effective for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan).
- **Right to Participate in Clinical Trials** -- Effective for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan).
- **Internal and External Review of Claims** -- Effective for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan); however, the effective date is predicated on the issuance of implementing regulations.
- **Requirement to Disclose Claims Denial Data and Other Information** -- Effective for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan).
- **Premium Rebates** -- Effective for plan years beginning on or after September 23, 2010 (i.e., January 1, 2011 for a calendar-year plan), with special effective date rules applying for grandfathered plans.

Effective in 2011

- **Elimination of Reimbursements for Over-the-Counter Expenses** -- Effective January 1, 2011.
- **Enhanced W-2 Reporting** -- Effective date is unclear; appears to be January 1, 2011, but may depend on issuance of regulations.
- **Simplified Cafeteria Plans** -- Effective January 1, 2011.
- **CLASS Act** -- Effective beginning in 2011.

Effective in 2012

- **Benefits Summary Disclosures** -- The first summaries must be distributed by March 23, 2012 (however, a special effective date appears to apply for grandfathered plans).
- **Per Participant Fee under Internal Revenue Code** -- Effective for plan years ending after September 30, 2012, i.e., December 31, 2012 for calendar year plans.
- **Quality Reports** -- Exact effective date is unknown, but appears to be effective within two years of March 23, 2010 (in accordance with regulations to be issued).

Effective in 2013

- **FSA Annual Contribution Limit** -- Effective January 1, 2013.
- **Increased Medicare Taxes** -- Effective January 1, 2013.

- **New Notice to Employees under Fair Labor Standards Act** -- Effective March 1, 2013 for existing employees, and on hiring dates thereafter for new employees.

Effective in 2014

- **Mandatory Coverage** -- Effective January 1, 2014.
- **Waiting Periods Limitations** -- Effective for plan years beginning on or after January 1, 2014.
- **Cost Sharing Limitations** -- Effective for plan years beginning on or after January 1, 2014.
- **Free Choice Vouchers** -- Effective for plan years beginning on or after January 1, 2014.
- **Discrimination Against Providers** -- Effective January 1, 2014.
- **Reporting to IRS and Covered Employees on Premiums and Other Information** -- Effective January 1, 2014.
- **Employees Required to Obtain Health Care** -- Effective beginning in 2014.
- **Exchanges** -- To be established by January 1, 2014.

Effective in 2017

- **Exchanges Open to Large Employers** -- Effective January 1, 2017.

Effective in 2018

- **Cadillac Plan Tax** -- Effective January 1, 2018.

Effective Date Unclear

The effective date of several provisions of the Health Reform Laws is unclear because the provisions are predicated on some other action (as described below) before they will become effective:

- **Automatic Enrollment** -- PPACA states that it is effective "in accordance with regulations." Therefore, we likely we need to await regulations and/or other guidance before learning the effective date of this provision.
- **Cost/Fee Transparency Reporting** -- Because this provision is tied to the State-level Exchanges, it is likely that this requirement will not be effective before the actual creation of those Exchanges. However, we cannot know this for certain until regulations and/or other guidance is issued on this subject.
- **Low Actuarial Risk Plan Assessment** -- Because this assessment will be made by individual States, we will need to await further guidance (either on the Federal or State level) to determine the effective date of this provision.

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If you have any questions about Health Care Reform, or about any other employee benefits matter, please contact the attorneys listed below or your usual Crowell & Moring contact.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.