



March 30, 2010

Understanding Health Care Reform *Changes Impacting Employer-Sponsored Plans*

The landmark health care reform legislation signed into law on March 23, 2010 and the reconciliation bill that President Obama signed today, contain a number of important provisions for employer-sponsored health plans that will take effect over the next several years. The following outlines the timeline for those changes as introduced by these two pieces of legislation, formally known as The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Affordability Act of 2010. We anticipate that the Internal Revenue Service, U.S. Department of Health and Human Services (HHS) and other agencies will provide further details and guidance on these measures in the coming months. We will provide additional information in the near future regarding other important changes, and in particular, new measures impacting plans providing health benefits to retirees.

2010

RETIREE REINSURANCE PROGRAM

Group health plans will be reimbursed for 80% of claims between \$15,000 and \$90,000 for pre-Medicare retirees ages 55 to 64. The reimbursement program has assigned funds in the amount of \$5 billion and is designed to be paid out on a first-come, first-served basis. The HHS must establish the program no later than June 21, 2010, and because the program is designed to be a bridge until the provisions regarding health benefit exchanges become effective in four years, the program will end in 2014.

AUTOMATIC ENROLLMENT FOR CERTAIN LARGE EMPLOYERS

As soon as the U.S. Department of Labor (DOL) issues regulations implementing this provision, large employers (more than 200 employees) who offer health coverage are required to enroll all employees automatically in the employer sponsored plan. Employees must be provided an opportunity to opt-out of coverage. Depending on the date the DOL regulations are issued, this may be effective as soon as this year.

January 1, 2011 or Earlier

First plan year beginning six months after enactment

PREEXISTING CONDITION EXCLUSIONS, LIFETIME LIMITS AND RESCISSION

Group health plans may not: (a) impose any preexisting condition exclusion for participant's dependents under 19 years old; (b) establish lifetime limits *on the dollar value of essential health benefits* (as defined under the PPACA) for any participant or beneficiary; or (c) rescind coverage for individuals who are enrolled under the plan, except in cases of fraud by the individual.



Employee Benefits

DEPENDENT COVERAGE FOR ADULT CHILDREN

Group health plans offering dependent coverage for children must continue providing that coverage for adult, unmarried children until age 26. For an extended discussion of this important provision of the Health Care Act see, "[2010 Health Care Act: New Dependent Coverage Obligations and Expansion of Tax Dependent Status](#)".

APPEALS PROCESS

Claimants must be allowed to present testimony as part of their administrative appeals process and to continue receiving coverage during the appeals process (pending its outcome), among other changes. Also, self-insured plans must implement an external review process that meets standards set by the Secretary of HHS.

REPORTING RESPONSIBILITIES

Employers must disclose the value of the benefit provided by them to each employee's health insurance coverage on the employee's Form W-2. This requirement is only for reporting purposes. No taxes will be assessed on these amounts.

January 1, 2013

HEALTH FLEXIBLE SPENDING ACCOUNTS

A new \$2,500 cap (to be adjusted for inflation) on annual salary reduction contributions will apply to health flexible spending accounts offered under cafeteria plans. Also, reimbursement of over-the-counter medicines or drugs (except insulin) without a prescription will no longer be allowed (with respect to reimbursement of expenses incurred after 2010).

SUMMARY PLAN DESCRIPTIONS

Summary plan descriptions must meet new requirements with respect to the format, content and timing of distribution of summary plan descriptions. Additional guidance is to be issued within 12 months of enactment of the Health Care Act.

PART D DEDUCTION

Employers who maintain plans with a prescription drug component for Medicare Part D eligible retirees will no longer receive a deduction. However, this change will not impact multiemployer plans or governmental plans.



Employee Benefits

January 1, 2014

HEALTH BENEFIT EXCHANGES, QUALIFIED HEALTH PLANS AND VOUCHERS

The PPACA provides funds to each state to establish a “health benefit exchange” (Exchange). Individuals and *small employers* (100 or less employees) will have an opportunity to purchase health insurance from the Exchange. Beginning in 2017, states *may allow large employers (more than 100 employees)* to purchase insurance for its employees from the Exchange as well. The Exchanges will make available “qualified health plans” (QHP) providing essential health benefits and limiting cost-sharing.

Employers that offer minimum essential coverage, and make a contribution to pay a portion of that coverage, must offer “free choice vouchers” to “qualified employees” for the purchase of a QHP through an Exchange. “Free choice vouchers” would have a value equal to the dollar value of the employer contribution to the employer offered health plan. “Qualified employees” are those who do not participate in the employer’s health plan and meet certain other requirements related to income level and cost of health plan contributions. Employers offering coverage through an Exchange may permit employees to pay for coverage with pre-tax dollars through the employer’s cafeteria plan.

EMPLOYER-PROVIDED COVERAGE

Although there is no mandate for employers to provide coverage, an “applicable large employer” (at least 50 full-time employees during the preceding calendar year– seasonal employees would be excluded), will be subject to penalties if any full-time employee of the employer has purchased health insurance through the state’s health benefit Exchange described above. The amounts of the penalties depend on the type of coverage offered by the employer, if any at all, and are as follows:

- If the employer does not offer coverage or the coverage offered is not “minimum essential coverage,” the employer will be subject to a penalty of \$2,000 per each employee receiving coverage purchased through the Exchange per year.
- If the employer offers minimum essential coverage, but this coverage is (a) unaffordable (the premium to be paid by the employee is more than 9.5 percent of the employee’s household income); or (b) consists of a plan under which the plan’s share of the total allowed costs of benefits is less than 60 percent; the employer will be subject to an annual tax of \$3,000 per year per employee receiving coverage purchased through the health Exchange with subsidy in the form of a premium tax credit and/or cost sharing reductions granted to that employee. This penalty is capped at an amount equal to \$2,000 per year times the total number of full-time employees.



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The first 30 full-time employees (counted on a controlled group basis) are not counted for purposes of the penalties. Also, no penalties are applied for employees receiving free choice vouchers.

PREEXISTING CONDITION EXCLUSIONS AND ANNUAL LIMITS

Group health plans may not: (a) impose any preexisting condition exclusion with respect to all participants in the plan; or (b) establish annual limits *on the dollar value of essential benefits* for any participant or beneficiary. Prior to January 1, 2014, restricted annual limits on essential benefits are permissible, as determined by HHS.

REPORTING OBLIGATIONS

Group health plans offering minimum essential coverage must report to the IRS and the individuals covered under the plan details regarding coverage (e.g., periods of coverage, applicable tax credits and cost-sharing reduction, and any other information the IRS may require regarding the coverage offered and the individuals covered).

WAITING PERIODS

Waiting periods as condition for eligibility to participate in a group health plan may not exceed 90 days.

January 1, 2018

EXCISE TAX ON CADILLAC PLANS

Group health plans with premium levels above the threshold (e.g., \$10,200 individual coverage and \$27,500 family coverage) will be subject to a 40% excise tax.

Other Provisions

WELLNESS PROGRAMS

The limit on rewards under a standard-based wellness program is increased by 10% for up to 30% of the cost of coverage. This limit may be increased even more to 50% of the cost of coverage, if deemed appropriate by DOL, HHS and Treasury per future guidance.

GRANDFATHERED HEALTH COVERAGE

Some of the provisions of the PPACA would not apply to plans in which an individual was enrolled on the date of enactment. However, a number of the mandates would still apply to grandfathered health plans. It is not yet clear what it takes to maintain a plan as “grandfathered.”



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Franczek Radelet P.C. was established in 1994 when 12 attorneys came together to form the Chicago boutique law firm. The firm, now nearly 50 attorneys, focuses exclusively on representing management in all aspects of labor and employment law and employee benefits matters in the private and public sectors. The firm's employee benefits services include benefit plan design, drafting and reviewing of plans, multi-employer plan representation, union bargaining over benefits, and representation in benefit claims and benefits-related litigation.

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