

# Health Care Reform – What's an Employer to Do?

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## Grandfathered Plans

- ★ The Patient Protection and Affordable Care Act (or “PPACA”) provides that there will be no changes required with respect to a group health plan or health insurance in which an individual was enrolled on the date of enactment (i.e., March 23, 2010)
  - > Reconciliation Act added required changes
- ★ Such plans are “grandfathered” and will continue to be treated as grandfathered plans even if coverage is renewed after March 23, 2010

## Grandfathered Plans

- ✦ What does it mean to be a “grandfathered plan”?
  - > A number of the Act’s insurance reform provisions will not apply or will apply on a delayed basis
  - > The special rule for collectively bargained plans is only applicable to insured plans and not to self-funded collectively bargained plans

## Grandfathered Plans

- > How can a plan lose grandfathered status?
  - Enter into a new insurance contract
  - Elimination of all or substantially all benefits to diagnose or treat a particular condition
    - Example: A plan covers mental health benefits, which includes counseling and prescription drug benefits. The plan eliminates the counseling benefit. Under the grandfathered rules, the plan has eliminated “an element that is necessary to treat the condition”
  - Increasing a coinsurance percentage by ANY amount above the level at which it was set on 3/23/10

## Grandfathered Plans

- ✦ How a plan can lose grandfathered status--  
continued
  - > Increase in copayment by more than the greater of:  
(1) \$5 (adjusted for medical inflation), or (2) medical  
inflation plus 15%, as measured from 3/23/10
  - > Increase in a deductible or out-of-pocket maximum  
by more than the medical inflation plus 15%, as  
measured from 3/23/10
  - > If an employer decreases its contribution rate toward  
the cost of any tier of coverage (*e.g.*, self or family)  
by more than 5% below the contribution rate on  
3/23/10

## Grandfathered Plans

- ✦ How a plan can lose grandfathered status—  
continued
- ✦ Change in Annual Limits
  - > No previous limits: If the plan did not have an overall annual limit or lifetime limit on the dollar value of benefits on 3/23/10, it cannot impose an overall annual limit on the dollar value of benefits
  - > Previous lifetime limits: A plan that imposed an overall lifetime limit on the dollar value of benefits, but no annual limit, cannot impose an overall annual limit on the dollar value of benefits that is lower than the dollar value of the lifetime limit on 3/23/10

## Grandfathered Plans

- ✦ How a plan can lose grandfathered status—  
continued
  - > Previous annual limits: A plan that imposed an overall annual limit on the dollar amount of all benefits cannot decrease the dollar value of the annual limit (regardless of whether the plan also imposed a lifetime limit on 3/23/10)

## Quiz time

- ✦ Sir Isaac Newton has been challenged to analyze Apple Byte's health plan to ensure that it maintains its grandfathered health plan status. Sir Isaac exercises his math skills and replaces the \$1 million lifetime limit with a new \$750,000 annual limit for 2011, raises the \$10 copayment and raises the out-of-pocket maximum so that they do not exceed the minimums provided for in the regulations. Did Sir Isaac succeed?

## Quiz time

- ✦ No, because the new \$750,000 annual limit is lower than the plan's old \$1 million lifetime limit, the plan has lost its grandfathered status.

## Grandfathered Plans

- ✦ The regulations also contain two “anti-abuse rules” and violation of these rules will cause a loss of grandfathered plan status
- ✦ The first anti-abuse rule is applicable to mergers and acquisitions
  - > The regulations state: “If the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan.”

## Grandfathered Plans

- ✦ The second anti-abuse rule applies when there is a change in eligibility
- ✦ The Regulations state that a group health plan or health insurance coverage ceases to be a grandfathered plan if:
  - > Employees are transferred into a plan or health insurance coverage from a plan or health insurance coverage under which the employees were covered on March 23, 2010;

## Grandfathered Plans

- > When comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating the transferee plan as if it were an amendment of the transferor plan, the transferor plan would lose grandfathered status; and
- > There was no bona fide employment-based reason to transfer the employees into the transferee plan.
  - For purposes of the last requirement, the Regulations state that “changing the terms or cost of coverage is not a bona fide employment-based reason”

# Grandfathered Plans

- ✦ How a plan can lose grandfathered status—  
continued
  - > The government is asking for comments on whether the following changes should impact grandfathered status:
    - Changes in a provider network
    - Changes to a prescription drug formulary

## Quiz time

- ✦ Because of increasing hostility from France and the Holy Roman Empire, King Henry has had to spend tremendous sums of money to build England's army and navy. The army and navy has also sustained countless casualties which led to bad claims experience. As a consequence, the HMO renewal that the King received is higher than expected. The plan is a grandfathered plan. The King has proposed an alternative plan design which will lower the coinsurance amount that the King will pay for all benefits from 90% to 88%. Will the plan lose grandfathered status?

## Quiz time

- ★ Yes, any increase in coinsurance percentage will cause a plan to lose its grandfathered status.

## Grandfathered Plans

- ✦ There are additional administrative requirements
  - > The plan must maintain all records evidencing that it has maintained grandfathered status
  - > A participant, beneficiary or the government can request to inspect these documents
  - > In any plan material provided to participants that describes benefits, the plan must include a statement that it believes it is a GF plan and that certain consumer protections do not apply to the plan because of that status
  - > Model language is provided in the regulations

## Plans Exempt from PPACA

- ✦ There are some health plans that are exempt from PPACA, including the following:
  - > True retiree-only plans
    - Needs own plan, own SPD, rated separately, own Form 5500, covers only retirees
  - > Excepted Benefits, such as limited-scope dental and limited-scope vision
    - If the benefits are: (a) provided under a separate policy, certificate, or contract for insurance, or (b) otherwise not an integral part of the group health plan (*i.e.*, the participant has the right to elect not to receive coverage and if he/she elects coverage, the participant must pay an additional premium or contribution for it)

# Maintaining GF Status—Does It Matter?

## Provisions Applicable to All PPACA Plans

- ✦ Effective first plan year beginning on or after September 23, 2010
  - > Coverage of adult children to age 26—can exclude adult children who are eligible to enroll in an employer-sponsored health plan (other than the plan of a parent)
  - > No preexisting condition exclusions can be imposed with respect to individuals under age 19
  - > No lifetime limits on “essential health benefits” (restricted annual limits until January 1, 2014)
  - > No rescission of coverage except in cases of fraud or intentional misrepresentation—must be 30 day advance notice
  - > Auto enrollment for employers who have 200 or more full-time employees and offer at least one health plan
  - > Summary of benefits (disclosure may not be required until March 23, 2012)
  - > 60 day advance notice of future material modifications

## Maintaining GF Status—Does It Matter?

### Provisions Applicable to All PPACA Plans

- ✦ Effective beginning with the first plan year beginning on or after January 1, 2014
  - > No preexisting condition exclusions for anyone
  - > Waiting periods cannot exceed 90 days

# Maintaining GF Status—Does It Matter?

## Provisions Applicable to Non-Grandfathered PPACA Plans

- ✦ Effective first plan year beginning on or after September 23, 2010
  - > Coverage of certain preventative care without cost-sharing
  - > Revised appeals process (e.g., external review, ability to present testimony, coverage during appeals process)
  - > Dependent coverage to children until age 26—without the ability to exclude adult children who are eligible to enroll in an employer-sponsored health plan (other than the plan of a parent)
  - > Ability to choose primary care provider who participates in the network
  - > No preauthorization or referral requirement for OB/GYN services
  - > Out-of-network emergency services—at almost the same cost as in-network and there can be no preauthorization required (discussed later)
  - > Non-discrimination rules (this effectively kills executive only plans)
  - > Quality of care assurances (reporting requirement)
  - > Review of unreasonable increases (insured only)

# Maintaining GF Status—Does It Matter?

## Provisions Applicable to Non-Grandfathered PPACA Plans

- ✦ Effective beginning with the first plan year beginning on or after January 1, 2014
  - > Comprehensive Health Insurance Coverage—must provide essential health benefits and limits cost sharing and deductibles (insured only)
  - > Approved Clinical Trials—Must not deny participation in or limit or impose additional conditions on coverage to a qualified individual in an approved clinical trial
  - > Guaranteed availability and renewability (insured only)
  - > No discrimination against health care providers
  - > Premiums—in the small group market may only vary based on individual or family coverage, rating areas, age bands and tobacco use (insured only)

## Dependent Coverage Rule

- ✦ Federal tax-free coverage for adult children to age 26
  - > There can be no requirement for coverage other than the relationship between the child and the participant
  - > Cannot condition eligibility on financial dependency on the participant (or any other person), residency with the participant (or any other person), student status, employment status, eligibility for other coverage (except as described above), or marital status
  - > Terms of coverage cannot vary based on age (except for children over age 26), and the plan cannot limit coverage to a specific benefit package if the plan offers more than one option
  - > Not required to covered grandchildren

# Dependent Coverage Rule

## ★ Notice Requirements

- > A child must be provided with the opportunity to enroll for at least 30 days
- > The enrollment opportunity must be provided no later than the first day of the first plan year beginning on or after September 23, 2010 and coverage must be begin as of the first day of such plan year
- > The written notice must include a statement that children whose coverage ended or who were denied coverage (or were not eligible for coverage) are eligible for coverage under the new rule (if applicable)

# Dependent Coverage Rule

## ✦ Special Rights

- > The child is treated as a special enrollee and must be offered all benefit package options available to similarly situated individuals under the plan
- > If the parent is enrolled in another benefit package option, then the parent can switch options
- > If the parent is not enrolled in the plan, then the parent must have an opportunity to enroll

## Quiz time

- ★ Kate has 8 children and all have coverage under her employer's plan. Kate has a sister with 6 kids under age 26 who live with her while the sister works to save money. Can Kate's employer's plan exclude the six other kids?

## Quiz time

✦ Don't know.

✦ Open Questions:

- > How can a plan define a "child"
- > Because the California State tax code does not automatically conform to the Federal tax code, this expanded definition of "child" may cause California state tax issues for employees who enroll dependents under this expanded definition

## No Lifetime Limits or Annual Limits on Essential Health Benefits

- ✦ No lifetime limit on essential health benefits
  - > Regulations need to be issued to define this term
  - > There is a list of benefits included in the Act—but no guidance as to what those terms mean
  - > The regulations state, “For plan years...beginning before the issuance of regulations defining “essential health benefits”, for purposes of enforcement, the Departments will take into account the good faith efforts to comply with a reasonable interpretation of the term...”

# No Lifetime Limits or Annual Limits on Essential Health Benefits

- ✦ Essential health benefits (as defined by the Secretary of Health and Human Services) must include at least the following:
  - > 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 chronic disease management
  - > Pediatric services, including oral and vision care

## No Lifetime Limits or Annual Limits on Essential Health Benefits

- ✦ No unreasonable annual limits on the dollar value of essential health benefits
  - > Restricted annual limits (as defined by Secretary) on essential health benefits are permissible through plan years that begin before January 1, 2014
  - > Limits may be imposed on non-essential health benefits

## No unreasonable annual limits on the dollar value of essential health benefits

- ✦ The regulations adopt a three-year phased approach for restricted annual limits. Annual limits on the dollar value of benefits that are essential health benefits may not be less than the following amounts:
  - > For plan years beginning on or after September 23, 2010 but before September 23, 2011--\$750,000
  - > For plan years beginning on or after September 23, 2011 but before September 23, 2012--\$1.25 million
  - > For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014--\$2 million

## No unreasonable annual limits on the dollar value of essential health benefits

- ✦ These limitations apply on an individual-by-individual basis
- ✦ Can only take into account essential benefits paid
- ✦ If a participant previously lost coverage due to a lifetime limit in the plan, he/she must be given notice (at least 30 days in advance) to rejoin the plan

## No Lifetime Limits or Annual Limits on Essential Health Benefits

- ✦ If a plan is to apply the restricted annual limits on essential health benefits (as permitted under the rule for a limited period of time), it must first consider how this affects the grandfathered status of the plan
- ✦ For example, if the plan had a previous lifetime limit of \$1 million and no overall annual limit, for the first plan year after September 23, 2010, the plan could add an overall annual limit on essential health benefits equal to \$1 million and still maintain grandfathered status
  - > However, if it adopted an overall annual limit on essential health benefits that was \$750,000 (which is lower than the previous lifetime limit), the plan would be in compliance with the above rule but it would lose its grandfathered status.

## Strict limits on cost-sharing for emergency services (applicable to non-grandfathered plans)

### ✦ This rule requires:

- > (a) non-GF health plans that cover emergency services to cover such services without prior authorization and without regard to whether the health care provider providing the services is a participating network provider,
- > (b) if the emergency services are provided out of network, no imposition of any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services from in-network providers,
- > (c) if the emergency services are provided out of network, complying with the cost sharing rules in the regulations, and
- > (d) that the plan not regard any other term or condition of the coverage other than (i) the exclusion of or coordination of benefits, (ii) permissible waiting periods, or (iii) applicable cost-sharing.

## W-2 Reporting

- ✦ Employers must report the aggregate cost of employer-sponsored health coverage on Form W-2
  - > Cost to be determined on the basis of COBRA premium
    - Regulations are to be issued on how to determine the COBRA premium
  - > “Cadillac Plan” tax will be based on these values
- ✦ Effective date – taxable years beginning 2011
  - > Provide by January 31, 2012 by the latest
  - > May need to be provided to employees prior to that date
  - > Regulations are needed in order to implement this provision in the Act

## Quiz time

- ★ George was terminated from his job at the White Haus Hofbrau on March 15, 2011 and loses health plan benefits as of March 31, 2011. He is a stickler about collecting information about matters that could result in adverse consequences to him, no matter how remote, and asks the Hofbrau for a copy of his Form W-2 on April 1. Does the W-2 have to include information about George's health plan benefits?

## Quiz time

- ★ Yes. Because the Form W-2 requirement applies to taxable years beginning 2011 and terminated employees have a right to receive the Form W-2 within 30 days of their request, the Form W-2 must include such information.

## Health FSA/HRA/HSA Regarding OTC Drugs

- ✦ Effective, January 1, 2011, the cost of an over-the-counter (OTC) medicine or drug cannot be reimbursed from an FSA, health reimbursement arrangement or HSA unless a prescription is obtained
  - > Only prescribed medicines or drugs (including OTC medicines and drugs that are prescribed) and insulin (even if purchased without a prescription) will be considered qualifying medical expenses and subject to preferred tax treatment.
  - > The new rule does not apply to items for medical care that are not medicines or drugs
    - Equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits will still qualify for reimbursement if purchased after Dec. 31, 2010, regardless of whether the items are purchased using a prescription

## Health FSA/HRA/HSA Change Regarding OTC Drugs

- > The changes do not affect purchases of OTC medicines and drugs in 2010, even if they are reimbursed after Dec. 31, 2010
- > Because the new rule applies to purchases that are made after December 31, 2010, purchases of OTC medicines and drugs that are made during any grace period that occurs after 2010 may not be reimbursed without a prescription
- > Use of debit or credit cards: Plan must ensure that debit and credit cards are reprogrammed no later than Jan. 15, 2011, so that they can no longer be used to purchase OTC medicines or drugs
- > After 2010, reimbursement for OTC medicines and drugs must be substantiated with a copy of the prescription (or a copy of the prescription or another item showing that a prescription for the item has been issued) and the customer receipt (or similar third-party documentation showing the date of the sale and the amount of the charge)

## Exchanges

- ✦ Effective not later than January 1, 2014, the Act requires each State to establish an “Exchange” to facilitate the purchase of qualified health plans
  - > Individuals
  - > Small employers in enrolling their employees in qualified health plans
    - Fewer than 100 employees (or 50 employees, as determined by the State)
  - > States may allow large employers access to the Exchange in 2017

## Exchanges

- ✦ Each Exchange will offer individuals and employers with a choice of bronze, silver, gold and platinum coverage levels and a catastrophic plan for young adults under age 30
  - > Premium credits and cost-sharing reduction will be available to individuals depending on income level
    - 100% - 400% of the federal poverty limit for their family size

## Disclosure About Exchanges

- ✦ Employers will be required to provide notice at the time of hire that informs employees:
  - > Of the existence of the Exchange and describes the services provided by the Exchange and how to contact the Exchange
  - > That the employee may be eligible for a subsidy under the Exchange if the employer's share of total costs of benefits is less than 60%
  - > That if the employee purchases a policy through the Exchange without the employer providing a voucher, he/she may lose the employer contribution to any health benefits offered by the employer

# Disclosure About Exchanges

## ✦ Effective date

- > New employees at the time of hire beginning March 1, 2013
- > Current employees not later than March 1, 2013

## Minimum Essential Coverage

- ✦ Effective on and after January 1, 2014, it will be important for individuals to maintain and employers to offer minimum essential coverage to avoid tax penalties
- ✦ Coverage must include “essential health benefits”
  - > Grandfathered health plans are deemed to provide essential health benefits

## Reporting Obligation

- ✦ Must report to the government that:
  - > The employer offers minimum essential coverage to full-time employees
  - > The applicable waiting period
  - > The lowest cost option
  - > The employee's share of the cost of benefits
  - > Total number and names of full-time employees receiving health coverage
- ✦ Effective January 1, 2014
- ✦ Appears to be an employer obligation

## Individual Responsibility

- ✦ The Act generally requires all U.S. citizens and lawfully present residents and their dependents to have minimum essential coverage (as defined in Internal Revenue Code Section 5000A) or be subject to a penalty
  - > Hardship waiver available
  - > For each month that an individual does not have minimum essential coverage for himself/herself and all dependents under age 18, a penalty will be assessed
- ✦ Effective date – Taxable years beginning January 1, 2014

## Employer Responsibility (Free Rider Surcharge)

- ✦ Beginning January 1, 2014, an applicable large employer must provide minimum essential coverage that is affordable or potentially be subject to assessments
  - > An applicable large employer is one that employs an average of at least 50 employees on business days during the preceding calendar year

## Employer Responsibility (Free Rider Surcharge)

- ✦ Full-time employee means an employee who is employed on average at least 30 hours per week
  - > Part-time employees will be included for purposes of determining the number of full-time employees employed by an employer
    - This will be done by adding up the hours of all part-time employees and dividing them by 120
  - > Note: Seasonal employees may be excluded

## Employer Responsibility (Free Rider Surcharge)

- ✦ The IRS will assess a penalty on a large employer for each month that the employer has one or more full-time employees who is enrolled in a qualified health plan offered through an Exchange and who receives a federal subsidy for such coverage (premium credit or cost-sharing reduction) if the employer either:
  - > Does not offer its full-time employees and their dependents minimum essential coverage; or
  - > Offers minimum essential coverage that is not “affordable” (i.e., the employee’s contribution for the coverage is more than 9.5% of the employee’s pay)

# Vouchers

- ✦ Employers who offer, and at least partially pay for, minimum essential coverage and who have employees with incomes of less than 400% of the poverty level and for whom the premium payments cost over 8% but less than 9.8% of their income, must offer these employees a “free choice voucher”
  - > Voucher amount equals the employer contribution under the employer’s plan
  - > Employees may then opt out of the employer’s plan and use the voucher as a credit towards the premium for coverage under an Exchange
    - The employer pays the amount of the voucher to the Exchange
- ✦ If the amount of the voucher exceeds the premium for the Exchange coverage, the excess will be paid to the employee
- ✦ Effective in 2014

## “Cadillac Tax” on High Cost Plans

- ★ IRS will impose a 40% excise tax on excess benefits provided to employees under group health plans whose actuarial value exceed certain dollar thresholds
  - > For 2018 –
    - Self-only coverage: \$10,200
    - Other than self-only coverage: \$27,500
    - The threshold for multiemployer plans is \$27,500 only

# “Cadillac Tax” on High Cost Plans

## > Who pays

- If coverage is insured, the health insurance issuer
- If any other employer-sponsored coverage, the person that administers the plan benefits (e.g., plan sponsor/employer)

★ Applicable to taxable years beginning after December 31, 2017

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