HUNTON& WILLIAMS

CLIENT ALERT

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Health Care Reform — What Employers Need To Know Now

President Obama recently signed into law both the Patient Protection and Affordable Care Act (the "PPACA") and the Health Care and Education Reconciliation Act of 2010, which amends the PPACA. These two Acts will significantly change the health care landscape in the United States.

Set out below is an overview of the rules that will apply to employer-sponsored group health plans ***before 2014*** — the year in which the major long-term reforms will first go into effect. As reflected below, some of the new requirements will **not** apply (or will apply on a limited basis) to "grandfathered" plans — generally, group health plans that were in existence on the date of enactment (March 23, 2010). In addition, there is a **delayed** effective date for collectively bargained programs (described in more detail below).

I. New Retiree Medical Subsidy

The new law establishes a $5 billion reinsurance fund to reimburse employer-sponsored plans for the covered health expenses of pre-Medicare-eligible retirees (and their dependents). The program will go into effect 90 days after enactment and end on December 31, 2013 (or when the fund is exhausted, if earlier). In general, the program will work as follows:

- It will apply only to the benefits of retirees who are 55 and older (up to the date the retiree becomes entitled to Medicare: generally, age 65).
- Under the program, 80 percent of the annual claims between $15,000 and $90,000 for the pre Medicare group can be reimbursed.
- Note, though, that the subsidy may **not** be used for general corporate purposes, but must be used to reduce plan participant premium costs/contributions, copayments, deductibles or other plan costs.
- Eligible employers must apply to the Department of Health & Human Services ("HHS") to participate; presumably, HHS will be providing guidance in the near future on how this process will work.

II. New Requirements For All Group Health Plans

The following requirements will apply to **all** group health plans, **including** grandfathered programs:

For the first plan year beginning on or after September 23, 2010 *(which, for calendar year plans, will be January 1, 2011):*

- Adult Child Coverage: Dependent coverage must be made available for adult children under **age 26**, regardless of the child's marital status. However, prior to 2014, grandfathered plans are **not** required to offer coverage to those adult children who are eligible to enroll under another group health plan.

  NOTE that the new law provides that such coverage can be provided on a tax-free basis.

- Lifetime/Annual Limits:

  a. Lifetime dollar limits may no longer be applied to "essential health benefits," which basically include emergency care, hospitalization, maternity/newborn care, preventive/wellness services, prescription drugs, mental health and substance abuse services, pediatric care and other basic benefits, but probably does not include dental and vision care.

  b. Group health plans may impose annual dollar limits only for essential benefits on a "restricted" basis through plan years beginning before 2014 (and not at all thereafter); government guidance obviously will be needed to determine permissible annual limits.

- Pre-Existing Condition Exclusions: No pre existing condition exclusions may be applied to children under the age of 19 for plan years beginning before 2014 (and **no** such exclusion may be applied at all thereafter).

- Rescission of Ongoing Coverage: Coverage may **not** be rescinded (other than presumably where the enrollee otherwise ceases to be eligible) except in the case of fraud or an intentional misrepresentation of a material fact (in which case, advance notice will be required).

For 2011 and subsequent calendar years:

- Reimbursement of Over-The-Counter Medicines: Over-the-counter medications that are **not** prescribed by a physician will no longer be reimbursable under a health care flexible spending account (FSA), health savings account (HSA) or medical savings account (MSA).

- New W-2 Reporting Requirements: The total annual cost of employer-provided coverage for each employee (excluding HSA and health care FSA contributions) must be reported on the Form W-2.

Within 24 months of enactment *(March 23, 2012):*

- Uniform Coverage Explanation & Notice of Material Changes: Group health plans will be required to provide:

  a. A summary to plan enrollees containing uniform terms in a format to be developed by HHS upon enrollment and annually thereafter, and

  b. 60 days' advance notice of any interim material change to the plan (or any plan coverage).

NOTE, though, that the effective date for these changes (for grandfathered plans) is the first plan year beginning after the date of enactment (March 23, 2010), which may mean that the 60-day advance notice requirement may be **applicable earlier**. It is anticipated that government guidance will clarify this matter.

For plan years ending after September 30, 2012 *(for calendar year plans, January 1, 2013):*

- Temporary Group Health Plan Fee: An annual fee ($1 per participant in the first year and $2 in the second) will be assessed to fund certain mandated research projects through the last plan year ending on or before September 30, 2019 —; in short, the fee will apply for seven years.

For 2013 and subsequent calendar years:

- Health Care FSA Contribution Cap: The maximum amount that an employee may elect to contribute to a health care FSA for any year will be capped at $2,500; note that this limit will be subject to adjustment for cost-of-living changes thereafter.

III. Requirements For Newly Established and other Nongrandfathered Group Health Plans

The following requirements will apply **only** to **nongrandfathered** health programs: generally, **new** group health plans established after the date of enactment (March 23, 2010).

For the first plan year beginning on or after September 23, 2010:

- Preventive Care: The plan must provide preventive care without any cost sharing and cover child health preventive services (as provided in government guidance).
- Patient Protections for In-Network Coverage: A plan with any in-network coverage (i) must permit participants and their dependents to select any participating doctor as their primary care physician and (ii) may not require advance authorization for emergency services.
- Expanded Claims Review Process: Covered plans will be required to (i) establish both an internal and external claims review process that meets certain statutory standards, (ii) provide expanded rights for claimants during the appeals process and (iii) allow them to maintain their coverage during that process.
- Expansion of Nondiscrimination Rules: The long-standing rules that generally bar self insured health plans from discriminating in favor of high-paid employees now will apply to insured health plans as well.

Lastly, the new law obligates employers to report annually claims, benefits and other plan information that may be required by future HHS or other government guidance.

IV. Delayed Effective Date for Union Employee Health Programs

The new law will **not** go into effect for health programs maintained pursuant to a collective bargaining agreement (CBA) that was in effect on March 23, 2010, **until** the date the CBA expires (or, if there is more than one CBA, the date the last one expires). Upon expiration, it appears these programs will be subject to the grandfather rules described above (but government guidance may be needed to clarify this).

We welcome the opportunity to answer any questions you may have regarding the new health care reform rules described above or assist you in complying with them.