Benefits Alert

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The Patient Protection and Affordable Care Act: Changes for 2010 and 2011 Require Immediate Attention

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On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (the "PPACA")[1], and, on March 30, 2010, he signed the Health Care and Education Reconciliation Act of 2010 (the "HCERA") (collectively, the "Act"). The Act sets forth significant new requirements for employers and employer-sponsored group health plans.

While many of the key provisions of the Act do not take effect until 2014 or later, there are certain provisions that will soon affect employers. In some cases (such as the new dependent coverage age limit, prohibition on pre-existing condition limitations, and prohibition on annual and lifetime limits), prompt action is required by employers *before* the beginning of their next plan year. In other cases (such as the "free rider" penalties, vouchers, and insurance exchanges), the changes will not take effect for several years; in the interim, it is quite possible that these provisions of the Act will be modified.

This newsletter provides a brief overview of the key provisions affecting employers this year and next year and recommendations on how to proceed. We will be sending out another newsletter regarding changes effective in later years.

Effective January 1, 2010

- Small-Business Tax Credit. A phased-in tax credit of up to 35% of the employer's contribution to purchase health insurance is now available for certain small employers.[2] Generally, these are employers that have no more than 25 full-time equivalent employees for the taxable year with average annual compensation of $50,000.[3] In 2014, when health insurance exchanges are established, the available tax credit will increase to 50%. *Small employers will want to evaluate the availability of the credit.*
- Adoption Assistance Programs. The Act increases the adoption assistance program exclusion (and adoption tax credit) by $1,000 to $13,170.[4] *Employers with adoption assistance programs may choose to increase the amount available under their programs.*

Effective June 21, 2010

- Early Retirees. The Act establishes a temporary reinsurance program for employers providing health coverage to retirees over age 55 who are not eligible for Medicare.[5] It reimburses employers for 80% of claims in excess of $15,000 up to $90,000. Plans are required to use the funds to lower costs assumed directly by participants and beneficiaries. The program ends on January 1, 2014. *Employers with early retiree coverage may want to consider obtaining these incentives.*

Effective for Plan Years Beginning on or after September 23, 2010

- Lifetime Limits. The Act prohibits lifetime dollar limits on "essential health benefits"—a term that will be specifically defined in forthcoming regulations of the Department of Health

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and Human Services ("HHS").[6] *Employers will need to review and amend their plans to remove these limits. From a cost standpoint, this may effectively result in employers having to raise their premiums.*

- Annual Limits. Group health plans are also prohibited from imposing unreasonable annual limits on the dollar value of benefits.[7] HHS is commissioned with setting the cap on annual limits that may be imposed. Beginning in 2014, the Act prohibits any annual limits. *As with lifetime limits, employers will need to review and amend their plans accordingly.*
- Pre-Existing Conditions. The Act provides that group health plans may not impose any pre-existing condition exclusions with respect to such plans or coverage. For individual under age 19, this requirement is effective for plan years beginning on or after September 23, 2010.[8] However, for others, it is generally effective for plan years beginning on or after January 1, 2014. *Employers who have plans with pre-existing conditions limitations need to amend their plans accordingly.*
- Dependent Coverage. The Act requires a group health plan that provides dependent coverage to continue to make that coverage available until the child turns age 26, if the child does not have access to other health coverage (without regard to the child's marital or student status).[9] *Employers will also need to amend their plans to provide the dependent coverage.*
- Nondiscrimination. The Act applies the non-discrimination rules of self-funded plans to insured plans.[10] *Employers with fully insured plans will now need to determine if their plans satisfy the nondiscrimination requirements regarding eligibility and benefits.*
- Transparency Disclosures. Group health plans under the Act will be required to provide the following transparency disclosures: claims payment policies and practices; periodic financial disclosures; data on enrollment, disenrollment, the number of claims that are denied, and rating practices; information on cost-sharing and payment with respect to any out-of-network coverage; information on enrollee and participant rights; and other information required by HHS.[11] *This will likely require plans to develop and distribute new disclosure documents.*
- Preventive Health Services. The Act requires that group health plans provide first-dollar coverage for certain preventive services (*e.g.*, not subject to a deductible, copayment, or coinsurance).[12] Examples of preventive services include well-childcare visits and certain immunizations. *Employers will need to amend their plan materials accordingly.*
- Appeals Procedure. Under the Act, group health plans must implement an effective internal appeals process; provide notice to participants of available internal and external appeals processes and the availability of any applicable office of health insurance consumer assistance or ombudsman established to assist such enrollees with the appeals processes; and allow participants to review their files, present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process. Self-funded group health plans must implement an external review process in accordance with minimum standards to be established. Insured plans will have to satisfy external review requirements mandated by the state, which will be binding, or by the Secretary of HHS if the state does not have procedures.[13] *Although plans may have claim and appeal procedures to comply with Department of Labor regulations, these additional procedures are required. However, it is not clear whether this will require changes to the ERISA claims procedures.*
- Provider Selection. The Act requires that a plan enrollee be allowed to select their primary care provider, or pediatrician in the case of a child, from any available participating primary care provider. It precludes the need for prior authorization or increased cost-sharing for emergency services, whether provided by in-network or out-of-network providers. Also, plans are precluded from requiring authorization or referral to an Ob-Gyn doctor.[14] *Employers will need to amend their plans accordingly.*
- Rescission. The Act prohibits rescission of group health plan coverage without prior notice (except in cases of fraud or misrepresentation).[15] *Plans may need to be amended accordingly.*

Effective January 1, 2011

- Restrictions on Drugs and Medicines. For health reimbursement accounts, health flexible savings accounts, health savings accounts, and Archer medical savings accounts, reimbursable medical expenses include medicines or drugs only if they are prescribed or are insulin.[16] *Benefit plans will need to be amended accordingly if they are designed to cover over-the-counter drugs or medicines.*
- W-2 Reporting. The Act requires employers to disclose the aggregate value of the health benefit provided by the employer for each employee on the employee's annual Form W-2.[17] *Employers will need to make this change in their payroll reporting procedures.*
- Health Savings Account ("HSA") Distributions. The Act increases the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 percent to 20 percent.[18] *For some participants, this may make an HSA less attractive. Employers may need to consider the effect this change could have on enrollment in their high deductible health plans.*
- Cafeteria Plans. The Act creates a new "simple cafeteria plan," which will allow small employers to provide tax-free benefits to their employees with a more simplified plan

design.[19] Small employers are those who on average employ 100 or fewer employees over the prior two years. The Act exempts employers who make contributions for employees under a simple cafeteria plan from certain nondiscrimination requirements applicable to highly compensated and key employees. *Small employers may want to consider adopting a simple cafeteria plan or restating their current plan to take advantage of the simplified format and nondiscrimination rules.*

- Long-Term Care. The Act creates a government-run voluntary long-term care program (CLASS Act). Employers are expected to automatically enroll employees and facilitate payroll deductions.[20]

As a final note on specific provisions, under the Act, large employers (with more than 200 employees) must automatically enroll eligible individuals in employer-sponsored coverage and provide adequate notice and an opportunity for such individuals to opt out.[21] The effective date of this change is unclear. The change could be effective as soon as implementing regulations are issued.

Effective Dates

It is very important to note that the Act does contain different effective dates with respect to certain provisions of the Act for "grandfathered" plans, which are generally plans in effect on March 23, 2010.[22] In addition, employers will need to consider the extent to which the provisions of the Act may not apply at all if their plans were in effect on March 23, 2010. Also, plans subject to a collective bargaining agreement ratified on or before March 23, 2010, are generally not required to comply with certain coverage standards until the current agreement terminates.[23]

The Act contains significant changes for employers sponsoring group health plans. Employers need to be aware of the changes and plan accordingly. We will follow up with a newsletter on changes that are scheduled to affect employers after 2011. However, it remains to be seen whether some of the changes will be modified before they become effective.

If you have any questions about the Act, please contact one of the attorneys in the Employee Benefits & Executive Compensation Group at Bradley Arant Boult Cummings LLP.

1 References to the PPACA include references to the Manager's Amendment to the PPACA.
2 PPACA Sections 1421, 10105.
3 Internal Revenue Service guidance on the credit can be found on the Internal Revenue Service website at http://www.irs.gov/newsroom/article/0,,id=220839,00.html
4 PPACA Section 10909.
5 PPACA Sections 1102, 1105, 10102(a).
6 PPACA Sections 1001(5), 10101(a); HCERA Section 2301(a).
7 PPACA Sections 1001(5), 10101(a); HCERA Section 2301(a).
8 PPACA Sections 1201, 10103(e); HCERA Section 2301.
9 PPACA Section 1001(5); HCERA Sections 1004(d), 2301(b).
10 PPACA Sections 1001(5), 10101(d).
11 PPACA Section 10101(c).
12 PPACA Section 1001(5).
13 PPACA Sections 1001(5), 10101(g).
14 PPACA Section 10101(h).
15 PPACA Section 1001(5); HCERA Section 2301(a).
16 PPACA Section 9003.
17 PPACA Section 9002.
18 PPACA Section 9004.
19 PPACA Section 9022.
20 PPACA Section 8002.
21 PPACA Section 1511.
22 PPACA Sections 1251(a), (e)
23 PPACA Section 1251(d).