

The New National Health Care Reform Law's Key Provisions for Multiemployer Plans

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. On March 30, 2010, the President signed into law the Health Care and Education Reconciliation Act (HCERA, also known as the “budget reconciliation bill”), which contains a package of significant amendments to the PPACA.¹ Together, these two laws will go into the history books as the new national health care reform law.

The centerpieces of health care reform — the individual mandate, subsidies, Health Insurance Exchanges and the employer free-rider penalty — are all effective in 2014. However, important changes to plan benefit design rules, certain tax rules and the Medicare program are effective either in the near future or over the next four years. This *Bulletin* summarizes the PPACA's key provisions of interest to multiemployer plan sponsors, as amended by the HCERA (for ease of reference, both are referred to as the “Act” or the “law”).

PROVISIONS EFFECTIVE IN 2010/2011 FOR EXISTING GROUP HEALTH PLANS

The Act generally grandfathers all group health plans in existence on the day of enactment. A grandfathered group health plan (insured or self-insured) will not have to comply with most of the health insurance reforms included in the Act. Plans appear to keep grandfathering protection even when new employees or family members are added to the plan. There are, however, some new plan standards applicable to existing group health plans.

¹ When the PPACA (Public Law 111-148) and the HCERA (Public Law 111-152) are available online, they will be accessible from the following page of the Government Printing Office (GPO) Web site: <http://www.gpoaccess.gov/plaws/111publ.html>

Plan Standards

Grandfathered group health plans will have to comply with the requirements listed below effective with the plan year that begins on or after October 1, 2010 (for calendar-year plans, that will be January 1, 2011). The statute contains a provision with a delayed effective date for collectively bargained plans. However, it is unclear how this provision applies. Therefore, fund counsel should be consulted about the effective date for collectively bargained plans.

- ***Lifetime/Annual Limits*** Lifetime and annual limits on the dollar value of essential benefits, such as hospitalization and prescription drugs, will be prohibited. However, the Secretary of Health and Human Services will establish rules allowing the application of some types of annual dollar limits prior to 2014.
- ***Adult Children*** Group health plans that provide dependent coverage of children will be required to continue to make that coverage available until the child reaches age 26. However, for plan years that begin prior to January 1, 2014, the requirement only applies to children who are not eligible to enroll in another employer-sponsored plan. A separate tax change in the law allows coverage for children to be provided on a tax-free basis through the end of the year the child turns 26. This tax change appears to take effect upon enactment of the HCERA (March 30, 2010).
- ***Preexisting Conditions*** Preexisting condition exclusions cannot be imposed for children under age 19. (This protection is extended to adults in 2014).
- ***Rescission*** Plans cannot rescind health coverage (except for fraud or intentional misrepresentation).
- ***Disclosure Requirements*** All plans will have to comply with new rules concerning standardized information disclosure (including a new requirement that plans notify participants of benefit modifications 60 days prior to their effective date), although it

appears that plans will have two years from the date of enactment to comply with these requirements.

Health Flexible Spending Account (FSA) Maximums and Restrictions on Paying for Over-the-Counter (OTC) Medications

Starting in 2011, a health reimbursement arrangement (HRA), an FSA or a health savings account (HSA) will only be permitted to reimburse the cost of over-the-counter medications if a health care provider prescribes them. Beginning in 2013, health FSA contributions will be capped at \$2,500 per year (indexed). The Act also increases the penalty for withdrawing HSA funds for nonqualified expenses from 10 percent to 20 percent beginning in 2011.

New Long-Term Care Program

The Act creates a new, voluntary, public long-term care insurance program beginning in 2011, called the Community Living Assistance Services and Supports (CLASS) program. Benefits are a daily or weekly cash benefit to help people with functional limitations purchase the services and supports needed to maintain personal and financial independence. The CLASS program will supplement, not supplant, traditional payers of long-term care (e.g., Medicaid and/or private long-term care insurance).

Employer W-2 Reporting

Employers will be required to report the value of the benefits provided by the employer for each employee's health coverage on the employee's annual Form W-2. The first set of these W-2 forms will be due in 2012, reflecting coverage provided in 2011. The law does not address how employers are to report coverage under a multiemployer plan.

PROVISIONS FIRST EFFECTIVE AFTER 2011 FOR EXISTING GROUP HEALTH PLANS

The following provisions will take effect after 2011 for existing group health plans:

- **Waiting Periods** Waiting periods for health care coverage of more than 90 days will be prohibited for plan years beginning on or after January 1, 2014.
- **Automatic Enrollment** Employers with more than 200 employees will be required to automatically enroll employees into their employment-based health plan. It is unclear when the automatic enrollment requirement is effective.
- **Wellness Programs** The Act increases the amount of the potential incentive/penalty under the Health Insurance Portability and Accountability Act (HIPAA) wellness rules to 30 percent of premium,

and prohibits questions in health-risk assessments that ask about gun ownership.

- **Comparative Effectiveness Research Fee** Beginning in 2012, the Act imposes a fee of \$2.00 (indexed) per covered life per calendar year to fund comparative effectiveness research. (The rate is \$1.00 per covered life in the first year.) The fee is payable by both insurers and self-insured plans and sunsets in 2019.
- **HIPAA Electronic Data Interchange (EDI) Certification** By the end of 2013 and 2015, health plans will be required to certify compliance with certain HIPAA EDI transaction standards.

PROVISIONS OF INTEREST TO RETIREE HEALTH PLAN SPONSORS

Retiree Reinsurance Program

Effective within 90 days of enactment, the Act establishes a temporary reinsurance program to reimburse employment-based plans, including multiemployer plans and Voluntary Employees' Beneficiary Associations (VEBAs), for a portion of the claims incurred by early retirees age 55 or older who are not eligible for Medicare. The program will reimburse plans for 80 percent of the claims for a covered individual between \$15,000 and \$90,000. Plans will be required to use the funds to lower costs for the plan. The program will be funded with \$5 billion and will terminate when funds run out.

Medicare Program Changes

The Act contains significant changes to the Medicare program. Those that directly affect employer-sponsored plans include the following:

- In 2010, Medicare beneficiaries in Prescription Drug Plans (PDPs) and Medicare Advantage (MA) plans that provide prescription drugs (MA-PDs) will receive a one-time \$250 payment when they reach the coverage gap ("doughnut hole").² Effective in January 2011 through 2020, many individuals in these Part D plans will receive additional discounts on brand-name and generic drugs purchased while the beneficiary is in the doughnut hole. The full negotiated price of the drug will count toward a beneficiary's True Out-of-Pocket (TrOOP) costs.³ By 2020, the doughnut hole is eliminated. However, these changes will affect both PDP and MA-PD costs and the actuarial equivalence calculations performed for the

² For an illustration of the doughnut hole in 2011, see the chart in The Segal Company's April 15, 2010 *Capital Checkup*: <http://www.segalco.com/publications-and-resources/multiemployer-publications/capital-checkup/archives/?id=1428>

³ These are the costs borne by the beneficiary before he or she reaches the catastrophic portion of the benefit.

Retiree Drug Subsidy, meaning retiree plans should reexamine their coordination with the Part D program.

- Medicare Part D premium costs will be higher for high-income beneficiaries.
- Medicare payments to MA plans will be frozen in 2011 at 2010 rates. Starting in 2012, those payments will be decreased. In addition, starting in 2014, MA plans will be required to spend at least 85 percent of revenue on medical costs.
- Beginning on January 1, 2011, Medicare beneficiaries will receive a free annual wellness visit where they will be provided with a personalized prevention plan, including a health-risk assessment and screening schedule. Cost-sharing will be waived for certain preventive care and screenings.

A variety of Medicare initiatives with potential for cost savings will be implemented, including an Independent Payment Advisory Board to review Medicare payments; comparative effectiveness research; and pilot projects around payment/quality reform.

SHORT-TERM HEALTH REFORMS

Small-Business Tax Credits

Tax credits of up to 35 percent of premiums will be available to small businesses that offer health coverage

Health Insurance Reforms Not Applicable to Existing Group Health Plans

Other requirements in the Act that will apply directly to newly established group health plans, but not to plans in existence on the date of enactment, include the following (many of which will be effective six months after enactment):

- Cost-sharing requirements that set maximum deductible and annual out-of-pocket limits for participants.
- New appeals processes that require both internal and external appeals.
- Cover preventive and wellness benefits with no deductibles or other cost-sharing.
- Allow plan participants to choose any participating primary care provider.
- Provide emergency care services without prior authorization and with the same cost-sharing both in and out of network.
- Applies existing Internal Revenue Code Section 105(h) rules that prohibit discrimination in favor of highly compensated employees to insured plans as well as self-insured plans.
- Cover treatment provided in a clinical trial.
- Provide additional information about plan costs, in order to meet certain “transparency” requirements.

beginning in 2010. Additional credits will be available in 2014 when the Exchanges go into operation. The credits will be available on a sliding scale to small businesses with fewer than 25 employees and average annual wages of less than \$50,000. The most generous credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. Application of the credits to employers that contribute to multiemployer plans is not yet clear.

Medical Loss Ratio

For plan years beginning on or after the date of enactment, insurers will be required to maintain a medical loss ratio of not less than 85 percent for large groups (80 percent in the individual and small group markets). Insurers that do not meet the medical loss ratio standard will be required to provide rebates to policyholders.

High-Risk Pools

The legislation establishes a national high-risk pool beginning in 2010 for individuals who have been uninsured for six months and have a preexisting condition.

LONG-TERM HEALTH REFORMS

Health Insurance Exchanges

Effective in 2014, the Act requires each state to establish an Exchange, which will serve as a marketplace in which individuals and small businesses can purchase health insurance coverage. Employers with 100 or fewer employees could provide coverage through a plan in an Exchange. Beginning in 2017, states could allow large employers (101 employees or more) to purchase health insurance coverage through an Exchange. Medicaid eligibility will be expanded to people under age 65 with incomes up to 133 percent of the Federal Poverty Level (FPL), while those with incomes between 133 percent and 400 percent of the FPL will be eligible for subsidies to assist them in purchasing insurance in the Exchange.

Individual Mandate

Starting in 2014, individuals will be required to obtain health coverage. Individuals who do not have health insurance coverage would pay a penalty when they file their income tax returns.

Employer Free-Rider Penalty

An employer with 50 or more full-time employees that fails to provide minimum essential coverage would have to pay a fine for every month that at least one of its full-time employees receives a federal subsidy to buy coverage through the Exchange. This fine would equal \$2,000 times one-twelfth times the number of full-time employees the employer had that month. An employee is not considered to have minimum essential coverage

Miscellaneous Tax Changes

The Act includes the following tax changes:

- > **Provider Fees** The Act imposes annual fees on various suppliers in the health care market, including pharmaceutical manufacturers (effective in 2011), medical device manufacturers (effective in 2013) and health insurers (effective in 2014).
- > **Medicare Tax Increase** Beginning in 2013, the Medicare hospital insurance tax on high-income individuals (single: \$200,000/couple: \$250,000) will increase 0.9 percent (to 2.35 percent), and people at those income levels will pay a 3.8 percent tax on net investment income (which would include interest, dividends, royalties and rents, but *not* distributions from qualified pension and profit-sharing plans).

if: (1) the employee's required contribution for the employer's coverage would exceed 9.5 percent of the employee's household income; or (2) the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

In addition, even employers that provide minimum essential coverage would be fined for each full-time employee who opts out of the employer's plan and receives federal subsidies through the Exchange. In this circumstance, the fine for every month that each such employee receives a federal subsidy would equal one-twelfth times \$3,000.

Free-Choice Vouchers

Effective in 2014, the Act requires an employer that offers minimum essential coverage to offer a free-choice voucher to employees who meet certain income standards and do not participate in the employer's plan. The voucher will equal the amount the employer would pay for health coverage under the plan for which the employer contributes the highest portion of the cost. The employee can use it to purchase coverage in the Exchange. If the voucher is for more than the price of the plan in the Exchange, the employee will receive the difference in cash.

Excise Tax on High-Cost Health Plans

Beginning in 2018, the Act will impose a 40 percent excise tax on the cost of health plans above a threshold of \$10,200 single/\$27,500 family. Multiemployer plans will be treated as providing family coverage for all of their participants. The thresholds will be increased for retirees over the age of 55 and individuals engaged in high-risk professions, long-shore workers, or workers employed to repair or install electrical or telecommunications lines, by \$1,650 for individual coverage and \$3,450 for family coverage. They will be indexed for inflation based on the Consumer Price Index for All Urban Consumers (CPI-U) plus 1 percent in 2019 and by the CPI-U thereafter. The thresholds can also be adjusted for age and gender of the group, but no adjustment

is made for plans covering people in high-cost areas. The cost of dental and vision benefits will not be counted.

IMPLICATIONS FOR PLAN SPONSORS

Plan sponsors will be working through the implications of national health care reform for years, but the first step is to review the reforms for the coming plan year and, if the plan includes retirees, plan for the changes that will come with the retiree reinsurance program and Medicare reforms. Plan sponsors should expect to hear from their insurers and administrators about their plans for compliance and the effect on plan administration and costs. In addition to the new administrative challenges, plan sponsors are likely to continue to face health care cost inflation and, at least in the short run, may need to deal with new cost pressures as the system adjusts to national health care reform.



As with all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their attorneys for authoritative advice on the interpretation and application of the sweeping national health care reform law. Segal can be retained to work with trustees of multiemployer plans and their fund counsel on compliance issues. In addition, Segal can help them to evaluate their current plan design and draft participant communications. Segal will keep clients informed as regulations related to the law are issued.



ATLANTA	678.306.3100
BOSTON	617.424.7300
CALGARY	403.692.2264
CHICAGO	312.984.8500
CLEVELAND	216.687.4400
DENVER	303.714.9900
HARTFORD	860.678.3000
HOUSTON	713.664.4654
LOS ANGELES	818.956.6700
MINNEAPOLIS	952.857.2480
MONTREAL	514.989.3735
NEW ORLEANS	504.483.0744
NEW YORK	212.251.5000
PHILADELPHIA	215.854.4017
PHOENIX	602.381.4000
PRINCETON	609.520.2700
RALEIGH	919.233.1220
SAN FRANCISCO	415.263.8200
TORONTO	416.969.3960
WASHINGTON	202.833.6400

www.segalco.com