July 2010 | *Volume 1, Edition 2*

Perspectives

AN EXECUTIVE COMPENSATION, BENEFITS, & HUMAN RESOURCES LAW UPDATE

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Print Newsletter

IN THIS EDITION...

QUESTIONS FROM OUR READERS...

Q. If I make changes to my grandfathered health plan, will it lose its grandfathered status under health care reform?

A. Not necessarily. New interim regulations under PPACA generally permit grandfathered plans to make routine changes, such as modest adjustments to benefits coverage, cost adjustments to account for medical inflation and changes in plan premiums. They also allow grandfathered plans voluntarily to adopt any of the consumer protections under PPACA and to make other amendments necessary to comply with state or federal law. There are, however, some changes that grandfathered plans cannot make without losing their grandfathered status. These include cutting or significantly reducing benefits, significantly increasing deductibles or co-payments, increasing co-insurance charges, significantly decreasing employer premium contributions and adding or increasing any annual limit on insurance payments. Any of these changes will cause an otherwise grandfathered plan to become subject to the full slate of market reforms set out in the PPACA.

Upcoming Events...

The Effect of Health Care Reform on Hospitals
Tuesday, July 13, 2010
Webinar

Health Care Reform Update:
Preparing for Open Enrollment
Tuesday, September 14, 2010
Webinar

Recent Publications...

Are You Ready For the IRS 401(k) Compliance Check Questionnaire?

Increased IRS Scrutiny: Why All Employers Should Review Worker Classifications Now

The Effect of Health Care Reform on Hospitals: A Summary Overview

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Health Care Benefits Update: Amending Plans for Adult Children; New COBRA Notices

by Mark Jones

Print this article

Several sets of health care guidance have recently been issued that require prompt employer action. Interim final rules have been published under the health care reform bill requiring employers that maintain group health plans covering children of participants to extend coverage to adult children. The IRS has issued companion guidance that permits employers to offer tax-exempt coverage of adult children retroactively to March 30, 2010, under their health plans, including cafeteria plans, provided the cafeteria plans are amended by the end of this year. The Department of Labor is also requiring employers to amend and distribute COBRA notices to employees and covered family members affected by the most recent extension of the COBRA subsidy period.

Mandatory Coverage of Adult Children

The Patient Protection and Affordable Care Act (the "Affordable Care Act"), as discussed in our client alert dated March 30, 2010, requires all insured group health plans and self-insured plans that offer coverage to participants' children to include any children who are under age 26 and would be treated as dependents under the plan but for their age. This change is effective for plan years beginning on or after September 23, 2010. Plans in existence on March 23, 2010, however, may wait until the 2014 plan year to extend coverage to adult children who are eligible to enroll in another employer-sponsored health plan.

On May 13, 2010, the U.S. Departments of Treasury, Labor, and Health and Human Services published interim final rules under the Affordable Care Act requiring plan sponsors to implement this change by amending their plans to re-define the term "dependent," for purposes of eligibility of children, solely in terms of the relationship between the child and the participant. Therefore, employers must remove from their plan documents, including summary plan descriptions and enrollment materials, any other eligibility requirements such as financial dependency, student status or shared residence. The preamble to the interim rules states that amendments to plan terms made to comply with the requirement to extend coverage to adult children, including voluntary compliance before the September 23, 2010 effective date, should not cause a plan in existence on March 23, 2010 to lose its grandfathered status for any purpose under the Affordable Care Act.

In broadening the definition of "dependent," employers may not vary the terms of coverage of children based on age. For example, employers may not impose an additional surcharge for the coverage of adult children or restrict the benefit available to adult children in a way that does not apply to children generally.

The interim final rules also require employers to revise their plan materials to offer a special enrollment period of at least 30 days, beginning no later than January 1, 2011, for calendar-year plans, for any children whose coverage ended or who were previously ineligible for coverage, including any such children receiving continuation health care ("COBRA"), because the plan imposed an age limit below age 26. These children must be offered the same benefits at the same cost offered to similarly situated individuals who retained coverage. Employers must also provide written notice, either as part of the plan's enrollment materials or separately, to all such children (or their eligible parents), informing them of their eligibility for coverage and the new enrollment period.

Tax Exemption for Coverage of Adult Children

In a companion piece of legislation to the mandatory coverage rules, the Health Care and Education Affordability Reconciliation Act of 2010 (the "Reconciliation Act") expanded the exclusion from gross income under Section 105(b) of the Internal Revenue Code (the "Code") for payments received under an employer-provided health plan for adult children (including children who are not "dependents" of the employee under Section 152 of the Code) through the end of the year in which they turn 26, effective as of March 30, 2010. The Reconciliation Act did not amend Section 106 of the Code, which excludes employer-provided health plan coverage from an employee's gross income, but on April 27, 2010, the Internal Revenue Service (the "IRS") released Notice 2010-38, which states that the agency intends to adopt regulations under Section 106 that relieve employees from having the value of employer-provided coverage for adult children imputed to them.

Notice 2010-38 also clarified that employee health plan contributions for qualifying adult child coverage will be tax-exempt, including contributions to a health reimbursement account or a cafeteria plan (including a health flexible spending account). Generally, these plans will need to be amended by the end of the year to take advantage of this exclusion, and the IRS has created specific transitional relief allowing cafeteria plans to be amended retroactive to March 30, 2010, to cover qualifying adult children if the employer adopts the amendments by December 31, 2010. For most plans, adopting these amendments in 2010 is voluntary. As discussed above, single-employer, calendar-year health plans are not required to cover adult children until 2011.

The IRS also intends to modify cafeteria plan regulations under Section 125 of the Code to permit mid-year changes in election in the event an adult child incurs a "change in status," such as becoming newly eligible for coverage or becoming eligible for coverage beyond the date on which the adult child would otherwise have lost coverage. Doing so would allow employees who participate in cafeteria plans to make pre-tax contributions this year to cover expenses for their adult children, if the cafeteria plans are amended by the end of the year.

Employers do not need to verify the age of any child who is added as a beneficiary to a plan. They may rely on an employee's representation of age for this purpose. Stepchildren, adopted children and qualifying foster children are considered "children" for all purposes of the exemption.

The IRS also clarified that the value of employer-provided coverage and payments from an employer health plan for adult children will not be subject to withholding taxes or treated as wages subject to employment taxes. In addition, the definition of "dependent" will be amended in applicable regulations so that the inclusion of adult children as beneficiaries under a health plan will not jeopardize the tax-exempt status of any VEBA or Section 401(h) account funding the plan.

Extension of COBRA Subsidy through May 31, 2010

On April 15, 2010, President Obama signed into law the Continuing Extension Act of 2010, extending by two months, through May 31, 2010, the eligibility period during which employees and their family members may receive a 65% subsidy toward premiums for federal COBRA coverage or coverage under comparable state laws, such as so-called "mini-COBRA" programs. Prior to this extension, COBRA premium subsidies were available only for employees whose employment ended prior to April 1, 2010. (The COBRA subsidy is discussed in our client alerts dated February 24, 2009, March 24, 2009 and April 10, 2009.)

To be eligible to receive the COBRA premium subsidy, the employee must have had either (i) an involuntary termination, resulting in eligibility under federal COBRA or comparable state law, between September 1, 2008, and May 31, 2010, or (ii) a reduction in hours between September 1, 2008, and May 31, 2010, resulting in a loss of coverage, followed by an involuntary termination between March 2, 2010, and May 31, 2010. During the subsidy period, which runs for up to 15 months from the

Health Care Benefits Update: Amending Plans for Adult Children; New COBRA Notices (continued)

date on which the individual first becomes eligible for assistance, individuals who pay 35% of their COBRA premium are treated as having paid the full amount. The remaining 65% of the premium is reimbursable to the employer maintaining the plan as a credit against payroll taxes.

Plan administrators must provide a general COBRA notice that describes the extended subsidy period to any individual or covered family member of an individual who experienced any event that qualified them for COBRA coverage (including, but not limited to, termination of employment) during the period between September 1, 2008, and May 31, 2010. If any individual whose employment was terminated between March 1, 2010, and April 14, 2010, already received a general COBRA notice, then the plan administrator must provide the individual and his or her covered family members with a supplemental notice describing the extended subsidy period. The Department of Labor has posted model notices for this purpose on its website at http://www.dol.gov/ebsa/COBRAmodelnotice.html, as well as special notices for individuals who lost coverage owing to a reduction in hours followed by a termination of employment, and for individuals covered by state laws comparable to COBRA.

In general, individuals have 60 days after loss of coverage to elect COBRA. However, if an individual's employment ended between April 1, 2010, and April 14, 2010, and the individual did not receive notice of the extended COBRA subsidy period, he or she will have 60 days after the date when the updated notice is provided to elect retroactive coverage. Therefore, plan administrators are advised to distribute the updated notices as soon as practicable.

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Health Care Reform—What Do Employers Need to Do, and When?

by Mark Jones

Print this article

The health care legislation recently enacted contains a number of provisions that require or invite employer action, including the amendment of existing employee health coverage, the preparation and distribution of communications, reports and filings, and the application of new withholding practices. Set out below is a summary of steps employers must take to ensure compliance with the Patient Protection and Affordable Care Act ("PPACA"), signed into law on March 23, 2010, and the Health Care and Education Affordability Reconciliation Act, signed into law on March 30, 2010, and considerations for restructuring health benefits to avoid incurring unnecessary penalties.

Throughout this alert, the effective dates assume a single-employer plan operated on a calendar year, except where otherwise noted. For collectively bargained plans and health plans that are not operated on a calendar year, the applicable effective dates may be earlier or later.

Plan Amendments and Design Changes

Changes Applicable to Existing Plans and New Plans

The following list of design changes applies to all plans, including plans that were already in existence on March 23, 2010, the date on which PPACA was enacted.

Coverage Extended to Older Children. Effective as of January 1, 2011, all insured group health plans and self-insured plans that offer dependent coverage must make coverage available to any children of a participant who are under age 26 and would be treated as dependents under the plan but for their age. The extension of coverage is not limited to full-time students or unmarried children, and the value of any subsidy by the employer will not be imputed to the income of the employee. Employers need to modify their coverage rules to reflect this change, including removing any student eligibility requirements that would otherwise apply prior to age 26. Employers also need to consider how the additional cost of covering older children should be allocated. Employers also need to amend their plan documentation, including enrollment materials, to reflect the new rules. Existing group health plans may continue to exclude adult children prior to January 1, 2014 if the children are eligible to enroll in another employer-sponsored health plan.

No Lifetime Limits. Effective as of January 1, 2011, no insured group health plan or self-insured plan may impose a lifetime dollar limit on "essential health benefits," which includes preventive care, hospitalizations, pediatric services, mental health care and prescription drug coverage, among other benefits. By constrast, stand-alone dental and vision care and long-term care are not treated as "essential" for this purpose. Employers must review their plans to ensure that these limits are removed, including from out-of-network care and retiree medical plans, and must determine whether additional changes in plan design are required to avoid a correspondent increase in the cost of premiums. Employers also need to amend their plan materials to reflect these changes.

Restrictions on Annual Limits. Effective as of January 1, 2011, the Department of Health and Human Services will set a cap on annual limits that may be imposed by group health plan or self-insured plan for essential health benefits. Effective as of January 1, 2014, annual limits on essential health benefits may not be imposed at all. As with the elimination of lifetime limits, employers must take particular care to ensure that these annual limits are removed from all of their health care

arrangements, including out-of-network coverage and retiree medical plans, and will want to consider whether additional changes in plan design may be required to avoid a correspondent increase in the cost of premiums. Employers must also amend their plan materials to reflect these changes.

No Preexisting Exclusions. Effective as of January 1, 2011, no insured group health plan or self-insured plan may impose a preexisting condition exclusion against a child under the age of 19, and effective as of January 1, 2014, no group health plan or self-insured plan may impose a preexisting condition exclusion on a participant of any age. Employers will need to amend their plan materials to reflect this change and must consider whether further changes in design are necessary to avoid an increase in premiums.

No Rescission. Effective as of January 1, 2011, no insured group health plan or self-insured plan may rescind coverage of any individual once the individual has already become a covered participant, unless the individual has committed fraud or made an intentional misrepresentation of material fact. Employers will need to amend their plan materials to reflect this new rule.

No Reimbursement of Over the Counter Medications. Effective as of January 1, 2011, nonprescription medicines, other than insulin, will no longer be eligible for reimbursement under a health flexible spending account ("FSA"), health savings account ("HSA") or health reimbursement account ("HRA"). Employers that maintain these plans must amend their plan materials and change their reimbursement procedures to monitor this restriction.

Limit on Flexible Spending Accounts. Effective for taxable years beginning on or after January 1, 2013, annual salary reduction contributions to health FSAs will be limited to $2,500, indexed for inflation. In order to implement this limit, employers that provide FSAs will need to amend their plan documentation, including their enrollment materials, and place appropriate restrictions on automatic reimbursement procedures, such as the use of debit cards.

Waiting Periods Limited to 90 Days. Effective as of January 1, 2014, no insured group health plan or self-insured plan may impose a waiting period in excess of 90 days. Employers that have longer waiting periods or that only permit admission on certain days (for example, the first of the month) will need to amend their plan materials to reflect this change.

Automatic Enrollment. Pursuant to the issuance of regulations, all employers that have 200 or more full-time employees must provide for automatic enrollment of new full-time employees in a group health plan under the coverage option with the lowest employee premium, unless the employee makes an affirmative election to opt out or elects a different option. Automatic enrollment may be subject to a waiting period, to the extent permitted by law. In addition to amending their plan materials, employers will need to prepare enrollment communications when the regulations are issued notifying new employees of their automatic enrollment in the plan and their ability to opt out.

Changes Applicable to New Plans Only

No Cost Sharing for Preventive Care. Effective as of January 1, 2011, insured group health plans and self-insured plans may not impose any "cost sharing requirements," including copayments, coinsurance charges and deductibles, on certain preventive care, child preventive services and women's preventive care and screenings. Employers that are implementing new plans must amend their plan materials to reflect this restriction.

Nondiscrimination for Eligibility based on Salary or Wages. Effective as of January 1, 2011, group health plans may not limit eligibility for coverage or continued coverage on the basis of the total hourly or annual salary of any full-time employees or otherwise establish eligibility rules that discriminate in favor of more highly paid employees. Outside of cafeteria plans, only self-insured health plans under existing law are subject to rules intended to preclude discrimination in favor of highly compensated employees; the change in law covers fully insured plans. Employers that differentiate among various employee

groups must take into account this change and may need to make appropriate amendments to their plans, particularly with respect to any special health benefits they provide to executives.

Guaranteed Availability and Renewability; Nondiscrimination based on Health Status. Effective as of January 1, 2014, health insurance insurers (but not self-insured plans) must accept every employer and individual in the state who applies for coverage during an annual or open enrollment period and must renew or continue the insurance at the option of the plan sponsor or individual, regardless of a participant's health status or utilization of health services. Insured group health plans and self-insured plans may not set eligibility rules based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. However, employers may continue to extend wellness incentives based on health factors. Effective as of January 1, 2014, the limit on wellness incentives will increase from 20% to 30% of the cost of employee-only coverage and, in the discretion of the applicable regulatory agencies, may be as high as 50% of such cost. Although the new availability, renewability and eligibility rules do not apply to existing plans, employers that currently maintain health plans may still want to take advantage of the increased latitude given to financial incentives for healthy living.

Long-Term Care

The new health care legislation requires the Department of Health and Human Services to implement a public, self-funded insurance program for long-term care, to be known as the Community Living Assistance Services and Supports (CLASS) Independence Benefit Plan. Generally, the program is intended to be effective as of January 1, 2011. Employers are required to permit employees who desire to participate in the program to make contributions by means of a payroll deduction. As the CLASS program is developed, employers will need to coordinate with their payroll services providers to facilitate these deductions and contributions.

Communications, Reports and Filings

Health Insurance Exchanges. PPACA requires each state to establish an American Health Benefit Exchange no later than 2014 to provide affordable health insurance to individuals and companies with 100 or fewer employees. States may elect to limit availability to individuals and employers with 50 or fewer employees for the first two years and are permitted, but not required, to open the exchanges to larger employers beginning in 2017. Smaller employers may offer their employees Exchange plans directly or under a cafeteria plan. (PPACA establishes "simple cafeteria plans" for this purpose, which offer an exemption to nondiscrimination requirements for employers who comply with additional requirements.) All plans available through the Exchange must be certified by the state as covering essential health benefits, passing through to employees no more than 40% of total benefit costs and limiting out-of-pocket limits to those allowed for health savings accounts (currently, $5,950 for individual coverage and $11,900 for family coverage), subject to adjustment for increases in premiums in 2015 and later. In addition, deductibles for group health plans for companies with 100 or fewer employees (50 or fewer employees in 2014 and 2015, in states that so elect) may not exceed $2,000 for individuals or $4,000 for families, indexed for the increase in average premiums. Individuals and families with annual incomes at or under 400% of the federal poverty level (currently, $10,050 for a single individual and $22,050 for a family of four) are eligible for a subsidy of up to 2/3 of the premiums charged in the Exchange for essential health benefits, subject to a cost-sharing floor. Under the new health care legislation, employers have primary responsibility for notifying employees about the availability of the Exchanges, informing them about how to contact an Exchange and identifying employees who may be eligible for premium assistance. To meet these requirements, employers must prepare and distribute new employee communications.

Free Choice Vouchers. Effective as of January 1, 2014, an employer that offers a group health plan must provide "free choice vouchers" for the purchase of health coverage through an Exchange to any employee who is eligible for a premium subsidy and whose required contribution to the employer's plan would exceed 8%, but not exceed 9.8%, of his or her household income, in each case indexed for the rate of premium growth. The voucher must be for no less than the maximum amount

that the employer would have contributed to provide group health care to the employee. If the voucher exceeds the health care premium under the Exchange, the employee may receive the difference in cash, subject to income taxes.

Internal and External Appeals Processes. Effective as of January 1, 2011, insured group health plans and self-insured plans must have in place written internal and external appeals processes that provide an impartial initial review, offer enrollees access to their records and give them the opportunity to give a presentation on appeal. A plan's internal procedures will need to meet the requirements set forth under ERISA's claims review regulation as well as new regulations to be issued by the Department of Health and Human Services. The external review procedures must comply with any applicable state review process. If the plan is self-insured or the state has not established a review process, the plan must implement external review procedures that meet minimum criteria, to be described in forthcoming regulations. Although the new appeals rules will not apply to existing plans, employers that maintain consistent claims procedures across their plans will need to review those procedures and revise them if necessary before adopting any new plans. In addition, administrators of non-grandfathered plans will need to distribute notices to enrollees informing them of the availability of the internal and external review processes and the availability, if applicable, of any state health insurance customer assistance or ombudsman.

Uniform Explanations of Coverage. No later than March 23, 2013, new and existing insured group health plans and self-insured plans must begin distributing uniform explanations of coverage to applicants and participants, employing standard definitions of common insurance and medical terms, in accordance with forthcoming regulations. The explanations, which can be no longer than four pages using a 12-point font, must describe in a "culturally and linguistically appropriate manner" the health benefits covered under the plan, limitations on and exceptions to coverage, cost-sharing provisions and any restrictions on renewability or continuation of coverage. In addition, the explanations must include illustrations of common benefits scenarios, such as the need for urgent care, must state whether the plan covers essential health benefits and meets minimum cost-sharing requirements, and must provide a contact if a participant has questions. Uniform explanations of coverage do not replace an employer's obligations under ERISA to provide a separate, more detailed summary plan description, and must be updated and distributed at annual enrollment to all participants that re-enroll in the plan. In addition, employers must provide notice of any material modification to the terms of the plan or the scope of coverage that is not reflected in the uniform explanation of coverage at least 60 days prior to the date on which the modification becomes effective.

Annual Reports. Effective for 2014, employers with more than 100 full-time employees must file an annual return with the Department of Health and Human Services disclosing whether they offer a health plan that covers essential health benefits and describing the length of any applicable waiting periods, the cost of the cheapest health plan options offered in each enrollment category, the employer's share of the total benefit costs for each plan, the number of employees participating in the plan each month and the name and address of each such employee. Employers must provide copies of these reports to participants.

W-2 Reporting. Effective as of January 1, 2011, employers must begin disclosing the aggregate cost of employer-sponsored health coverage on each covered employee's W-2. Employers will need to develop a process for determining this amount and facilitating communication between the necessary departments and with third-party payroll providers to ensure that this amount is captured.

Subsidies, Credits, Penalties and Taxes

Retiree Medical Subsidy. Effective as of June 1, 2010, the Secretary of Health and Human Services established a reinsurance program to reimburse employers for up to 80% of the cost of providing health insurance to retirees between the age of 55 and 64 and their spouses and dependents. The fund reimburses claims in excess of $15,000 and below $90,000, indexed for inflation. PPACA appropriates $5 billion to this fund, which will sunset on January 1, 2014 or, if earlier, when funding runs

out. The program is available on a "first come, first served" basis, so employers that offer retiree medical benefits are advised to apply to participate in the program and submit claims as soon as possible.

Small Employer Tax Credit. Beginning in 2010, employers (including partnerships and sole proprietorships) that have 25 or fewer full-time employees and average annual wages of $50,000 or less may receive a sliding-scale tax credit of up to 35% of the premium cost of group health insurance. Beginning in 2014, the maximum credit will increase to 50% of the cost of health insurance obtained through an Exchange. When determining the number of full-time employees for this purpose, all members of the employer's controlled group are taken into account, and the aggregate hours of part-time employees are converted into full-time equivalents (based on service of 2,080 hours per year). After 2014, the credit may not be taken for more than two consecutive years, beginning with the first year in which the employer offers health insurance through the Exchange.

Limit on Deduction by Health Insurance Providers for Remuneration over $500,000. Effective for taxable years beginning on or after January 1, 2013, PPACA amends Section 162(m) of the Internal Revenue Code to limit a health insurance provider's deduction for annual remuneration paid to any of its officers, directors, employees or other individual service providers to $500,000. This restriction applies only to licensed companies and organizations, including HMOs, that are regulated under state insurance laws and receive premiums from providing health insurance coverage, of which at least 25 percent are attributable to the provision of the "minimum essential coverage" required to be maintained by individuals once health care reform becomes fully effective. For purposes of this limitation, all members of an employer's controlled group are taken into account.

"Free Rider" Penalties. Employers are not required to provide group health care under the new legislation. However, effective for plan years beginning on or after January 1, 2014, if an employer with 50 or more full-time employees does not provide any group health coverage and at least one full-time employee obtains federally subsidized health coverage through an Exchange, the employer will be subject to a "free-rider penalty." The monthly penalty is equal to 1/12 of the product of $2,000 and the total number of its full-time employees minus 30. For purposes of determining the number of full-time employees, all members of the employer's controlled group are taken into account, and the aggregate hours of part-time employees are converted into full-time equivalents, based on service of 120 hours per month.

Effective for plan years beginning on or after January 1, 2014, if an employer with 50 or more full-time employees does offer employer-sponsored group health coverage and at least one full-time employee obtains federally subsidized health coverage through the Exchange other than with the use of a free choice voucher, the employer will be subject to a monthly penalty equal to 1/12 of the product of $3,000 and the number of full-time employees receiving such assistance, up to 1/12 of the product of $2,000 and the total number of full-time employees minus 30. For purposes of determining the number of full-time employees, all members of the employer's controlled group are taken into account, and the aggregate hours of part-time employees are converted into full-time equivalents, based on service of 120 hours per month.

To minimize the risk of being subject to a penalty, employers will want to think strategically about how to differentiate their health benefits, so that lower-income employees who would otherwise be eligible for subsidized coverage under an Exchange will still find the employer plans attractive. In making this assessment, employers need to consider how market reform may change the relative costs of coverage. Employers with part-time employees also must take into account the impact of the 120-hour exchange rate for calculating full-time equivalents, which generally renders a higher penalty amount for companies with multiple part-time employees than for companies with a smaller number of full-time employees.

Health Care Reform—What Do Employers Need to Do, and When? (continued)

Penalties for Violation of Plan Design Requirements. For group health plans, PPACA incorporates most of the new requirements on plan design, described above, into the Health Insurance Portability and Accountability Act ("HIPAA") provisions of ERISA and the Internal Revenue Code. As a consequence, employers that maintain group health plans not brought into compliance with the new provisions will be subject to an excise tax for violation of HIPAA equal to $100 per participant per day during the period of noncompliance, up to an annual maximum of $500,000 or, if less, 10% of the employer's group health plan expenses for the prior year.

Excise Tax on High-Cost Plans. Effective for taxable years beginning on or after January 1, 2018, so-called "Cadillac" plans will be subject to a 40% excise tax on the amount by which the aggregate costs of coverage (including the portions borne both by the employer and by the employee) exceed an annual limit (for 2018, $10,200 for individuals or $27,500 for families), indexed for inflation. Higher limits apply to retirees between the ages of 55 and 64, employees engaged in certain high-risk professions and plans covering an employee population that differs, in age or gender, from that of a national risk pool. When determining the aggregate costs, employers must use the methodology prescribed for determining the plan's "applicable premium" under COBRA. Stand-alone dental and vision plans are excluded from the benefits limits, but employer contributions to health savings accounts and Archer medical savings accounts are included, and the portion of any excise tax attributable to these benefits is allocated directly to the employer. For group health plans, the excise tax is imposed on the health insurance issuer, and for health FSAs and HRAs, the tax is imposed on the plan administrator. If an employee has coverage under more than one plan, the "excess benefit," for calculating the relative tax obligation, is allocated ratably according to each plan's portion of the employee's aggregate health care costs. Given the delayed effective date of this provision, it may be prudent for employers with high-cost health plans to monitor further Congressional development on the excise tax before making immediate changes to their plans.

Tax on Retiree Prescription Drug Subsidy. Employers that have continued to provide retiree prescription drug coverage that is actuarially equivalent to the coverage available under Medicare Part D receive a federal subsidy equal to 28% of certain covered charges. This amount is not currently subject to corporate income tax. Effective for taxable years beginning on or after January 1, 2013, however, PPACA requires employers to report any Medicare Part D subsidies they receive as taxable income. Employers that provide retiree prescription drug coverage need to consider whether to continue doing so, given the potential impact of this change on their financial statements. In making this determination, employers must take into account the fact that retirees that participate in Medicare Part D and whose prescription drug costs exceed the annual limit (currently, $2,380) will receive a $250 rebate this year. In addition, pharmaceutical manufacturers are required to provide a 50% discount on brand-name medicines in 2011 under Medicare Part D and phase in a 75% discount by 2020 on brand-name and generic medicines to the extent that they exceed the annual limit and are less than the threshold for catastrophic coverage (currently, $4,550).

Increase in Medicare Hospital Insurance Tax. Effective for taxable years beginning on or after January 1, 2013, employers will be responsible for collecting an additional hospital insurance (Medicare) tax equal to 0.9% on wages in excess of $200,000 for single filers, or $250,000 for joint filers. This additional tax will effectively increase the employee-paid portion of FICA on these "excess wages" from 1.45% to 2.35%. Employers will need to put into place a system for monitoring these limits and applying the appropriate withholding percentage and reporting mechanisms.

Conclusion

It is too early to predict the ultimate impact of health care reform on employer-provided health care, but not too early for employers to begin taking the steps necessary to ensure compliance with the new rules and to begin thinking strategically about whether any plan design changes may be necessary or advisable to avoid penalties and taxes.

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Health Care Reform Legislation Makes Significant Changes to Fraud & Abuse Laws

by Douglas A. Grimm

Print this article

The recently enacted health care reform law, the Patient Protection and Affordable Healthcare Act (the "Act") (Pub. L. No. 111-148), includes substantial modifications to federal fraud and abuse laws. One such change is to the physician self-referral law, commonly referred to as the "Stark Law," which regulates the financial relationships between physicians and the health care entities to which the physicians refer. A brief summary of the more significant changes follows.

Overview of the Stark Law

The Stark Law prohibits the referral of a patient by a physician to an "entity"[1] for the provision of designated health services ("DHS") if the physician (or an immediate family member) has a financial relationship with the entity, absent application of an ownership, compensation, or investment interest exception to the law. 42 U.S.C. § 1395nn. Entities may not submit a claim or bill to a federal health care program for DHS furnished pursuant to a prohibited referral.

Modifications to the Stark Law

Medicare Self-Referral Disclosure Protocol

The Act requires that the Department of Health and Human Services ("HHS"), in conjunction with the Office of the Inspector General, implement a disclosure protocol for use by providers that discover actual or potential Stark law violations. See § 6409 of the Act. The Self-Referral Disclosure Protocol ("SRDP") must be developed and effective by September 30, 2010. Instructions for use will be posted on the Centers for Medicare and Medicaid Services' website, and will identify the specific person or office to whom disclosures should be made, as well as the effect of the SRDP on existing corporate integrity or corporate compliance agreements.

Significantly, HHS is authorized to consider the facts and circumstances related to the actual or potential violation, and to exercise its discretion in reducing the amounts due for any violations. HHS may consider the following factors in its analysis:

1. The nature and extent of the improper or illegal practice;
2. The timeliness of self-disclosure by the provider;
3. The provider's level of cooperation in providing additional information; and
4. Such other factors as HHS deems appropriate.

HHS is required to monitor the effectiveness of the SDRP, and make a report to Congress by September 30, 2011, regarding its implementation and usage. The report will include the volume of providers making disclosures, amounts of penalties collected, and the types of violations reported.

[1] "Entities" are generally defined as physician practices, hospitals, health plans, or any other health care provider that furnishes DHS.

Limitation on Stark Exception for Physician Ownership of Hospitals

The Act curtails the Stark Law exception allowing physicians to hold ownership interests in hospitals. See § 6001 of the Act. The Act limits physical expansion of current facilities, expansion of physician aggregate ownership percentages, and requires facilities currently under construction to obtain Medicare provider numbers by December 31, 2010 or face permanent exclusion from Medicare.

Specifically, unless a facility meets a narrowly defined set of criteria involving geographic location and Medicaid payor mix percentages, existing facilities are prohibited from adding operating rooms, procedure rooms, and beds after March 23, 2010. "Procedure rooms" is defined broadly by the Act to "include rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed." Existing facilities should pay close attention to the implementing regulations of this broad statutory provision to determine whether the forthcoming regulatory language broadens or narrows the statute's breadth.

Disclosure Requirements for Use of the In-Office Ancillary Services Exception for Imaging Services

The Act also increased the requirements for use of the in-office ancillary services exception by requiring a physician making a referral for MRI, CT or PET services (or other services to be designated by HHS in the implementing regulations) to inform the patient in writing, at the time of the referral, that the patient may obtain these services from a physician other than the referring physician. See § 6003 of the Act. In addition, the physician must provide the patient with a list of providers that furnish these services in the area in which the patient resides. The amendment applies to services furnished on or after January 1, 2010. However, the statute makes no comment on the method of retroactive application of this requirement.

Conclusion

In keeping with the federal government's increased focus on health care fraud and abuse, the Act makes substantial changes to the Stark law. These changes have the potential to significantly affect providers' business and compliance strategies. Close attention should be paid to the issuance of HHS's regulations, as they will provide further guidance on implementation of the statutory provisions above.

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