Q&A on US Health Reform:
The Impact of National Health Reform and How it May Affect Your Business

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Developed from Conner Strong's web briefing of April 8, 2010

On April 8, Conner Strong held a web briefing covering several important employer requirements related to the new health reform law. While there are several immediate changes, the major aspects of health care reform will not take effect until 2014. Until then there are a number of reforms effective for self-insured and fully-insured group health plans for plan years beginning six months after the date of enactment. This generally means January 1, 2011 for calendar year plans and as soon as this year for plans that have a plan year beginning October 1 or later this year. There are also a number of tax provisions with varying effective dates.

The April 8 web briefing discussed these new employer requirements and provided a list of key next steps for employers.

We have prepared this Q&A in response to questions received from participants. To help keep our clients informed, we have also created a special section on our website providing information and tools you can use to review the major aspects of the law, what they mean, when they will take effect and what steps need to be taken to ensure compliance. Check back for daily updates, for news and analysis, and for updated tools to help you navigate this complex process.

Q1. ***Does the dependent to age 26 coverage apply to all dependents or only full- time students? Does the child have to live in the parent's household?***
A1. It applies to all adult children, whether enrolled in college or not. It is also assumed that the law also covers other young people living on their own. It will include married children but not their spouses or their kids.

Q2. ***If a dependent has been terminated already because of reaching the maximum age can they reenroll?***
A2. Yes, but they will have to wait until the next plan year after September.

Q3. ***How do we handle enrollment under the new dependent provisions?***
A3. With your next ERISA plan year beginning after September, you will be required to permit children to stay on your plan until age 26. This applies unless the adult child has an offer of coverage through his or her employer, and apparently this applies even if the child has to pay for the employer coverage but the parent coverage is offered at no additional cost. But beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have an offer of coverage through their employer.

Q4. ***Our open enrollment was 4/1/10. Is a 24 year old dependent not on our plan as of 4/1/10 eligible as of 1/1/11 or 4/1/11?***
A4. The child is eligible with your next plan year beginning after September 2010, which will be 4/1/11.

Q5. ***Will our fully-insured plan still be subject to various state rules regarding coverage of adult children?***
A5. Yes. Your plan will be subject to both the federal and state mandates regarding dependent coverage. Therefore, you will need to provide the better of the two in each state. Self-insured plans are generally not required to follow state law mandates (i.e., a self-insured plan in PA does not have to follow the NJ state dependent to age 31 fully-insured mandate).

Q6. ***Does a college student that will graduate May 2010 need to go on COBRA or can they stay on their parents plan?***
A6. The requirement takes effect with your next plan year. So it appears that a college student graduating in May who is on their parents' plan now but who loses that coverage when they graduate from college may want to consider COBRA in the interim period and then at the next enrollment they will have the option of rejoining their parents' plan in the new plan year (when the age 26 provision becomes effective). This would apply as well to young adults who previously lost coverage, as parents could sign them up as well at the next open enrollment.

Q7. ***What is the age 26 coverage end date rule - is it end of month or end of year in which they turn 26?***
A7. This applies to young adults up to their 26th birthday who don't have access to insurance through their employer. So coverage can be provided through the end of their 25th year (as the law requires coverage be provided up to their 26th birthday).

Q8. Does ***the new law stipulate this rule for RX as well as Medical (if RX is a separate plan/election)?***
A8. The age 26 provision generally applies to individual or group health coverage. The rule generally does NOT apply to HIPAA-excepted benefits (including Medicare supplemental insurance, on-site medical, clinic coverage, and limited scope dental and vision plans). It is likely that the age 26 provision applies to carve-out prescription drug plans (as the HIPAA rules do not specifically exempt carve-out prescription and similar plans).

Q9. ***Under the adult child coverage provisions, would coverage for non students to age 23 and any child over 23 to age 26 be taxable income to the employee.***
A9. No, it generally won't be taxable to the employee (this appears to be effective immediately). Any covered dependent child of the employee who as of the end of the taxable year has not attained age 27 will be considered a tax dependent and therefore the coverage will be on a non-taxable basis.

Q10. ***Who qualifies for assistance under the retiree plan pool?***
A10. By June 21, a new short-term program will offer employers partial reimbursement of group health plans' costs for Medicare-ineligible early retirees and their dependents. The program will end once the $5 billion funding runs out. Only health plans with cost-saving procedures targeting expensive and chronic conditions can receive reimbursements, which will cover 80% of each early retiree's health care costs between $15,000 and $90,000 in 2010. All payments must go toward lowering plan costs. Once guidance is provided we will be able to assist employers with determining whether a particular plan would qualify and how much potential is involved.

Q11. ***Will the government provide forms for employees who wish to opt out of the new national employee-funded long-term care benefit known as the "Community Living Assistance Services and Supports Act" or the CLASS Act?***
A11. No opt out is required as involvement is voluntary, but employers are being encouraged to participate in the CLASS Act and to adopt automatic enrollment rules that default employees into the CLASS Act, starting January 1, 2011. We could see government forms to assist employers who choose to participate and adopt automatic default rules, but we will have to wait and see what is issued in regulations.

Q12. ***Can you have a private long- term care and enroll in the voluntary government plan?***
A12. We haven't seen guidance on this yet but since the government plan is voluntary this may be permitted.

Q13. ***What is the general rule regarding annual limits under a plan? Does this apply to dental?***
A13. A plan may not establish annual limits on the dollar value of benefits for any participant or beneficiary. This provision generally applies to individual or group health coverage. The rule generally does NOT apply to HIPAA-excepted benefits (including limited scope dental and vision plans).

Q14. ***Can an employee get coverage under our plan for a 6-year-old who has a pre-existing condition?***
A14. Yes. Effective with your next plan year after September it will be illegal for plans that cover children to deny coverage to the child based on a preexisting condition. This applies to all new employer plans and existing employer plans.

Q15. ***Can an employee get coverage under our plan for his own pre-existing condition?***
A15. For adults, the pre-existing condition limitation under plans goes into effect in 2014.

Q16. ***Are ERISA-governed plans and self-insured plans covered by the new law?***
A16. Yes, these types of plans are subject to most of the provisions of the new health reform law. The legislation does not affect ERISA preemption. ERISA plan beneficiaries will still be limited to ERISA's remedies. States will still not have jurisdiction over ERISA plans.

Q17. ***How is the value determined for reporting health coverage on W-2 forms?***
A17. The law requires employers to report on Form W-2 the aggregate "cost" of employer provided group health coverage that is excludable from the employee's gross income (other than through an Archer MSA, an HSA, or employee salary reductions to a flexible spending arrangement under Code section 125). The aggregate cost is determined under COBRA-like rules. This is not the value of claims but the value of the coverage elected. The value of the coverage elected will be determined under the COBRA premium setting rules. This applies to tax years beginning after December 31, 2010. Employers must begin Form W-2 disclosure on the Form issued in January 2012 for the preceding year.

Q18. ***Does the cap on Flexible Spending Account (FSA) contributions apply to dependent care FSAs also?***
A18. No, the law limits contributions to health FSAs only – at $2,500 a year. Dependent care FSAs will continue to have a $5,000 cap for married individuals.

Q19. Does the ***"grandfather provision" only apply to individuals covered under the plan as of the date of enactment?***
A19. No, the grandfather rule extends to new employees and their family if they are covered under an employer's grandfathered plan. Family members of current employees covered under a grandfathered plan may also be added to the plan.

Q20. ***Am I required to offer insurance to my employees?***
A20. No. There is not a so-called "employer mandate" in the legislation. But beginning January 1, 2014, under "Pay or Play" (the free rider assessment) large employers with an average of at least 50 employees working at least 30 hours per week during the preceding calendar year who do not offer affordable minimum essential coverage may have to pay the free rider penalty. Certain part-time employees are included in the calculation only to determine whether employers meet the minimum threshold of 50 full-time equivalent employees. Companies whose employees are receiving taxpayer assistance will have to pay $2,000 per full-time worker.

Q21. ***Do we have to cover paid interns and part-time employees working less than 20 hours a week under our medical plan or pay the penalties?***
A21. The employer penalty applies to full-time employees (defined as at least 30 hours per week). There would be no penalty for not offering coverage to employees working less than 30 hours per week. You may be required to provide coverage to paid interns (beyond the permissible 90 waiting period).

Q22. ***What are the preventative care benefits that must be covered with no cost sharing within six months of the bill passing?***
A22. Effective for plan years beginning after September 23, 2010, a group health plan must provide preventive health care and screenings (e.g., immunizations and infant preventive care) without cost-sharing (i.e., no co-payments, deductibles or co-insurance). The to-be-issued list of preventive care services will be recommended by U.S. Preventive Service Task Force, CDC, and the Health Resources and Services Administration.

Q23. ***How will the bills affect health insurance provided to active and retired members of the military?***
A23. Nothing in legislation would directly change coverage for the millions of beneficiaries in the government's health program for the military, which is called TRICARE. Retired members of the military who are over 65 receive their primary health coverage through Medicare and are also entitled to a supplemental program, called TRICARE for Life.

Q24. ***What role does the employer play in regards to the excise tax on high cost employer-sponsored plans when the health coverage is fully insured?***
A24. The excise tax will be imposed at the insurer level. Employers will be required to aggregate coverage subject to the limit and issue information returns for insurers indicating the amount subject to the excise tax.

Q25. ***When will employers no longer be able to qualify for the Medicare Part D subsidy?***
A25. For tax years beginning Jan 1, 2013, employers will no longer be able to take a deduction for the subsidy employer are currently eligible for when they maintain prescription drug plans for their Medicare Part D eligible employees.

Q26. ***Will the healthcare reform bill in any way have an effect on workers compensation?***
A26. Health reform does not specifically mention workers compensation. However, changes to Medicare are likely and those may affect workers compensation because nearly all workers compensation fee schedules are based on Medicare.

Q27. ***What is the definition of a "retiree plan"?***
A27. Certain retiree only plans may not be subject to certain provisions, but it is not clear what that means as the definition is applicable for various provisions. Permissive aggregation rules and how an employer determines a plan will come into play. We expect there will be more clarification on this over time.

Q28. ***Will information about insurance companies be posted on the web?***
A28. Effective July 1, 2010, a website will provide information to help consumers choose the plan that is best for them. The Secretary of HHS will establish an Internet website through which residents of any State may identify affordable health insurance coverage options in that State. The website will include information on coverage options for small businesses as well. Effective January 1, 2011, health plans, including existing plans, must annually report on what percentage of premium dollars they spend on medical care, as opposed to profits, marketing, and administrative expenses. That information will be posted online and plans may be entitled to a rebate if the plan spent too much on overhead and profits.

Q29. ***Does the law affect the current COBRA subsidy?***
A29. No.