

HEALTH CARE REFORM UPDATE: PROVISIONS IMPACTING SELF-FUNDED EMPLOYER PLANS WITH GRANDFATHERED STATUS FROM 2011-2013

This issue briefly summarizes provisions of health care reform that will take effect for grandfathered plans in the years in between September 23, 2010 and January 1, 2014. For information about health care reform provisions with nearly immediate impact, effective for plan years beginning after September 23, 2010, please see **Immediate Implications for Employers**.

Grandfathered Status

Grandfathered status is given to employer-sponsored health insurance plans that currently exist. The new law specifically allows plans to add new enrollees without losing grandfathered status, and it does not prohibit plan design changes. There is no additional guidance at this time as to the extent of changes that may be made to a plan before losing grandfathered status. Plans with grandfathered status are exempt from a number of reform/plan design provisions in the new law.

Provisions Impacting Self-Funded Grandfathered Plans between 2011-2013

In 2011:

- » The Department of Health and Human Services will issue standards for plans (including self-funded plans) to follow when describing coverage to enrollees.
- » The Department of Labor will begin annual studies on self-funded plans using data from 5500s.
- » Costs for over-the-counter drugs not prescribed by a doctor can no longer be reimbursed through an HRA or health FSA or on a tax-free basis through an HSA or MSA.
- » The tax on distributions from an HSA or MSA not used for qualified medical expenses is increased to 20 percent.
- » CLASS program (voluntary long term care) takes effect; employers may facilitate payroll deductions but participation is not mandatory.

In 2012 (or within 24 months from date of enactment):

- » Plans must begin to report value of employer-sponsored health insurance coverage on **W-2s**.
- » Plans must provide a summary of benefits to enrollees using format described in first bullet above.
- » Plans must provide a 60-day prospective notice of plan changes.
- » Plans must pay \$1 per plan participant for the first plan year ending after September 30, 2012 to support comparative effectiveness research. This fee increases to \$2 per participant in the following plan year, and then the fee is indexed by the cost of "national health expenditures" after.

In 2013:

- » Subsidies to employers who maintain prescription drug plans for Medicare Part D eligible retirees will cease to be deductible, which has an immediate impact on employers' FAS 106 accounting.
- » Employee salary reduction contributions to FSAs will be limited to \$2,500, indexed by the Consumer Price Index.
- » Employers must provide a notice to employees about the availability of the exchange and how to obtain assistance, and their potential eligibility for premium credits if the employer's share of costs is less than 60 percent of the allowed total cost of benefits.
- » Medicare payroll tax increases by 0.9 percent for high income earners (employee portion only). High income earners are joint filers with incomes above \$250,000 or others with incomes above \$200,000. A new 3.8 percent tax on unearned income for the same filers will also go into effect.

If you have questions about your plan's compliance with these requirements or how to implement them, please contact your attorney.

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