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Issue: # 2010-4 **April 13, 2010**

The recently passed (March 23, 2010) healthcare reform legislation has been a priority of the President and Congress since his inauguration in 2009. At over 2,400 pages, this comprehensive legislation provides for a litany of changes to basic required benefits offered to most Americans, to how employers and health insurance companies must provide this coverage and to how these plans must be administered. The changes will be implemented over the next few years, with the bulk of the legislation effective in 2014.

Harbridge Consulting Group is in the process of reviewing the entire legislation and is committed to providing our clients with the best advice on how to navigate its implementation. We will be offering an assessment service to help our clients understand and comply with the law. Highlights of the earliest requirements are:

Reinsurance Program (Effective 90 Days following enactment)

The legislation creates a temporary reinsurance program for retirees who are age 55 and over, but not yet eligible for Medicare. The program reimburses 80% of retiree medical and prescription drug claims between $15,000-$90,000 to the employer or insurer. Reimbursements must be used to reduce cost sharing, premiums or participant contributions. Employers may apply for the reinsurance only if the medical plan has a cost savings program intended to reduce chronic or high cost medical conditions. The reinsurance program is in effect until the earlier of 1/1/2014 or exhaustion of $5 billion in reinsurance payments.

There are a number of considerations for employers offering retiree health care coverage including:

- Implementation of or necessary changes to the employer's cost savings program required for participation in the reinsurance program.
- Data aggregation for plans with separate medical and prescription drug vendors.
- Resources and costs of submitting for and receiving funds

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from the program compared to estimated reinsurance amounts.

- **Value of the program for access only plans.**

- **Potential impact on 2011-2014 budgeting and to a limited extent, postretirement health care benefit valuation liability.**

Grandfathering Status (Effective Immediately)

The new legislation has grandfathered plans in existence as of the date of enactment. Changing enrollment or renewing a grandfathered plan will not affect that status. However, it is still uncertain how plan design changes will impact the status. Grandfathered status alleviates health plans of some changes otherwise required by the legislation and delays the timing of implementation of some provisions.

Plan Design Changes (Effective for plan years beginning on or after 6 months following enactment)

- **All health plans must extend eligibility to dependent children until their 26th birthday (regardless of whether the child qualifies as a tax dependent of the employee). Until 2014, grandfathered plans must extend eligibility only if the adult child is ineligible to participate in another employer sponsored plan.**

- **Plans must remove all lifetime dollar limits and annual dollar limits on benefits. Grandfathered plans may have *reasonable* annual dollar limits, which will be determined by the Secretary of Health and Human Services, until 2014 at which point all annual dollar limits must be eliminated as well.**

- **Plans must limit waiting periods for coverage to no more than 90 days.**

- **Plans may not rescind coverage for enrollees unless the individual acts fraudulently.**

- **Children with pre-existing conditions can not be denied coverage. Effective January 2014 the provision is extended to adults with pre-existing conditions.**

Preventive Services (Effective for plan years beginning on or after 6 months following enactment)

Non-grandfathered health plans must provide certain preventive services without any cost-sharing for the participant, consistent with guidelines issued by several professional and regulatory agencies including the U.S. Preventive Services Task Force and the CDC.

Nondiscrimination Rules (Effective for plan years beginning on or after 6 months following enactment)

All non-grandfathered health plans will be subject to the nondiscrimination rules under Internal Revenue Code (IRC) Section 105(h). These rules currently apply only to self-insured plans. These rules will now apply to insured plans and establish nondiscrimination testing standards to determine whether a plan discriminates in favor of highly compensated individuals (HCI) with respect to benefits or eligibility. The value of a discriminatory benefit will be taxable income to the HCIs.

Treatment of Health Care Accounts (FSA, HCA and HRA) (Effective for plan years after 12/31/10)

The new legislation made several changes to the tax treatment of health care expenditures and include:

- Over the counter drugs that have not been prescribed by a physician will no longer be eligible for reimbursement through a Health Reimbursement Arrangement (HRA) or Flexible Spending Arrangement (FSA) and cannot be reimbursed on a tax-free basis from a Health Savings Account (HSA).

- The excise tax on distributions from an HSA that are not considered qualified medical expenses is increased to 20%.

Medicare Part D Coverage Gap (Effective immediately)

Certain drug plans for Medicare eligible retirees have a coverage gap where the retiree is responsible for 100% of the cost. In 2010, this gap is between $2,830 and $6,440 in total drug cost (this equates to $3,610 in out-of-pocket costs for the retiree). For Medicare drug plans that have a coverage gap, retirees are going to receive additional coverage under the new health care legislation:

- In 2010 Part D enrollees who reach the coverage gap will receive $250.

- In 2011 Part D enrollees who reach the coverage gap will pay 93% of the cost for generic drugs and 50% of the cost for brand-name drugs within the coverage gap.

The portion of the drug cost that Part D enrollees will have to pay through the coverage gap will steadily decrease until 2020 when they will be responsible for only 25% of the cost.

Medicare Part D Subsidy (Effective 1/1/13)

Medicare Part D subsidy payments will continue to be non-taxable but will no longer be considered tax deductible income. In the past employers have been able to deduct the entire cost of the prescription drug coverage for retirees. The new health care bill disallows the subsidy portion to be deducted from the

employer's taxes. As a result, an expense associated with adjusting this deferred tax asset may need to be recognized under ASC 740 (formerly FAS 109) *as soon as the first quarter 2010*. Given the complex nature of accounting for this provision, employers should consult with their tax and accounting advisors.

Please note this provision only applies to those employers receiving the RDS subsidy. Employers who have enrolled all of their Medicare eligible retiree presecription drug benefit through an MAPD, PDP, or EGWP will not be affected by this provision.

Conclusion

As noted, Harbridge is committed to assisting clients in understanding the legislation and complying with its requirements. We are offering an assessment service which will provide the following items:

- **Initial assessment of your plan's compliance**
- **Explanation of how you are affected by the legislation**
- **Outline of necessary plan changes**

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