A SUMMARY OF HEALTH REFORM

The passage of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (herein collectively referred to as the Health Care Reform Act), represents one of the most comprehensive pieces of health care legislation in this nation’s history. Because employers have pressing concerns as to how the Health Care Reform Act will affect their businesses over the next several years, Susanin, Widman & Brennan, P.C. has prepared this newsletter as a general overview focusing in on several key changes facing employers.

Generally, the overarching goal of the Health Care Reform Act is to have most U.S. citizens and legal immigrants obtain health insurance, either through state-based health insurance exchanges or an employer-based plan. The state health insurance exchanges are a “virtual marketplace” where individuals and groups can shop for the health insurance coverage that best fits their needs. These exchanges are designed to make it easier for individuals to pool their resources in order to obtain coverage under policies that have built in consumer protections. Furthermore, lower-income individuals who cannot afford health insurance will be provided access to federal subsidies in order to obtain coverage through the newly created state health insurance exchanges. When state-based exchanges become operational in 2014, they would only be open to individuals and employers with fewer than 100 employees.

As a means of implementing nationwide health coverage through employer-based plans, the Health Care Reform Act imposes considerable new responsibilities on employers. There are new mandates on health plan coverage, new reporting and disclosure requirements, new subsidies and tax credits, and severe penalties for noncompliance. While most of these changes will not become effective until January 1, 2014, employers should be aware that time is of the essence as several provisions already require compliance or will become effective after September 23, 2010.

IMMEDIATE STEPS

Nursing Mothers Act

Effective March 23, 2010, employers covered by the Fair Labor Standards Act (“FLSA”) are required to furnish “reasonable” break periods to mothers “each time an employee has a need” to express breast milk for the first year following the birth of a child. Moreover, employers must provide a location for the employee to express milk, other than a bathroom, that is shielded from view and free from intrusion by coworkers and the public. Employers are not required to compensate an employee receiving reasonable break times under this provision. Since this new provision is an amendment to the FLSA’s Section 7 rights, this provision does not apply to any employee who qualifies as exempt under Section 213’s executive, administrative, professional, outside sales, or computer professional exemptions. Furthermore, the new law does not apply to
employers with fewer than 50 employees if compliance with the law would impose an “undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature or structure of the employer’s business.”

**Early Retiree Medical Reinsurance Program**

The Health Care Reform Act creates a $5 billion reinsurance fund to help employers with the cost of certain early retiree medical claims. Employment-based plans will be eligible for reimbursement for part of the cost of providing health insurance coverage to early retirees (age 55 or older who are not eligible for Medicare) and their dependents. A valid claim under this program will entitle the plan to 80 percent reimbursement of the cost attributable to each claim that exceeds $15,000 but is less than $90,000. The program begins June 1, 2010, and lasts until either December 31, 2013, or whenever the funds are exhausted. Because the Secretary of HHS has issued regulations explaining how to qualify to receive early retiree reimbursement, employers should consult with an attorney to determine their eligibility.

**Small Employer Tax Credit**

Beginning with the 2010 tax year, qualified employers are eligible to receive a tax credit of up to 35 percent the amount paid for health insurance premiums for their employees. In order to be qualified, an employer must (1) have 25 or fewer full-time equivalent (FTE) employees for the tax year, (2) the average annual wages of its FTE employees must be less than $50,000, and (3) the employer must pay at least 50 percent of the cost of health insurance coverage. The credits will be available on a sliding scale, with the full credit available to employers who have 10 or fewer FTE employees, and whose average annual wage is less than $25,000 per FTE employee. The credit is only available to offset actual tax liability and employers must claim this credit on their annual tax return. As such, the tax credit is not payable in advance to the employer. The employer must pay the employees’ premiums during the year and wait until the end of the tax year to claim the credit on the employer’s income tax return. Tax-exempt employers are also eligible for a small business tax credit, however, separate rules apply. Because the IRS has provided guidance on calculating the amount of credit applicable through the sliding scale, employers should consult with an attorney to determine the amount of credit available.

**NEW REQUIREMENTS FOR HEALTH PLANS**

The Health Care Reform Act generally “grandfathers” a group health plan or a plan through a health insurance issuer who offers group or individual health insurance coverage that was already in effect as of March 23, 2010. Furthermore, an employer may add new employees (and their families) to the plan after March 23, 2010, without destroying the plan’s grandfathered status. Similarly, an individual may reenroll himself
or his dependents into the plan after March 23, 2010, without affecting the plan’s status. Collectively bargained multi-employer and single-employer plans in effect on March 23, 2010, are not subject to the Health Care Reform Act’s rules until the date on which the last of the collective bargaining agreements relating to the coverage expires. It is unclear at this point what effect any significant amendments or modification of coverage under a plan design will have on a grandfathered plan’s status.

PROVISIONS NOT APPLICABLE TO GRANDFATHERED PLANS

Provisions Effective September 23, 2010, Not Applicable to Grandfathered Plans

The following is a list of several key provisions that will be required for all non-grandfathered health care plans, both insured and self-funded, for plan years starting after September 23, 2010:

- The Health Care Reform Act now applies parts of section 105(h) of the Internal Revenue Code self-insured nondiscrimination rules to insured health plans. Employers are now prohibited from limiting eligibility for health coverage to highly compensated individuals.

- Plans must now cover certain preventative services such as immunizations, women and infant preventative care, and screenings without cost to the participant.

- Plans cannot require pre-authorization or referrals for obstetrical or gynecological care.

- Plans must provide coverage for emergency services without the need for pre-authorization or increased cost-sharing, whether such service is provided by in-network or out-of-network providers.

- If a health plan requires or provides for designation by a participant of a primary care provider, the enrollee is allowed to select their primary care provider, or pediatrician in the case of a child, from any available participating primary care provider in the network.

- The Health Care Reform Act requires plans to implement effective internal appeals processes for claims and coverage determinations, and comply with any applicable state external review process. Such internal appeals processes shall allow enrollees to review their file, present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process. Furthermore, plans must provide notice to enrollees, in a linguistically appropriate manner, of the availability of the internal and external appeals processes, including information on how to receive guidance from state
appeals assistance offices. If there is no state external review process, the plan must implement an external review process that meets minimum standard requirements set by Secretary of Health and Human Services (HHS). External review processes in operation as of enactment may comply with this requirement. However, plans should consult an attorney to review whether their current internal appeals process complies with this provision’s requirements.

**Provisions Effective January 1, 2014, Not Applicable to Grandfathered Plans**

The following is a list of several key provisions that will be required for all non-grandfathered health care plans for plan years starting after January 1, 2014:

- Premiums in the individual and small group markets (fewer than 100 employees) may vary only by family structure, geography, the actuarial value of the benefit, age (limited to 3:1), and tobacco use (limited to 1.5:1). This provision applies to insured plans in the large group market if the State allows them to participate in the Exchange.

- Plans may not establish eligibility rules based on health status, medical condition (including physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, or any other health status-related factor identified by the Secretary of HHS.

- Plans must provide coverage to individuals who participate in a clinical trial and cannot deny routine coverage because an individual is enrolled in a clinical trial. Applies to clinical trials that treat cancer and other life-threatening diseases.

**PROVISIONS APPLICABLE TO ALL PLANS**

While grandfathering relief allows plans to avoid many provisions of the Health Care Reform Act, some provisions apply to all plans regardless of their grandfathered status.

**Effective First Plan Year After September 23, 2010**

The following is a list of several key provisions that will be required for all health care plans regardless of grandfathered status for plan years starting after September 23, 2010:
• Plans are prohibited from establishing lifetime limits on coverage for essential health care benefits. Annual limits are also prohibited except that prior to 2014, certain restricted annual limits may be permitted in accordance with regulations adopted by the Secretary of HHS. Group health plans and health insurance issuers who offer group or individual coverage will continue to be able to place lifetime or annual limits for nonessential medical benefits.

• Plans are prohibited from rescinding coverage once enrolled except in instances of fraud or intentional misrepresentation.

• Plans that offer coverage to dependent children must allow such children to remain on their parent’s health insurance until age 26, whether married or not. Prior to 2014, grandfathered plans are only required to continue offering coverage to dependent children who are not eligible to enroll in another employer-sponsored plan. Coverage of adult children under the age of 27 is tax free. The plan is not required to make coverage available for a child of a child receiving dependent coverage. Employers and plans who fail to extend this coverage are subject to an excise tax of $100 per day per failure.

• Plans may not impose any preexisting condition exclusions on children under the age of 19.

• Plans must provide 60 days’ prior notice of a material modification of any plan term or coverage to enrollees prior to the date such modification becomes effective. The penalty for willful noncompliance with this provision can be as high as $1,000 per day per enrollee.

• A “wellness and health promotion” activity may not require the disclosure or collection of any information relating to the presence, use, possession or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual. Insurance premiums may not be increased or discounts/rebates denied because of lawful gun use or ownership.

**Effective First Plan Year After January 1, 2014**

The following is a list of several key provisions that will be required for all health care plans regardless of grandfathered status for plan years starting after January 1, 2014:

• Plans are prohibited from placing annual limits on essential medical benefits.

• Plans may not impose waiting periods in excess of 90 days.
• Plans are prohibited from imposing any preexisting condition exclusions.
• Plans must provide coverage for adult dependent children up to age 26.

**EMPLOYER MANDATES**

*Pay-or-Play*

The Health Care Reform Act heavily relies on employers providing employment-based health insurance in order to achieve its goal of nationwide health coverage for U.S. citizens and legal immigrants. As such, the federal government recognized the importance of giving employers an incentive to provide health care coverage to their employees. This incentive takes the form of a “pay-or-play” penalty.

Effective January 1, 2014, employers with more than 50 full-time employees will be required to offer health care coverage to their employees and dependents with certain minimum levels of health coverage or pay a penalty. Employers who do not provide health coverage at all and have at least one full-time employee receiving a “premium assistance tax credit” from the federal government will have to pay a monthly tax of $166.67 ($2,000 for the year) per full-time worker employed. The Health Care Reform Act exempts the first 30 workers from this penalty payment calculation. *As an example, if an employer has 65 full-time employees and is penalized for violating the abovementioned employer mandate, the employer will be fined $166.67 per month multiplied by 35 (because the first 30 workers are ignored).*

Even if an employer does offer coverage, the employer may still be liable for a penalty if the health coverage is deemed “unaffordable”. Generally, the employer-offered health coverage is deemed unaffordable if (1) the employee has to pay more than 9.5 percent of his or her income, or (2) the employer contributes less than 60 percent of the actuarial value of the plan. In such cases, the employer must pay a monthly penalty of $250.00 ($3000 for the year) for each full-time employee receiving a “premium assistance tax credit” from the federal government. The maximum penalty any employer could have levied against them would equal $750.00 multiplied by the number of full-time workers employed by the employer. Again, The Health Care Reform Act exempts the first 30 workers from this penalty payment calculation. *As an example, suppose an employer has 40 full-time employees and offers “unaffordable” health coverage as applied to all 40 employees. If each employee receives a premium assistance tax credit, the employer will be penalized $250.00 multiplied by 40, which equals $10,000.00. However, the maximum penalty imposed under this employer mandate for this particular employer equals $750 multiplied by 10, which is $7,500.00 (because the first 30 employees are ignored). Therefore, the maximum penalty levied against the employer will be $7,500.00.*

For purposes of these penalties, a full time employee is an employee who works at least 30 hours per week. Furthermore, the “premium assistance tax credit” is generally
provided to employees who are offered coverage by an employer in which the plan’s share of the total costs of benefits provided under the plan is less than 60 percent of such costs or the premium paid for by the employee exceeds 9.5 percent of the employee’s income.

**Automatic Enrollment**

In addition to the “play-or-pay” penalties, employers with more than 200 employees will be required to automatically enroll full-time employees in health coverage. An employee has the right to affirmatively opt-out of the coverage if they so choose. Employers are required to notify employees of the plan’s automatic enrollment policy and their right to affirmatively opt-out of coverage.

**Free Choice Vouchers**

Effective January 1, 2014, employers offering minimum essential health coverage through an employer-sponsored plan are required to provide eligible employees, who do not qualify for federal subsidies, the opportunity to opt-out of their employer-sponsored plan and receive a “free choice voucher”. The “free choice vouchers” are equal to the value of the employer’s contribution to the plan and must be used by the employee to join a state-based exchange plan. These vouchers will only be available to employees who would have to pay over 8 percent but less than 9.8 percent of their income to cover the premium for employer-based coverage, whose family income is below 400 percent of the federal poverty level, and who do not participate in an employer-sponsored health plan. The amount of the voucher is paid by the employer directly to the exchange on behalf of the employee. Employees are able to cash-in the amount of the voucher in excess of the cost of purchasing insurance through the exchange.

**W-2 Reporting**

For the 2011 tax year, employers are required to report the value of the benefits provided by the employer for each employee’s health insurance coverage, determined using COBRA premium rates and including the employee paid portion, on the employee’s annual Form W-2.

**Disclosure Requirements**

Another goal of the Health Care Reform Act is to increase the transparency of health insurance. To this end, the Health Care Reform Act requires the Secretary of HHS to create new disclosure requirements for health plans. These requirements will call for the creation of a uniform explanation of coverage by the health plan, which will be distributed to plan participants by March 23, 2012. This explanation of coverage must be in 12-point font, no more than four pages long, and written in a culturally and linguistically appropriate manner. A $1,000 per participant penalty will be imposed for each willful failure to distribute the explanation.
OTHER PROVISIONS OF INTEREST TO EMPLOYERS

The following is a list of other key provisions that are of interest to many employers.

• Effective January 1, 2012, businesses that pay more than $600 to any individual or corporation in a tax year for a good or service will have to issue to such individual or corporation a tax Form 1099. This provision is designed to track business payments for goods and services and will likely impose a heavy administrative burden on employers.

• The Health Care Reform Act prohibits employers from discriminating against employees who receive premium assistance tax credits.

• Effective 2011, the Health Care Reform Act creates a new national employee-funded long-term care benefit known as Community Living Assistance Services and Supports Act (the CLASS Act). The CLASS Act provides the option of either a daily or weekly cash benefit, which is intended to help people with functional limitations purchase the services and supports needed to maintain personal and financial independence. The CLASS Act is voluntary, but employers are encouraged to participate.

• The Medicare Part D “doughnut hole” will be gradually reduced so that it is fully closed by 2020. In the meantime, a one-time $250 subsidy will be provided to participants who fall within the coverage gap.

• Effective plan years beginning after September 30, 2012, all health plans will have to pay a $2 per participant fee ($1 fee for fiscal year 2013) to finance the newly established Patient-Centered Outcomes Research Trust Fund. This fee ends in 2019.

• By the end of 2013 and 2015, health plans will be required to certify compliance with certain HIPAA EDI transaction standards aimed at providing administrative simplification.

• Beginning in 2013, health Flexible Spending Account salary deferral is capped at a maximum of $2,500. The cap is indexed for subsequent years.

• Effective January 1, 2018, employers must pay a 40 percent excise tax on certain types of high-cost health coverage (known as “Cadillac coverage”). The 40 percent tax is imposed on an employer to the extent the value of the health coverage is in excess of $10,200 for individual coverage, $27,500 for family coverage, $11,850 for retiree coverage, and $30,950 for employee coverage in high-risk professions, subject to future adjustment.
This is meant to serve as an introduction to the myriad of challenges facing employers in the coming years because of the Health Care Reform Act. Employers who have any questions regarding these or other provisions of the Health Care Reform Act, or would like more information on how to implement a program that will most effectively allow you to comply with this new legislation, should contact an attorney at Susanin, Widman & Brennan P.C.