



Federal Health Care Reform: Impacts on Employers

April 7, 2010

The newly enacted federal Patient Protection and Affordable Care Act (the "Act")¹ makes significant changes to the health and other benefits that employers offer to their employees. Additionally, there are administrative requirements required in the act with which an employer will need to comply.

It is imperative that employers have a detailed understanding of what changes are on the immediate horizon, as well as what changes will be required in the future, so that they may adequately plan and account for the administrative and financial impact of these changes to their business and on their workforce. While we continue to analyze the hundreds of provisions in the over 2,000 pages of new federal law, the purpose of this paper is to provide employers with a preliminary summary and explanation of the changes, and to alert employers to ambiguous areas in the act that will need to be clarified by regulations yet to be issued by federal agencies such as Health and Human Services and the IRS.

A glossary of defined terms is located at the end of this paper.

Timing of new requirements; details continue to be defined

It is important to note that most of the provisions that will have a major impact on the health insurance marketplace — such as the new framework for health insurance products and the employer mandate to offer coverage — are not scheduled to go into effect until 2014. However, some of the provisions that have been less publicized in the media have effective dates in 2010 or are even retroactive to the beginning of 2010.

Many of the deadlines discussed in this document are calculated from the date of the act's enactment, March 23, 2010. For example, most of the effective dates in 2010 apply to plan years beginning on or after six months after the date of enactment (or September 23, 2010).

It is also important to note that many of the provisions in the act instruct federal agencies such as Health and Human Services and the IRS to define details, issue implementation guidelines or regulations, and resolve ambiguities. Such a process is typical with enacted legislation, and while a few guidelines have been issued, many of the provisions with near-term implementation dates have yet to be defined.

Where interpretation of the law is unclear, employers should consult their legal counsel for guidance.

Health plan auto-enrollment effective date is unclear

The act will require employers with more than 200 full-time employees to automatically enroll new full-time employees in health coverage, although employees have the ability to opt out of coverage. The effective date for this requirement is unclear, but because the act states that the enrollment must be in accordance with regulations to be issued, it is possible that this requirement is not effective until those regulations are issued.

¹ In this paper, reference to the "act" refers collectively to the Patient Protection and Affordable Care Act (H.R. 3590, Public Law No. 111-148), and the so-called reconciliation bill (H.R. 4872, the Health Care and Education Affordability Reconciliation Act of 2010). Together, these two pieces of legislation make up the entirety of the federal health care reform law.



Changes required in 2010

There are numerous changes that the act makes effective this year, which will impact employers' health plans for both active and, in some instances, retired employees. These changes apply to both fully insured and self-funded health plans. Unless otherwise noted, these changes are effective for plan years beginning on or after September 23, 2010. For example, if an employer's health insurance renews or its self-funded health plan's plan year begins on January 1, these provisions will need to be complied with effective January 1, 2011.

Keeping current health benefits ("grandfathering")

A key item that employers need to know concerns whether and to what extent the employer may continue to maintain the employer-sponsored health plan it had in effect on the date of the act's enactment (March 23, 2010), without having to comply with certain benefit and other plan changes the act requires both in 2010 and in future years. Maintaining current coverage is called "grandfathering" in the act.

The act does explicitly permit the employer to maintain current health coverage for individuals already enrolled, subsequently enrolled family members and new hires. Also, collectively bargained plans are grandfathered until the date on which the last of the collective bargaining agreements relating to the grandfathered coverage in effect on date of the act's enactment terminates. However, there are a number of unanswered questions on the grandfathering provisions. It is likely that these questions will be answered by the federal agencies charged with issuing regulations interpreting the act. For example, it is unclear:

- What circumstances would cause the grandfathering to end (for example, can a copay change);
- What happens when the employer changes plans or insurers;
- What happens if the employer extends coverage to a new category of employees;
- What happens if an employee previously receiving coverage through his or her spouse's plan wants to come onto the employer's plan; and
- How a collectively bargained plan must comply when the collective bargaining agreement terminates before 2014.

Benefit changes

For plan years beginning on or after September 23, 2010, employers with self-funded health plans, or the health insurers from which they obtain employer-sponsored health insurance, must make the following changes to their health plan benefits:

- Adult children up to age 26 are eligible to receive coverage from their parent's plan, regardless of student status or marital status. These children need not be supported by or living with their parents.² This provision also applies to "grandfathered" plans.
- No lifetime maximum benefit limits may be imposed. This provision also applies to "grandfathered" plans.
- The plan may not apply annual maximum benefit limits for "essential benefits," except as may be permitted in regulations to be issued at a later date. This provision also applies to "grandfathered" plans.
- The plan cannot limit coverage for pre-existing conditions for children under age 19, regardless of whether the child has a gap in coverage.

² Additionally, for parents with group health coverage, they must not be eligible for other employer-sponsored coverage (such as that offered through the child's employer). This condition applies until 2014.



- Employers' plans must provide preventive care without cost sharing, and must cover certain child preventive services.
- Employers' self-funded health plans must provide covered individuals with the right to seek external independent medical review of certain claims, such as claims that are denied based upon medical necessity.
- The plan cannot impose a prior authorization requirement or increased cost-sharing for emergency services (regardless of whether the services are provided in or out of network).
- The plan may not discriminate in favor of highly compensated employees.

Wellness program change

A minor provision of which employers still need to be aware is that effective in 2010, wellness programs may not require disclosure or collection of any information relating to the presence of firearms, and may not base premiums, discounts, rebates or rewards on basis of firearm or ammunition ownership.

Reinsurance for retiree benefits

Finally, beginning in 2010 and ending January 1, 2014, is a temporary reinsurance program for employers providing health coverage to retirees over age 55 who are not Medicare eligible. This federal reinsurance program will reimburse employers for 80 percent of claims between \$15,000 and \$90,000 (these amounts are indexed for inflation). The funding for the reinsurance program is \$5 billion for the entire period, and it is unclear how long the funding will last. The federal Health and Human Services agency is required to establish the program by late June 2010 and — as of this writing — program details have not been issued.

Changes required in 2011

Changes to flexible spending accounts (FSAs), health reimbursement accounts (HRAs) and health savings accounts (HSAs)

Beginning in 2011, the act will require several changes to FSAs, HRAs and HSAs. Employees will not be able to receive pre-tax reimbursements from their FSA, HRA or HSA for non-prescribed over-the-counter medications. Additionally, the excise tax for nonqualified HSA withdrawals is increased from 10 percent to 20 percent, and the excise tax for nonqualified withdrawals from Archer Medical Savings Accounts will be increased from 15 percent to 20 percent.

Reporting value of coverage

The requirement that employers report the value of employer-provided health coverage on each employee's W-2 is effective in 2011. However, it is unclear whether this provision applies to the value of health benefits provided in tax year 2010 or tax year 2011. Regulations yet to be issued will hopefully clarify the effective date of this requirement.

Enrollment in new long-term care program

The act also establishes a new, government-run voluntary long-term care program called the CLASS Act.³ Employers must automatically enroll employees into the program and make payroll deductions for the premiums, although employees can elect not to participate. Employers may choose not to participate in the program. Employees will not be eligible to receive benefits until after paying premiums for five years.

Changes required in 2012

Issue 1099s for corporate service providers

One important change made by the act unrelated to health benefits requires employers beginning in 2012 to provide an IRS Form 1099 to all corporate service providers receiving more than \$600 per year for

³ "CLASS" is the acronym for Community Living Assistance Services and Supports. See Sections 8001 and 8002 of the act.



services or property. Currently, 1099s need only be generated for non-corporate service providers and only on services.

Changes Required in 2013

Effective in 2013, employee contributions to FSAs will be capped at \$2,500 annually, with the cap adjusted annually to the Consumer Price Index.

New fees and other financial changes

Beginning in 2013, the act will require new fees and other financial changes for employers that have established and maintained self-funded health plans.

- **Comparative effectiveness fee:** A fee will be assessed on employers with self-funded health plans to fund a comparative effectiveness research agency. (For employers with fully insured health plans, the health insurer will be assessed the fee.) For plan years ending after September 31, 2012, this fee will be \$1 times the average number of lives covered under the plan; in subsequent plan years, the fee will be \$2 times the average number of covered lives. The fee will end on September 30, 2019.
- **Additional Medicare taxes for high-income earners and on unearned income:** There will be an additional 0.9 percent Medicare tax imposed upon employees who have wages over \$200,000 (\$250,000 for joint tax filers). Also, there will be a new 3.8 percent Medicare tax imposed upon unearned income (interest, dividends, annuities, royalties and rents) for taxpayers in those same income brackets.
- **Elimination of Medicare Part D subsidy deduction:** The act also eliminates an employer's tax deduction for the amount of the Medicare Part D retiree drug subsidy. In other words, the employer's allowable tax deduction for retiree prescription drug expenses must be reduced by the amount of the tax-free subsidy payment the employer receives. Although this provision does not go into effect in 2013, for companies subject to FASB⁴ rules, FASB 106 requires the immediate recognition of the loss of this future tax benefit.

New employee notice required

Effective March 1, 2013 (or subsequently for new hires), the act requires employers to issue a new notice to employees containing information about state exchanges, the availability of premium assistance if the actuarial value of the employer's plan is below 60 percent, and the availability of free choice vouchers in the upcoming plan year (2014).

Changes required in 2014

The exchanges

Beginning in 2014, states will begin to operate what are called "exchanges," which are marketplaces for individuals and some employer groups to obtain private health insurance choices. In 2014, small group employers with fewer than 100 employees are eligible to purchase health insurance coverage in the exchange; while beginning in 2017, states may choose to open the exchanges to employers with more than 100 employees.

Private health insurance sold in the exchange must contain "essential benefits" (although each state has the opportunity to add benefits if the state funds the addition). There are numerous other rules governing exchange plans, such as insurance premium rating rules and the actuarial value of benefits that can be sold in the exchange.

⁴ FASB is the acronym of the Financial Accounting Standards Board, found at <http://www.fasb.org/home>.



Individual and employer responsibilities about health care coverage

Beginning January 1, 2014, employers will be subject to a number of provisions that affect the health benefits they provide to full-time employees. Importantly, beginning in 2014, individuals also have the personal responsibility to obtain qualifying health coverage. They can do this by enrolling in an employer-sponsored health plan, a government-sponsored health plan (such as Medicare, Medicaid, TRICARE, etc.), or a health plan in the exchange, if they meet the criteria to qualify to buy in the exchange.

Prior to 2014, each employer will need to calculate how many full-time (or full-time equivalent) employees it employs to determine whether or not it must comply with the act's 2014 provisions (per thresholds described below).

The employer must count all full-time employees (defined as those working 30 or more hours per week, determined on a monthly basis) and must also take into account part-time employees on a full-time equivalency basis. Certain seasonal workers are not counted; refer to specific act provisions for details on this exception.⁵

New employer penalties

If an employer has 50 or more full-time employees, then the employer may be subject to penalties under the act if it provides either **no** health coverage to full-time employees⁶, or provides coverage to full-time employees that is **not affordable**, as explained below.

The act subjects an employer to penalties if it does not provide **any** "minimum essential coverage"⁷ for its full-time employees, and one or more full-time employees enrolls for coverage in an exchange and qualifies for a premium tax credit or cost-sharing reduction. In this situation, the employer penalty imposed is \$2,000 for each of its full-time employees; however, no penalty is assessed on the first 30 full-time employees. Penalties are assessed monthly.

The act also makes an employer subject to penalties if it offers its full-time employees the chance to enroll in "minimum essential coverage" and one or more full-time employees enrolls for coverage in an exchange and qualifies for a premium tax credit or cost-sharing reduction because **either** the employee's share of the premium exceeds 9.5 percent⁸ of the employee's income, **or** the employer's plan has an actuarial value of less than 60 percent. (The employer will be notified by the exchange if the employee qualifies.) In this situation the penalty on the employer is \$3,000 for each full-time employee receiving a tax credit or cost-sharing reduction. This penalty is often called the "free rider" penalty.

The penalty is capped and cannot exceed the total penalty that would have been imposed had the employer offered employees no coverage. Penalties are assessed monthly.

⁵ See Section 1511 of the act.

⁶ The act does not require employers to provide health coverage to part-time employees.

⁷ "Minimal essential coverage" is merely defined as an employer-sponsored plan offered in the small or large group market in a state; there are no particular benefits required to be included to constitute "minimal essential coverage." See Sections 1501 and 1513 of the act.

⁸ There is a notable discrepancy between the percentage of employee income making coverage "unaffordable" (for purposes of the "free rider" penalty), and the percentage of employee income qualifying the employee for a "free choice voucher." The reconciliation bill, at Section 1001, changed the percentage of employee income making coverage unaffordable from 9.8 to 9.5 percent. However, no similar change was made to the percentage of employee income qualifying an employee for a "free choice voucher," which remains at 9.8 percent.



Changes to benefits

- **Waiting period changes:** An employer may not impose a waiting period greater than 90 days for the employee to satisfy before getting health coverage. (This provision also applies to “grandfathered” plans as of the effective date of the act.) However, there is no penalty specified for violating this provision.
- **Coverage of certain costs in clinical trials for life-threatening diseases:** This coverage mandate requires health plans to provide coverage for routine patient costs for items and services furnished in connection with participation in clinical trials for life-threatening illnesses such as cancer.
- **Extension of Paul Wellstone & Pete Dominici Mental Health Parity and Addiction Equity Act to groups of all sizes and to individual market coverage:** The act extends the new mental health parity law to groups of under 50 employees, and to individual health insurance coverage.

Manner of obtaining benefits

- **Free choice vouchers:** Apply to employers that offer health coverage and pay a portion of the cost of that coverage. An employee qualifying for a “free choice voucher” must have income below 400 percent of the federal poverty level; the employee’s contribution to premium would be between 8 percent and 9.8 percent of the employee’s family income, and the employee does not participate in the employer’s health plan.

If these conditions are satisfied, the employer must pay to the exchange the value of what the employer would have paid toward the employee’s cost of health coverage under the plan with respect to which the employer pays the largest portion of the plan. The employer’s payment is keyed to the kind of coverage the employee purchases in the exchange (self only or family).

Changes to wellness programs

The act codifies the HIPAA nondiscrimination rules on wellness programs and increases the incentive cap of 20 percent of premium to 30 percent. The HHS Secretary has the discretion to increase the incentives cap to 50 percent.

New Employer Administrative Reporting

Finally, the act will require employers to annually report to the IRS a number of pieces of data, including the following:

- Whether the employer offers minimum essential coverage to full-time employees;
- Any waiting period for health coverage;
- The monthly premium for the lowest cost option in each enrollment category under the plan;
- The employer’s share of the total allowed cost of benefits provided under the plan;
- The number of full-time employees during each month;
- The name, address and taxpayer identification number (or Social Security number) of each full-time employee, and the months each employees was covered under the employer’s plan, and
- “Such other information as the [HHS] Secretary may require.” This requirement will likely be further refined in later regulations.



Changes Required in 2018

Finally, in 2018 a 40 percent excise tax on high-cost plans will be applied to plans costing more than \$10,200 for individual coverage, or \$27,500 for family coverage. The thresholds are adjusted to \$11,850 and \$30,950 for retirees over age 55 and individuals in high-risk professions; threshold adjustments are also available for plans that have higher-than-average costs due to the age or gender of their workers. Thresholds will be automatically increased if health costs increase more than expected between 2010 and 2018; thresholds will be indexed to the Consumer Price Index (CPI) plus 1 percent in 2019, and to the CPI thereafter. The tax will apply to the cost of benefits over these threshold amounts.

Coverage subject to this excise tax includes employee and employer contributions, whether pre-tax or after-tax. Also included are contributions to FSAs, HRAs and HSAs, and on-site clinics or wellness plans that are ERISA plans. Not included are ancillary benefits such as dental, vision, accident, disability, long-term care, and after-tax indemnity or specified disease coverage.

New Employee Legal Rights Against Employers

Finally, employers should be aware of several provisions⁹ that have not been much discussed. The act creates new legal rights for employees to charge their employers with discrimination having to do with health benefits, based upon federal laws such as the Age Discrimination Act, the Rehabilitation Act, the Civil Rights Act, the Fair Labor Standards Act and others. The act's amendment of the Fair Labor Standards Act prohibits an employer from discriminating in any way against an employee who has received a premium subsidy or reduced cost-sharing under the act, while another provision protects individuals from discrimination in terms of exclusion from participation in or denial of benefits under any health program or activity.

These provisions also provide whistleblower protections for employees who provide information to or cooperate with federal or state government authorities concerning alleged violations of the act. These new rights apply regardless of whether the employer's health benefits plan is fully insured or self-funded.

⁹ Sections 1557 and 1558 of the act.



Glossary

Actuarial Value – An “actuarial value” of a plan is the portion of allowable costs paid by the plan.

Adult Children – In this paper, the term means children, whether natural, adopted or foster, who are older than age 18. It is important to note that adult children eligible to become enrolled on their parents’ plan do not have to be “dependents” of their parents, as defined by the IRS. Adult children eligible to be added to their parents’ health coverage may be married, living separately and/or self-supporting, but must not be eligible for other employer-sponsored health coverage.

Cost-Sharing Reduction – An individual eligible for a reduction in cost-sharing under a health plan must have income between 100 and 400 percent of federal poverty, and must have enrolled in an exchange plan. Cost-sharing is reduced on a sliding scale based upon income.

ERISA Plan – A health and welfare benefit plan established and maintained by an employer or other plan sponsor (such as a union) for the benefit of its employees or other eligible plan participants and beneficiaries, and that is governed by the federal Employee Retirement Income Security Act of 1974.

Essential Health Benefits – The act defines certain categories of benefits as “essential health benefits” (See Section 1302 of the Act). In general, essential health benefits are those that must be included in private health insurance sold in the exchange. The categories of essential health benefits are:

- a) Ambulatory patient services.
- b) Emergency services.
- c) Hospitalization.
- d) Maternity and newborn care.
- e) Mental health and substance use disorder services, including behavioral health treatment.
- f) Prescription drugs.
- g) Rehabilitative and habilitative services and devices.
- h) Laboratory services.
- i) Preventive and wellness services and chronic disease management.
- j) Pediatric services, including oral and vision care.

Exchange – A state-based agency or non-profit entity responsible beginning in 2014 to perform the following functions: assist in consumer and small employer education about health plan choices; assist consumers in enrollment; assist with financial handling of premium tax credits, cost-sharing reduction and free choice vouchers; certify health plans as qualified to sell in the exchange;

External Review – Also called independent medical review, external review is the opportunity a plan participant has to obtain an outside medical opinion of the plan’s claims decision (usually based on medical necessity, or determination of experimental or investigational coverage). The external review organization is not affiliated with the plan.

Free Choice Voucher – A “free choice voucher” is essentially the value of the largest employer contribution to premium, credited to an employee who chooses to obtain health coverage in the exchange. There are conditions that must be satisfied before an employee is eligible for a free choice voucher. If the value of the free choice voucher exceeds the cost of health coverage for the employee who obtains exchange coverage, the excess funds must be paid to the employee.

Free Rider Penalty – If an employer offers employer-sponsored health coverage to employees that either (a) has an actuarial value of less than 60 percent, or (b) requires the employee to spend more than 9.5 percent of the employee’s income on health coverage, qualifying the employee for health coverage in the exchange, the employer will be penalized \$3,000 for each employee who receives exchange coverage (and premium tax credit and/or cost-sharing limitations).

Full-Time Employee – The act defines a “full-time employee” as working 30 or more hours per week, determined on a monthly basis.



Grandfathering – This term refers to the ability of a health plan to escape legal requirements of the act that would otherwise be applicable. In general, if an employer maintains the exact same health plan it did on March 23, 2010, most (but not all) of the health plan provisions will be “grandfathered” and need not be altered.

HIPAA – The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and regulations issued thereunder.

HHS – The U.S. Department of Health and Human Services, headed by Secretary Kathleen Sebelius.

IRS – The federal Internal Revenue Service.

Mental Health Parity – In this paper, this term refers to the Paul Wellstone & Pete Dominici Mental Health Parity and Addiction Equity Act of 2008, and interpreting federal regulations.

Minimum Essential Coverage – As defined in the act, “minimum essential coverage” means any employer-sponsored health coverage. This term is not equivalent to the term “essential health benefits” (see above).

Premium Tax Credit – This term refers to the amount of tax credit an individual with income between 100 percent and 400 percent of federal poverty level may receive towards the cost of premium for health plans in the exchange.

Preventive Care – The definition of “preventive care” includes the following:

1. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph;
5. for the purposes of this act, and for the purposes of any other provision of law, the current recommendations of the U.S. Preventive Service Task Force regarding breast cancer screening, mammography and prevention shall be considered the most current other than those issued in or around November 2009.

Regulations – When a federal law is enacted, many times there are provisions in the law needing clarification. Federal agencies are responsible for issuing federal regulations (also called federal rules) that interpret the federal law and provide clarification. Regulations, once final, have the force of law.

Reinsurance – In this paper, the term means the federal government’s reimbursement to the employer of certain large medical expenses incurred by the employer’s retiree health plan.

Self-funded health plan – This refers to a health plan that is fully funded by monies from the employer and is not an insurance arrangement.

Wellness program – The program an employer offers to its employees to encourage healthy behaviors, such as weight loss or smoking cessation.