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The Implications of Health Care Reform for Employers

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The Patient Protection and Affordable Care Act and the House Health Care and Education Reconciliation Act of 2010 were signed into law last month. Together, these laws represent major reform of the nation's healthcare system, with significant implications for employers. The following represents a brief summary of the important consequences for employers and their group health plans, laid out in order of effective dates.

Effective Immediately

Small Business and Non-Profit Tax Credit- Small businesses and small non-profits that provide qualified health plan (which must, among other things, provide certain minimum essential health benefits) for their employees will be eligible for a tax credit for contributions beginning in the tax year 2010. To qualify for the credit, an employer must have:

- 25 or fewer full-time equivalent employees, and
- average annual wages of $50,000 or less, and
- the employer must have a qualified health care plan in effect, for which the employer contributes at least 50% of the premium.

The full credit is available for employers with 10 or fewer full-time equivalent employees and annual wages of $25,000 or less. After that, the credit begins to phase out. In 2010-2013, the maximum credit is 35% of the employer's contribution to providing health insurance for employees (the percentage increases in 2014, see discussion on page 4).

Small nonprofit organizations are eligible for a tax credit of up to 25%. Any organization which (1) meets the criteria above, (2) is an organization described in section 501(c) of the Internal Revenue Code, and (3) is exempt from taxation under section 501(a) of the Internal Revenue Code may be eligible for the small non-profit tax credit. The credit is refundable for non-profits.

These tax credits are in effect beginning in the calendar year 2010.

Temporary Reinsurance Program for Retiree Coverage- This provision will provide reimbursements to employer-based health insurance plans to encourage insurance coverage of early retirees, and to lower the costs of such plans.

The program allows a reimbursement to employer-based health insurance plans of up to 80% of the cost of retiree health benefits (defined as the actual amount expended by the participating employment-based plan within the plan year for the health benefits provided to an early retiree or the spouse, surviving spouse, or dependent of such retiree), for costs between $15,000 and $90,000 (these amounts are to be adjusted annually), for retirees between the ages of 55 and 64.

These reimbursements are to be used to lower costs to the plan to reduce premium costs, premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. This program has a $5 billion funding maximum and is scheduled to last until 2014. Effective 6/23/2010.

Coverage Changes- Group health plans will have to make certain changes, detailed below. Certain provisions have different application dates or do not apply at all to "grandfathered plans," which are any group or individual health plan that was in existence before March 23, 2010 (as noted). Plans may enroll new employees or dependants and maintain the grandfathered status, but it is not clear what other changes may be allowed for the plan to continue to be grandfathered. In addition, any health insurance plan which is maintained pursuant to a collective bargaining agreement ratified before March 23, 2010, will not be subject to the reforms until the date on which the agreement terminates (not the next plan year thereafter). Collectively bargained plans are permitted to be amended early for some or all of the new health care reform rules, which will not subject the plan to an earlier compliance deadline.

- All group health plans or plans in the individual market that provide dependent coverage for children must continue to make that coverage available until the child turns 26 years of age (for grandfathered plans, prior to 1/1/2014, this applies only if the child is not eligible to enroll in other employer-provided coverage). Effective first plan year beginning on or after 9/23/2010.
- All employer plans and new plans in the individual market are prohibited from imposing pre-existing condition exclusions on children's coverage. Effective first plan year beginning on or after 9/23/2010 (effective 1/1/2014, this prohibition extends to all plans).
- All health plans are prohibited from placing lifetime limits on coverage, or from using restrictive annual limits in all employer plans and new plans in the individual market. Effective first plan year beginning on or after 9/23/2010.
- All health plans must have an HHS-approved external review process. Effective first plan year beginning on or after 9/23/2010. Does not apply to grandfathered plans.
- New group health plans and all individual plans must generally provide coverage for preventive services without co-pays. Effective first plan year beginning on or after 9/23/2010, but effective 1/1/2014 for grandfathered group health plans.
- All health plans are prohibited from the practice of canceling coverage after someone has submitted medical claims (known as rescission). Rescission would still be permitted if an individual committed fraud or made an intentional misrepresentation of a material fact. Effective first plan year beginning on or after 9/23/2010.
- Health plans must provide coverage with no co-pays or other cost-sharing for certain evidence-based preventive care, including well-child care and certain immunizations. Effective first plan year beginning on or after 9/23/2010. Does not apply to grandfathered plans.

Time for Breast Milk Expression- For a year after giving birth, nursing mothers must be allowed breaks on the job to express breast milk as often as necessary, and a private place to do so that is not a bathroom. Employers with fewer than 50 employees are exempt. Employers in New York State should note that the New York Labor Law

already requires time for milk expression within the first three years of childbirth, with no exception for small employers. For more information on New York State Requirements, please contact anyone in the Labor and Employment Group at Cullen and Dykman.

Effective in 2011

Reporting Health Coverage Costs on Form W-2- This provision requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2. Effective for tax years 2011 and after (Form W-2 issued in January 2012).

Automatic Enrollment- This provision requires employers with more than 200 employees to automatically enroll all eligible employees in the employer's group health plan. An employee thereafter may "opt-out" of the employer's group health coverage, and the employer must provide notice of these opt-out rights. (N.B. there is no effective date for this provision, and regulations must be enacted before it is effective. It is thought that the regulations will not be issued until sometime after 2010).

Standardizing the Definition of Qualified Medical Expenses- Individuals will be prohibited from using the funds in HSAs, FSAs, and HRAs for the cost of over the counter medications that are not prescribed by a physician. Effective for tax years 2011 and after.

Cafeteria Plan Changes. Creates a Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax©\free benefits to their employees. This would ease the small employer's administrative burden of sponsoring a cafeteria plan. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from pension plan nondiscrimination requirements applicable to highly compensated and key employees. Effective for tax years 2011 and after.

Wellness Grants- Employers with less than 100 employees that did not provide a wellness program on March 23, 2010, will be eligible for wellness grants. The grants will be available upon HHS initiating the program and will last up to 5 years.

Uniform Explanation of Coverage- Not later than March 23, 2012, a Uniform Explanation of Coverage must be provided to employees on an annual basis. For insured plans, the insurer must provide the explanation; for self-funded plans, the employer must provide it. The Uniform Explanation is in addition to the Summary Plan Description required by ERISA.

Effective in 2013

Medicare Payroll Tax Increase - The Medicare portion of the FICA tax will increase to 2.35% (up from 1.45%) for individuals with modified adjusted gross incomes of more than $200,000 a year ($250,000 for married couples). In addition, a new Medicare tax on unearned income of 3.8% takes effect for the same income limits.

Limitations on Health Flexible Savings Account Contributions- Limits the number of contributions to health FSAs to $2,500 per year, indexed by CPI for subsequent years.

Elimination of Deduction for Employer Part D Subsidy- Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

Notice Requirements- Effective 3/1/2013, employers must give employees certain notifications regarding health insurance exchanges. The health insurance exchanges will enable people to comparison shop for standardized health packages and will facilitate enrollment and administer tax credits to facilitate affordable coverage.

Effective in 2014

Health Insurance Exchanges- Health insurance exchanges in each State will open to individual and small group markets (increases in 2017 for employers with up to 100 employees).

Individual Responsibility- All U.S. citizens and legal residents (with certain exceptions, including those who cannot afford or fall below the federal poverty level) will be required to have acceptable health coverage or pay a penalty, which will be phased in from 2014 through 2016. After 2016, penalties are indexed to CPI. A refundable tax credit will be provided for certain low-income individuals to help purchase coverage through a health insurance exchange. Employees who are exempt from the individual mandate for coverage but who do not qualify for the tax credits can take their employer contribution and join a health insurance exchange plan through the use of a free choice voucher (see below).

Employer Play or Pay Mandate- Two possible penalties are put into place:

- For employers that do not offer minimum coverage- Requires employers with 50 or more employees who do not offer health insurance coverage to their employees to pay $2,000 annually for each full-time employee over the first 30 as long as one of their employees receives a low-income tax credit for the purchase of health coverage (as described in Individual Responsibility, above).

- For employers that do offer coverage, but the coverage is unaffordable or does not provide minimum essential coverage- If an employer offers health insurance, but the coverage does not provide minimum essential coverage or if an employee's cost for employer coverage exceeds 9.5% of household income, a full-time employee would be eligible for the government-subsidized coverage. The penalty, in this case, is equal to the lesser of: (a) $3,000 multiplied by the number of full-time employees who receive the premium tax credit, or (b) $750 multiplied by the number of the employer's full-time employees, up to an aggregate cap of $2,000 per full-time employee.

Free Choice Vouchers- Employees who qualify for an affordability exemption to the individual responsibility policy but do not qualify for tax credits can take their employer contribution and join a health insurance exchange plan. A qualified employee is an employee who: (a) has income below 400% of the federal poverty level, (b) would otherwise have to pay between 8%-9.8% of his or her income for the employer coverage premium, and (c) enrolls in a plan in the health insurance exchange.

Reporting Obligations- Employers with more than 50 employees must report certain information regarding insurance coverage to the IRS and covered individuals.

Small Business Tax Credit- Continues the second phase of the small business tax credit for qualified small employers, which will cover up to 50% of premiums (see discussion on page 1).

Waiting Period Prohibition- Beginning January 1, 2014, waiting periods for health plan eligibility cannot exceed 90 days.

Wellness Program Discounts- Employers and insurers may offer increased incentives for participation in certain types of wellness programs, up to a 30% premium discount or other rewards. HHS may choose to increase the allowable discount rate to 50%.

Effective in 2018

Excise tax on high-cost employer-provided health plans becomes effective- Employers must pay a 40% excise tax on coverage in excess of $27,500 (family coverage) and $10,200 (single coverage) (increased to $30,950 (family) and $11,850 (single) for retirees and employees in high-risk professions). The dollar thresholds are indexed with inflation, and employers with higher costs on account of the age or gender demographics of their employees may value their coverage using the age and gender demographics of a national risk pool.

We will continue to keep you updated as the new regulations are issued. If you have questions about this or any other labor and employment issue, please contact any member of our labor department at 516-357-3700.

Practices

- Labor and Employment
- Civil Rights and Employment Litigation
- Health Care

Attorneys

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