



Preparing for Health Care Reform A Chronological Guide for Employers

This Article provides an overview of the major provisions of health care reform legislation affecting employers and explains the requirements they should focus on in each year.

This Article: know-how was first published by Practical Law Company on its PLC Law Department web service at <http://usld.practicallaw.com/6-502-1419>.

Christy Tinnes, Brigen Winters and Christine Keller, Groom Law Group, Chartered

President Obama signed the Patient Protection and Affordable Care Act (Act) into law on March 23rd, 2010. Amendments to this sweeping reform were then enacted on March 30, 2010 as part of the Health Care and Education Reconciliation Act of 2010. The legislative phase is over, but the implementation phase is just beginning. Now is the time for employers to begin looking at what health reform means to them and when they will be impacted. The various reforms take effect gradually and can be broken into three categories:

- The immediate reforms: what's happening now.
- Reforms on the horizon: 2011 to 2013.
- Distant reforms: 2014 and later.

Employers must consider each category now because each will have a major impact on how employers do business and what opportunities are available.

THE IMMEDIATE REFORMS: WHAT'S HAPPENING NOW

Employers should immediately educate themselves on the reforms and:

- Determine which of their plans are affected and to what extent (see *Determining if a Plan is "Grandfathered"*).
- Decide whether to apply for the temporary reinsurance program (see *Temporary Reinsurance Program*).
- Determine whether they are eligible for the new tax credits for small employers (see *Credits for Small Employers*).

Determining if a Plan is "Grandfathered"

Health reform divides the universe of healthcare plans into two groups:

- **"Grandfathered" plans.** A grandfathered plan is a group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010 (the date of enactment of the Act). Employer-sponsored grandfathered plans may continue to add family members and new employees. Grandfathered plans only have to follow some of the insurance market reforms.
- **Non-grandfathered plans.** Non-grandfathered plans must comply with all of the insurance market reforms as they become effective.

A number of questions remain about the effect of the reforms on grandfathered plans:

- Can a grandfathered plan make changes and still keep its grandfathered status?
- How significant do the changes to grandfathered plans have to be before they lose their grandfathered status?

Government regulators are expected to issue more guidance on grandfathered plans.

In the chart below, reforms are categorized based on whether they apply to grandfathered plans or solely to non-grandfathered plans (see *Summary of Provisions Affecting Grandfathered Plans and Non-grandfathered Plans*).

Temporary Reinsurance Program

The Department of Health and Human Services (HHS) is working to establish a "temporary reinsurance" program to



reimburse employer-sponsored plans for a portion of the costs associated with health insurance coverage to early retirees. The program:

- Is scheduled to begin in June 2010.
- Will reimburse some costs associated with individuals over the age of 55 who are not yet eligible for Medicare.
- Will reimburse 80% of expenditures between \$15,000 and \$90,000.

Employer-sponsored plans need to apply to be a part of the program and will be limited in how reimbursements are used. After the application is released by HHS, employers who want their plans to participate in the program must act quickly, because Congress has appropriated only \$5 billion for the program. When the pool is gone, the program will end.

For more details on the program and how to apply, see *Article, Retiree Reinsurance Program Interim Final Regulation* (www.practicallaw.com/2-502-3203), and *Article, Early Retiree Reinsurance Program* (www.practicallaw.com/3-502-3325).

Credits for Small Employers

The Act includes a new tax credit for small employers that purchase health insurance for their employees and that:

- Have fewer than 25 full-time equivalent employees.
- Pay average annual wages under \$50,000.
- Contribute a uniform percentage of at least 50% of the total premium cost.

The full credit is available to employers with ten or fewer full-time equivalent employees and average annual wages of less than \$25,000, and begins phasing out over those amounts.

Beginning in 2014, the credit is available only for qualified health plan coverage through an exchange (see *The Exchanges*), and employers may only receive the credit for a maximum of two consecutive years.

REFORMS ON THE HORIZON: 2011 TO 2013

Beginning in 2011, new provisions of the Act become effective each year:

Provisions Effective in 2011

In 2011, employers should focus on the new rules for:

- The tax treatment of reimbursements for over-the-counter (OTC) drugs (see *Tax Treatment of Reimbursement for OTC Drugs*).
- Distributions from health savings accounts (HSAs) for non-medical purposes (see *HSA Distributions for Non-medical Purposes*).
- Insurance market reforms (see *Insurance Market Reforms*).
- Form W-2 reporting for health benefits (see *Form W-2 Reporting of Health Benefits*).

Tax Treatment of Reimbursement for OTC Drugs

Beginning in 2011, the definition of qualified medical expense for HSAs, health flexible spending arrangements (health FSAs), health reimbursement accounts (HRAs) and other employer-provided health coverage excludes OTC drugs unless the drug is a prescribed drug or insulin. This means that beginning in 2011:

- Participants will not be able to use amounts in a health FSA or HRA to pay for OTC drugs (unless the OTC drugs are prescribed or insulin).
- Distributions from an HSA for these expenses will be includable in income and subject to a 20% additional tax (see *HSA Distributions for Non-medical Purposes*).

HSA Distributions for Non-medical Purposes

Also beginning in 2011, the additional tax on distributions from an HSA that are not used for qualified medical expenses is increased from 10% to 20% of the disbursed amount.

Insurance Market Reforms

All plans must implement some insurance market reforms for plan years beginning six months after enactment (September 23, 2010). Under the Act, group health plans and health insurers are not permitted to:

- Impose lifetime or annual limits on essential benefits (to be defined by HHS), except to the extent certain annual limits are permitted by the Secretary of HHS.
- Rescind coverage unless there was fraud or misrepresentation by the enrollee.
- Drop coverage for adult children on their parents' coverage, regardless of the adult child's student or marital status, until the adult child turns 26 years old.



- Impose pre-existing condition exclusions on enrollees under the age of 19.

Also, insured group health plans are prohibited from discriminating in favor of highly compensated individuals under the requirements in section 105(h)(2) of the Internal Revenue Code (IRC).

Many of the requirements apply to both insured and self-funded plans.

The reforms are set out in the chart below (see *Summary of Provisions Affecting Grandfathered Plans and Non-grandfathered Plans*).

Form W-2 Reporting of Health Benefits

Beginning in 2011, employers must include the cost of employer-sponsored health coverage on an employee's Form W-2. The first Form W-2 containing this information will have to be provided by January 31, 2012.

Provisions Effective in 2012: New Summaries of Insurance Plans

Beginning in 2012, all health plans and insurers must create and distribute a document summarizing benefits to plan enrollees and policyholders. The document must include:

- Definitions of standard medical and insurance terms.
- A summary of the coverage provided, including any cost-sharing provisions.
- A description of any exceptions or limitations on coverage and the renewability and continuation of coverage terms of the plan or policy.
- Examples of common benefits scenarios to illustrate coverage.
- A statement of whether the plan or policy provides minimum essential coverage.
- Contact information for consumer convenience.

The Act prescribes specific formatting requirements for this summary document. For example, it must not exceed four pages and must be in at least 12-point font. HHS will issue a standard format and guidance by 2011.

Provisions Effective in 2013

In 2013, employers should focus on:

- The disallowance of the deduction for retiree prescription drug costs (see *Disallowance of Deduction for Certain Retiree Prescription Drug Costs*).
- New health FSA contribution limits (see *Health FSA Contribution Limits*).

Disallowance of Deduction for Certain Retiree Prescription Drug Costs

The Medicare Modernization Act of 2003 created both the Medicare Part D prescription drug benefit and a related 28% federal subsidy for employers that provide retiree drug coverage (at a level actuarially equivalent to the Medicare Part D benefit) to eligible retirees. Before the Act, the subsidy was excludable from the employer sponsor's taxable income and the employer did not have to reduce its deduction for retiree drug expenses as a result of receiving the subsidy.

Beginning in 2013, the Act disallows the deduction for retiree prescription drug benefits provided by an employer to its Medicare Part D eligible retirees if the employer receives the federal retiree drug subsidy. This will increase an employer's costs of continuing to offer retiree drug coverage. More immediately, the change caused a number of companies to incur large expense charges in their income statements for the quarter including the date of enactment of the Act.

Health FSA Contribution Limits

Beginning in 2013, employee salary reduction contributions to a health FSAs are limited to \$2,500 a year. This amount will be indexed for cost-of-living increases in later years.

DISTANT REFORMS: 2014 AND LATER

Many provisions of the Act do not become effective until 2014 or later. This gives employers time to prepare and analyze the effects of the reforms on their employee benefit plans.

Provisions Affecting Employers in 2014

Some of the most comprehensive changes become effective in 2014 including:

- Long-term insurance market changes (see *Long-term Insurance Market Changes*).



- The implementation of health insurance exchanges (see *The Exchanges*).
- Individual insurance coverage mandate (see *Individual Mandate*).
- Employer-provided insurance mandate (see *Employer Mandate*).
- The availability of free choice vouchers (see *Free Choice Vouchers*).

Long-term Insurance Market Changes

Starting in 2014, additional health insurance market reforms take effect. For example:

- Plans and insurers are prohibited from discriminating based on pre-existing conditions or other health status.
- Waiting periods will be limited to 90 days for all plans.
- These two requirements also apply to grandfathered plans.

Plans can use discounts of up to 30% of the cost of an employee's coverage (currently limited to 20%) as an incentive for employees to participate in wellness programs. The percentage can be raised to 50% at HHS' discretion.

The Exchanges

By 2014, the Act requires each state to establish one or more American Health Benefit Exchanges through which individuals and small employers can purchase health insurance. Lawful residents of the US (except incarcerated individuals) who wish to enroll in coverage generally will be able to purchase individual health insurance through the exchange in the state in which they live.

Initially only small employers will be allowed to purchase group health coverage through an exchange. However, beginning in 2017, states may allow large employers to purchase group health coverage as well. States have some flexibility to define "small" and "large" employers before 2016, but generally, small employers are defined as those with not more than 100 employees. Individual, small and large group coverage may continue to be offered by health insurers outside of the exchange.

Each state must establish an exchange for individuals and one for small businesses, but a state may merge the two. In addition, states may establish in-state subsidiary exchanges to serve geographically distinct areas. States also may enter

into agreements to form multi-state or regional exchanges with approval from HHS. Health insurance issuers may also offer multistate plans through the exchange in each state if they enter into a contract with the US Office of Personnel and Management. If a state elects not to establish an exchange, or if, by January 2013, HHS determines that a state will not have an exchange operational in time, HHS must establish an exchange in that state.

A state's exchange can be set up as either a governmental or a non-profit agency that will help individuals and small groups purchase insurance by offering plans that provide defined standards of coverage in a regulated easy to access portal. Plans offered through an exchange will be required to meet the insurance market reforms (see *Long-term Insurance Market Changes*).

The states are responsible for overseeing the exchanges and the health plans that they offer. HHS is required to establish regulations outlining the criteria for plan certification. There is no explicit statutory deadline for HHS but it seems likely that HHS will issue these regulations well before 2014 so that the exchanges will be operational within the proposed time frame.

Individual Mandate

Beginning January 1, 2014, the government will impose an individual mandate requiring each person to obtain "minimum essential coverage." Participants in government-sponsored programs, employer-sponsored plans, individual health plans, and grandfathered health plans, as well as other coverage recognized by the HHS will be deemed to have minimum essential coverage.

With a few exceptions, failing to maintain this coverage for an entire year results in a penalty. If a person's coverage lapses for one or more months, a penalty will be assessed when that individual files his personal income tax return. Individuals are allowed one penalty waiver per year for a gap in coverage that does not last longer than three months. Intermittent uninsured periods cannot be combined for purposes of the waiver.

If an individual's income exceeds the filing threshold (\$9,350 for a single filer under age 65 in 2009) and he is uninsured, he has not met the requirements of the mandate and must pay a penalty. The monthly penalty is calculated as follows:

- For 2014, determine the lesser of:
 - one-twelfth of the flat rate for a household (\$285); or



- one-twelfth of the variable rate (\$95 per uncovered adult and \$47.50 per uncovered minor).
- Compare this amount to 1% of household income over the filing threshold. The greater amount is the penalty.

The flat rate household penalty will increase to \$975 in 2015 and \$2,085 in 2016. The household income percentage will increase to 2% in 2015 and 2.5% in 2016. The variable penalty will rise to \$325 per adult and \$162.50 per minor in 2015, and \$695 per adult and \$347.50 per minor in 2016.

After 2016, variable penalties will be indexed for inflation. For monthly penalties, the charges will be aggregated for each month the individual and his dependants are without health insurance coverage. The total penalty will never exceed the national average premium of a bronze level qualified health plan (one providing 60% of the full actuarial value of the benefits provided under the plan) offered through an exchange. Therefore, participants facing the maximum penalty can purchase the lowest cost coverage option available through an exchange because the cost for complying with the mandate and the fine for noncompliance will be the same.

Special allowances will be made for individuals who cannot afford coverage. No penalty will be imposed for any month in which an individual's insurance premium exceeds 8% of his household income. Penalties will not be assessed for taxpayers with income below the filing threshold set out in IRC section 6012(a)(1). The filing thresholds for taxpayers under 65 years of age in the 2009 tax year were:

- \$9,350 for single taxpayers.
- \$12,000 for those filing head of household.
- \$18,700 for married individuals filing jointly.
- \$3,650 for married persons filing separately.

For tax years 2014 and beyond, an uninsured person who makes less than the filing threshold effective at that time will be exempt from the mandate.

Employer Mandate

Unlike an earlier version of health care reform legislation that passed the House of Representatives, the Act does not impose an explicit "pay or play" requirement on employers.

Effective 2014, the Act imposes penalties on certain employers that:

- Offer inadequate or unaffordable minimum essential coverage or do not offer minimum essential coverage.
- Have a least one full-time employee who qualifies for federal premium assistance for coverage through an exchange.

The penalty applies to employers with an average of 50 or more full-time employees. For this purpose, employees working an average of 30 or more hours per week are considered full-time. Part-time workers are converted into full-time equivalents by dividing the number of hours per month that they work by 120. Controlled group employer aggregation rules also apply.

The penalty, which is calculated on a monthly basis, varies depending on whether the employer does not offer minimum essential coverage or offers inadequate or unaffordable minimum essential coverage:

- An employer that does **not** offer minimum essential coverage to full-time employees but has at least one full-time employee who enrolls in health coverage through an exchange and obtains federal premium assistance is subject to an annual penalty of \$2,000 for each full-time employee, after subtracting the first 30 employees.
- An employer that offers minimum essential coverage to full-time employees, but has at least one full-time employee who enrolls in health coverage through an exchange and obtains federal premium assistance (because the employer coverage does not provide a minimum value or is unaffordable) will pay the lesser of:
 - \$3,000 for each full-time employee receiving assistance; or
 - \$2,000 for each full-time employee, after subtracting the first 30 employees.

Free Choice Vouchers

Beginning in 2014, employers that offer minimum essential coverage through an employer-sponsored plan and pay for any portion of the coverage must provide "free choice vouchers" to qualified employees to purchase qualified health plan coverage through an exchange.

A qualified employee eligible for free choice vouchers is one:

- Whose required contribution for minimum essential coverage through the employer's plan exceeds 8% but is less than 9.8% of the employee's household income for the year.



- Whose household income does not exceed 400% of the federal poverty level.
- Who does not participate in a health plan offered by the employer.

The amount of the voucher is the most generous amount the employer would have contributed for self-only coverage or, if applicable, family coverage, under the employer's plan. Employers pay this amount to the exchange, and the exchange then credits the amount toward the monthly premium of the exchange plan elected by the employee. If the voucher amount exceeds the exchange plan premium, the difference is paid (and is taxable to) the employee. Employers may deduct the amount paid in vouchers as an amount paid for personal services and will not be assessed the employer mandate penalty with respect to those employees who receive vouchers.

Provision Affecting Employers in 2018: High Cost Plan Excise Tax

Beginning in 2018, a 40% excise tax will apply to the aggregate value of employer-sponsored health plan coverage that exceeds:

- \$10,200 for self-only coverage.
- \$27,500 for family coverage.

The tax is imposed on insurance companies, employers and plan administrators, depending on the type of arrangement involved, and applies to both fully-insured and self-insured plans.

The thresholds could be increased in 2018 (when the provision takes effect) if the actual growth in US healthcare costs exceeds expected growth. After 2018, the thresholds are indexed for cost-of-living increases.

The thresholds may also be increased:

- To reflect the age and gender of the population covered.
- For retired, non-Medicare eligible individuals ages 55 to 64.
- For individuals in a plan of an employer, if the majority of the employees in the plan are engaged in certain high risk professions.

Summary of Provisions Affecting Grandfathered Plans and Non-grandfathered Plans

Applicable to Grandfathered Plans	Applicable to Non-grandfathered Plans
<p>Effective in 2011 (2011 plan year if calendar year plan):</p> <ul style="list-style-type: none"> ■ No annual limits on essential benefits for group health plans (Secretary of HHS may allow annual limits on restricted benefits through January 1, 2014). ■ No lifetime limits on essential benefits. ■ No rescissions (except for fraud or misrepresentation). ■ Must offer coverage to adult children of enrollee up to age 26 (but, prior to January 1, 2014, not applicable to grandfathered group plans if adult child is eligible for employer-sponsored coverage). ■ No pre-existing condition exclusions for individuals under 19 years old. ■ HSA, HRA, FSA cannot reimburse OTC drugs. 	<p>Effective in 2011 (2011 plan year for calendar year plans):</p> <ul style="list-style-type: none"> ■ No annual limits on essential benefits for group health plans (Secretary of HHS may allow annual limits on restricted benefits through January 1, 2014). ■ No lifetime limits on essential benefits. ■ No rescissions (except for fraud or misrepresentation). ■ Must offer coverage to adult children of enrollee up to age 26 (see <i>Article, Tax-free Treatment for Adult Child's Health Care Coverage</i> (www.practicallaw.com/8-502-3200) and <i>Article, Dependent Coverage to Age 26 Interim Final Rule</i> (www.practicallaw.com/0-502-3204)). ■ No pre-existing condition exclusions for individuals under 19 years old. ■ HSA, HRA, FSA cannot reimburse OTC drugs. ■ Increase in additional tax on HSA distributions for non-medical expenses. ■ W-2 reporting begins (filed in January 2012 for the 2011 calendar year).



<ul style="list-style-type: none"> ■ Increase in additional tax on HSA distributions for non-medical expenses. ■ W-2 reporting begins (filed in January 2012 for the 2011 calendar year). 	<ul style="list-style-type: none"> ■ No discrimination in favor of highly compensated individuals (IRC section 105(h) rules) extended to insured plans. ■ Must allow individuals to choose pediatrician for child's primary care physician. ■ Must allow females to choose gynecologist or obstetrician without referral. ■ Must allow emergency services without preauthorization and treat as in-network. ■ Must provide internal appeals and external review process. ■ No cost sharing for immunization or preventive care (as defined by Act).
<p>Effective in 2012</p> <ul style="list-style-type: none"> ■ Must create summary documents using HHS uniform definitions. 	<p>Effective in 2012</p> <ul style="list-style-type: none"> ■ Must create summary documents using HHS uniform definitions.
<p>Effective in 2013</p> <ul style="list-style-type: none"> ■ Health FSAs limited to \$2,500/year. ■ Medicare Part D subsidy deduction repealed. 	<p>Effective in 2013</p> <ul style="list-style-type: none"> ■ Health FSAs limited to \$2,500/year. ■ Medicare Part D subsidy deduction repealed.
<p>Effective in 2014</p> <ul style="list-style-type: none"> ■ No annual limits on essential benefits (where Secretary of HHS has allowed restricted annual limits). ■ No pre-existing condition exclusions. ■ Waiting periods limited to 90 days. ■ Employer mandate effective. ■ Individual mandate effective. 	<p>Effective in 2014</p> <ul style="list-style-type: none"> ■ No annual limits on essential benefits (where Secretary of HHS has allowed restricted annual limits). ■ No pre-existing condition exclusions. ■ Waiting periods limited to 90 days. ■ Employer mandate effective. ■ Individual mandate effective. ■ No discrimination based on health status. ■ No discrimination on health care providers acting within the scope of their license. ■ Must cover "essential benefits" (only applies to individual and small group markets).
<p>Effective in 2018</p> <ul style="list-style-type: none"> ■ Excise tax on high-cost plans effective. 	<p>Effective in 2018</p> <ul style="list-style-type: none"> ■ Excise tax on high-cost plans effective.

The authors of this article would like to give special thanks to Kevin Walsh, Andrew Banducci and Dionne Benjamin.