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CLIENT ALERT

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How 2010 Health Care Legislation Impacts Employers

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On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (the "Act") into law, and on March 30, 2010, signed the Health Care and Education Reconciliation Act of 2010, which made significant changes to the Act. The Act, as amended, represents comprehensive health insurance reform that will have a direct impact on employers. The Act provides for the establishment of "exchanges" through which employers will be able to purchase health insurance for their employees, and imposes new requirements on employers and the employer-sponsored health insurance plans.

Beginning in 2014, all U.S. citizens and legal residents will be required to obtain qualifying health insurance, and there will be automatic employee enrollment requirements for employers with more than 200 employees. Employers will have to provide specified minimum levels of coverage to employees or pay an excise tax. Also an employer provided voucher program for employees will be implemented, as further elaborated below.

Even though some of the provisions will only take effect beginning 2014, there are certain provisions that will take effect in 2010. The Act does exempt (*i.e.*, "grandfather") certain health plans existing on or before the enactment date from some of the Act's requirements. Employers' grandfathered group health plans may also continue to enroll new employees and their families in plans existing on the enactment date without application of a number of the new requirements, but such plans will be subject to the excise tax on "excess" benefits.

The following is a brief synopsis of the provisions that will specifically affect employers and an implementation timetable.

Discrimination Prohibited—Effective immediately, the Act prohibits employers from denying benefits or precluding an employee from participating in a health program that receives Federal financial assistance based on an employee's race, color, national origin, sex age or disability. The prohibition will be enforced through existing Federal anti-discrimination statutory law.

Further, the Act prohibits an employer from discharging or discriminating against any employee because that employee: (1) received a subsidy under the Act, (2) provided information to a government-entity or his/her employer relating to actions that the employee reasonably believed to be a violation of Title I of the Act (*i.e.* sections regarding employer-sponsored group health plans), (3) provided testimony regarding such a violation, (4) assists or participates in a proceeding relating to a violation, or (5) refuses to participate in any activity, practice or task that the employee reasonably believes is in violation of the Act.

Small Businesses Implications—For tax years 2010 to 2013, qualified small businesses will be eligible for tax credits up to 35 percent of certain qualifying contributions for health coverage. Small employers generally include employers with fewer than 25 full-time employees with annual average wages of $50,000 or less per employee. The amount of the credit is reduced for employers with 10 to 25 employees and average annual wages not to exceed $50,000 per employee. Qualified small businesses will be able to purchase insurance for their employees through state-based web portals that will be called Small Business Health Options Programs. These programs will allow small businesses to pool together in order to spread and thereby minimize financial risk.

For tax years 2014 and later, qualified small businesses that purchase coverage through an exchange will be permitted a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. Beginning in 2014, a qualifying employer may claim this credit for a maximum of two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of $25,000 or less, with smaller credit amounts available to employers with more employees or higher average wages, and no credits available to employers with more than 25 full-time equivalent employees or average wages of at least $50,000 per year.

Temporary Reinsurance—To encourage employers to provide coverage to early retirees who are not yet eligible for Medicare (and to eligible spouses, surviving spouses and dependents of such retirees), the Department of Human & Health Services ("HHS") will establish a temporary $5 billion reinsurance program to reimburse employment-based plans for part of the cost of such coverage. The reinsurance program ends on December 31, 2013 or when the $5 billion is exhausted, whichever occurs first. To obtain reimbursement, an employment-based plan must, among other things, implement cost saving measures for chronic and high-cost conditions, apply for participation in the program, and be certified by the HHS. To be eligible for reimbursement, a claim may not be less than $15,000 or greater than $90,000; and the program will reimburse the plan for 80% of the amount of the claim in excess of $15,000. Payments received by a plan under the program must be used to lower costs for the plan and cannot be used as general revenues.

Restrictions on Annual and Lifetime Limits—Plans and insurers will be prohibited, for plan years beginning six months after the enactment of the Act (*i.e.* September 23, 2010), from imposing lifetime limits on the dollar value of those of the benefits to be provided to any participant or beneficiary that constitute essential health benefits. Essential health benefits are defined by the Act to include emergency services, maternity and newborn care, hospitalization, pediatric care, and substance abuse services. Plans will also be prohibited, beginning September 23, 2010, but prior to 2014, from imposing annual limits on the dollar value of the essential health benefits to be provided to participants or beneficiaries, except for any annual limit that qualifies as a restricted annual limit. This rule applies to grandfathered plans as well as non-grandfathered plans.

Prohibition on Rescissions—Plans are prohibited from rescinding coverage except in cases where the covered individual committed fraud or intentional misrepresentation. All plans are subject to this provision.

Coverage for Preventative Care—Plans must provide for certain preventative care and immunizations. There can be neither deductibles nor cost-sharing for this coverage.

Adult Children—Plans that provide dependent coverage must include coverage to a participant's children (married or unmarried) up to the age of 26. This provision applies to grandfathered plans. There is no requirement, however, to provide coverage for children of covered dependent children.

Information Requirements—Employers who provide minimum essential coverage will be required to file information returns with the Internal Revenue Service stating, as applicable, any employee who pays a premium, and the coverage and amount paid. There will be penalties imposed on any employer who fails to file an information return.

Uniform Explanation of Coverage and Reporting Requirements—Plans must prepare and distribute a summary of coverage to all eligible enrollees and participants, both at the time of enrollment and annually. Plans must also notify enrollees of any material changes to the coverage no less than 60 days in advance of the effective date of the changes. Failure to comply may result in a $1,000 penalty for each violation.

Ensuring Quality of Care—Plans must report benefits under the plan that improve health (*i.e.* case management, disease management and wellness and health promotion activities) annually to the HHS and to participants. The HHS will develop the reporting standards within two years from the enactment date.

Nondiscrimination Rules—Internal Revenue Code section 105(h) is extended to fully-insured group health plans. Essentially, there may be adverse tax treatment to officers, 10% owners, and highly compensated employees who participate in insured as well as self-insured health plans that discriminate in favor of such employees with respect to eligibility for coverage and benefits.

Pre-existing Conditions for Children Under the Age of 19—Plans may not impose a pre-existing condition exclusion or limitation for children under the age of 19. (**Note**: prohibition on pre-existing condition exclusion or limitation becomes effective for adults in 2014).

Claims Procedures—The Act requires that plans must establish an internal claims appeals process and an external review process.

Patient Protections—In the event that a plan requires or permits a participant to designate a primary care provider, the plan must allow each participant to choose any participating primary care provider under the plan who is available and who is in a position to accept a participant.

Use of Health Flexible Spending Accounts ("FSA")—Beginning in 2011, FSA resources may not be utilized to reimburse over the counter prescription drugs except for insulin and the Act reduces annual contributions to $2,500.

Certain Employer Tax Changes—Effective in 2013, the Act eliminates the deduction previously permitted employers for the Medicare Part D subsidy. Further, beginning in 2013, employers with employees with wages exceeding $200,000 for single filers and $250,000 for married filers will be subject to an additional 0.9% FICA (social security) tax increase on any wages above these figures.

Effective 2014, employers must also meet the following requirements:

Automatic Enrollment—Employers are not required to provide health insurance coverage under the Act. However, Employers with 200 or more full-time employees that offer at least one health plan benefit option must enroll all new employees into a health insurance plan offered by the employer.

Any employer with 50 or more employees that does not offer coverage and who has at least one full-time employee who receives a premium tax credit will be assessed a fee of $2,000 per full-time employee, excluding the first 30 employees. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full time employee. Employees may opt out of coverage.

Prevention/Wellness—Employers will be permitted to offer employees rewards of up to 30%, increasing up to 50% if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards.

Free Choice Voucher—If an employer pays a portion of the cost of coverage under an employer-sponsored plan, then the employer must also provide "free choice vouchers" to employees whose income is less than 400% of the poverty level. The "free choice voucher" corresponds to the monthly portion of the cost of coverage that the employer would have paid in the event the employee was covered under the employer's plan. The free choice voucher can be used by the employee to purchase alternative health care coverage through the exchanges. The amount of the free choice voucher is deductible by the employer.

Conclusion

The Act will begin impacting employers and their group health plans beginning as early as September 23, 2010, which is six-months after the enactment date. The foregoing is a brief synopsis of the most significant provisions of the Act that will affect employers almost immediately and in the future. Of course, this Act is voluminous legislation containing general and specific provisions and requirements which will take interpretation, rule making and, possibly, litigation to completely understand its full impact on business entities and society in general. If you have a question about this Client Alert, please do not hesitate to contact Buchalter Nemer's Labor and Employment Practice Group, its Tax Practice Group or its Health Care Practice Group.

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