



Understanding Health Care Reform

Employer ALERT

President Obama signed into law the Patient Protection and Affordable Care Act (the "Act") on March 23, 2010. The historic legislation will require significant changes to employer-sponsored group health plans. Over the next four years, plan sponsors will need to change administrative practices, comply with new reporting requirements, change coverage, and amend plan documents and summary plan descriptions.

Below are highlights of the legislation for employers. This summary reflects amendments made to the Act by the Health Care and Education Affordability Reconciliation Act of 2010.

LEGISLATIVE CHANGES EFFECTIVE IN 2010 OR 2011

- **Reinsurance for Early Retirees.** The Act requires the establishment of a temporary reinsurance program to provide a reimbursement to participating employer-sponsored plans for a portion of the cost of providing health insurance to retirees between the ages of 55 and 64. Reimbursement claims must be at least \$15,000 and no greater than \$90,000. The reimbursements may only be used to reduce the employer's premium costs or to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. The Act appropriated \$5 billion for the reinsurance program which will be established no later than June 19, 2010. The program will end on January 1, 2014.
- **Medicare Part D Retiree Drug Subsidy Becomes Taxable in 2013.** Although employers do not lose the deduction for the Retiree Drug Subsidy until 2013, the future

loss of this deduction may have an immediate impact on employers' financial statements.

- **Whistleblower Protections and Retaliation Prohibitions.** The Act prohibits an employer from retaliating against employees who exercise their rights under the new law. The Act also provides whistleblower protections.

The following changes are effective as of the **first day of the plan year beginning six months after the date of enactment of the Act.** Therefore, for group health plans that have a calendar plan year, compliance is required by **January 1, 2011.** For group health plans with a plan year beginning on October 1st or later, compliance will be required as of the start of the new plan year in 2010. For group health plans with a plan year beginning September 1st or earlier, compliance will be required as of the start of the new plan year in 2011.

- **Coverage for Children up to Age 26.** Group health plans and health insurance issuers that offer dependent coverage must offer coverage to employees' children up to age 26. The children do not have to live with the employee, rely on the employee for support, be students, or even be reported as tax dependents on the employees' tax returns. The children can be married, but coverage is not extended to the child's spouse or children. Employees will not be taxed on the value of the coverage. Through 2013, existing group health plans need only extend coverage to those children who are not eligible for coverage under another employer's plan. However, beginning in 2014, that requirement drops away. Until 2014, employers need to consider how they will substantiate that the child is not eligible for other employer health care coverage.



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Health Care Reform from page 1

- ***Pre-Existing Condition Exclusions on Children under Age 19.*** Group health plans must eliminate pre-existing condition exclusions on children under age 19.
- ***No Lifetime or Annual Limits on the Dollar Value of Coverage.*** Group health plans cannot impose lifetime or annual limits on the dollar value of coverage for certain essential health benefits. Essential health benefits include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The Secretary of Health and Human Services is expected to allow existing group health plans to impose certain restricted annual limits until 2014, however existing group health plans must eliminate annual limits on coverage beginning in 2014. This provision does not restrict group health plans from imposing lifetime or annual limits on non-essential health benefits, nor does it prohibit lifetime or annual limits that are based on something other than the dollar value of coverage, e.g., number of visits.
- ***Prohibition of Discrimination Based on Salary.*** Sponsors of insured group health plans cannot establish plan eligibility rules for any full-time employee that are based on total hourly or annual salary or otherwise discriminate in favor of higher wage employees. A plan may, however, require lower contributions from employees with lower pay.
- ***Automatic Enrollment for Employees of Large Employers.*** The effective date of this change is uncertain because the date was not provided in the Act, so it is considered effective on March 23, 2010. The effective date may be delayed until 2013. Under this provision, an employer that offers a health benefit plan and has over 200 full-time employees must automatically enroll all new full-time employees in the plan, subject to the plan's waiting period. Additionally, an employer must continue the enrollment of full-time employees in the plan. Employees must be provided adequate notice of enrollment and the opportunity to opt out of coverage.
- ***Tax Credit for Small-Business Employee Health Coverage.*** As of January 1, 2010, certain small businesses and eligible tax-exempt employers required to make employer contributions to the costs of employee health benefits will be eligible for small business tax credits to offset the cost of employee health insurance. For years 2010 through 2013, employers may receive tax credits of up to 35% (25% for tax-exempt

employers) of the lesser of: (1) the employer contributions for premiums paid for health insurance coverage; or (2) the average premium for the small group market in the employer's state.

LEGISLATIVE CHANGES EFFECTIVE IN 2011

- ***Reimbursement of Over the Counter Drugs under Health FSAs, HRAs and HSAs.*** Beginning January 1, 2011, reimbursement of over-the-counter drugs (except insulin) under health flexible spending accounts, health reimbursement arrangements and health savings accounts will be prohibited unless the employee provides a prescription for the drugs from the health care provider.
- ***W-2 Reporting of Health Care Coverage.*** Employers will be required to disclose the aggregate cost of employer sponsored health care coverage (medical, dental, vision) on employees' 2011 W-2 tax forms. Salary reduction contributions to flexible spending accounts and health savings accounts will not need to be included. The aggregate cost will be calculated in a manner similar to the calculation of the plan's applicable COBRA premium.
- ***Community Living Assistance Services and Support ("CLASS") Act Enrollment.*** The CLASS Act is a national, government run, *limited* long-term care program. The program is voluntary, but employers who choose to participate must automatically enroll employees and begin payroll deductions for premiums, unless the employee affirmatively opts out. Participants must pay premiums for five years before they become eligible to receive the intended long-term care benefits. Enrollment is set to begin January 1, 2011. Because the benefit is limited (approximately \$50/day), it is not intended to replace other long-term care insurance offered by employers. Instead CLASS Act benefits would provide a base for long-term care benefits and could be supplemented by any additional long-term care insurance employees purchase through their employers.
- ***Simple Cafeteria Plans for Small Businesses.*** The Act creates "simple cafeteria plans" for employers with 100 or fewer employees, effective January 1, 2011. Simple cafeteria plans will be deemed to comply with the Internal Revenue Code's nondiscrimination rules if certain contribution requirements are satisfied. Specifically, an employer must make a contribution to provide plan benefits on behalf of each qualified employee. The contribution must be in an amount equal to (i) a uniform percentage (of at least 2%) of the employee's compensation for the plan year; or (ii) an amount that is not less than the lesser of (A) 6% of the employee's plan year

Health Care Reform from page 2

compensation, or (B) twice the amount of the employee's salary reduction contributions. Contributions must be made regardless of whether the employee makes any salary reduction contributions.

LEGISLATIVE CHANGES EFFECTIVE IN 2012

- **Explanations of Coverage.** No later than March 23, 2012, health insurance issuers and sponsors or designated administrators of self-insured health plans must provide summaries of coverage to applicants at the time of application; to enrollees prior to enrollment or reenrollment; and to policyholders or certificate holders at the time of issuance of the policy or delivery of the certificate. The summary must satisfy the requirements of regulations that will be issued by March 23, 2011. If a plan is modified, the plan or insurance issuer must provide a notice of modification to enrollees no later than **60 days prior to** the date the modification will become effective. Failure to comply with the new notice requirements may result in a penalty of up to \$1,000 per day, per failure.
- **1099 Reporting of Other Income.** The Act expands the 1099 reporting requirements to include corporations. Effective after December 31, 2011, persons engaged in a trade or business must report the amount of gross proceeds paid in consideration for property or services on Form 1099, including, without limitation, payments made to corporations (other than corporations exempt from income tax under Code Section 501(a)).

LEGISLATIVE CHANGES EFFECTIVE IN 2013

- **FSA Reimbursement Cap.** Effective for years beginning on or after January 1, 2013, the maximum annual contribution that an employee can make to a health flexible spending account ("FSA") is \$2,500. Currently, the law does not limit contributions to health FSAs, but most employers already impose a cap on these contributions in order to reduce the financial risk of FSAs and to make sure they pass nondiscrimination rules.
- **Employment Tax Withholding.** The hospital insurance tax on wages is increased by .9% (from 1.45% to 2.35%) on pay in excess of \$200,000 (or \$250,000 in the case of a joint return) effective for taxable years beginning on or after January 1, 2013. The Act requires employers to withhold the employee's tax from wages. If an employer fails to collect the tax, but its employee subsequently pays the tax, the employer will **not** be liable for its failure to collect the tax. The

employer, however, will remain liable for any penalties associated with the collection of the tax.

- **Medicare Tax on Unearned Income.** As of January 1, 2013, a Medicare tax of 3.8% will be applied to unearned income arising from interest, dividends, royalties, rents, gross income from a trade or business involving passive activities, and net gain from the disposition of property (other than property held in a trade or business). The tax will apply to the lesser of (1) the taxpayer's net investment income or (2) the excess, if any, of the taxpayer's modified adjusted gross income over a threshold amount (\$200,000 for singles and \$250,000 for joint filers).

LEGISLATIVE CHANGES EFFECTIVE IN 2014

- **Wellness Plan Reward Increased.** For wellness plans that require the satisfaction of a health status factor, the maximum reward that can be offered (combined with any other wellness program reward that is met by satisfying a health status factor) is increased from 20% to 30% of the cost of employee-only coverage under the plan. If family members are allowed to participate in the wellness program, then the reward cannot exceed 30% of the cost of the employee's coverage option. The cost of coverage is based on employee and employer contributions. The Secretaries of Labor, Health and Human Services and Treasury may increase the maximum reward to 50% of the cost of coverage if they deem it appropriate. This provision is effective for plan years beginning on or after January 1, 2014.
- **Waiting Periods Limited to 90 Days.** Plans may not impose eligibility waiting periods that are longer than 90 days effective for plan years beginning on or after January 1, 2014.
- **Play or Pay.** Effective any month beginning on or after January 1, 2014, an employer with more than 50 employees who offers health benefits, but has at least one full-time employee enrolled in government subsidized coverage, must pay a monthly penalty equal to the lesser of \$250 for each employee (full-time or part-time) receiving the subsidy, or \$167 per full-time employee. An employer who does not offer health insurance to employees would face a monthly fine of \$167 for each full-time employee who qualifies for subsidized coverage through an exchange. To calculate the fine, the Act subtracts 30 employees from the actual number of people employed at a firm. For instance, a company with 51 full-time employees in which any employee receives subsidies, would pay a fine for 21, rather than 51, employees.

Health Care Reform from page 3

- **Pre-Existing Condition Exclusion on Adults.** Group health plans must eliminate pre-existing condition exclusions for adults by 2014.
- **Reporting Requirements.** Beginning January 1, 2014, the Act imposes reporting requirements on large employers and insurers (including self-insurers) who provide the minimum essential health coverage to an individual during the calendar year. Insurers providing minimum coverage to individuals must report the following information to covered individuals and the Treasury Secretary on an annual basis: individual identifying information, dates of coverage, any premium tax credit or cost sharing subsidy received by the individual in connection with the coverage, and any other information required by the Treasury Secretary. Employers providing insurance through an employer's group health plan must report the name, address and EIN of the employer maintaining the plan, the portion of the premium paid by the employer, and any information the Treasury Secretary may require in administering the new tax credit for qualified small business employers. Large employers subject to the rules for maintaining minimum essential coverage must file a return with the Treasury Secretary identifying the employer, certifying whether it offers full-time employees with an option to enroll in the minimum essential coverage plan, providing the number of full-time employees during each month of the cal-

endar year, and identifying each full-time employee covered under the employer-provided health plan. An insurer's failure to comply with the Act's reporting requirements triggers existing penalties applicable to the filing of information returns.

LEGISLATIVE CHANGES EFFECTIVE IN 2018

- **Excise Tax on High Cost Employer Health Plans ("Cadillac Plans").** Effective January 1, 2018, the Act imposes a non-deductible 40% excise tax on the "excess benefit" provided in any month under any employer-sponsored health plan (including, without limitation, reimbursements under a health FSA or an HRA, contributions to an HSA, or vision or dental coverage). Generally, an "excess benefit" will exist in 2018 if the cost of the benefit, on an annual basis, exceeds \$10,200 for individuals or \$27,500 for families. Beginning in 2019, the threshold amounts will be indexed annually to reflect cost of living adjustments based on the Consumer Price Index for All Urban Consumers. The excise tax is imposed proportionately on each coverage provider, or, if such coverage is provided under an employer plan through insurance coverage, on the issuer of the coverage. Penalties will be imposed on employers that undervalue insurance costs subject to the 40% excise tax.

We welcome the opportunity to address your concerns. As you develop questions, please contact any one of our attorneys listed within this alert. This information is provided as an educational service and is not meant to be and should not be construed as legal advice. Readers with particular needs on specific issues should retain the services of competent counsel.

SAVE THE DATE!

Williams Mullen will host a webinar offering a more comprehensive perspective of the recent changes in Health Care Reform. In addition, we will issue additional Alerts addressing the impact of this historical legislation on health care providers.

- **Topic:** Analysis of Health Care Reform - The Patient Protection and Affordable Care Act & The Health Care and Education Reconciliation Act
- **Date:** Wednesday, April 14, 2010
- **Time:** 12:00 p.m., eastern daylight time
- **Event Link:** <http://www.williamsmullen.com/analysis-of-health-care-reform-04-14-2010/>
- **Registration Link:** <http://www.williamsmullen.com/events/register.aspx?event=317>

Webinar Questions? Please contact Elizabeth Gaddy at egaddy@williamsmullen.com or 757.473.5444.

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