Health Care Reform:
FINDING YOUR WAY
Vol. 1, No. 4
Coppersmith Schermer & Brockelman PLC

# It's a Brave New World for Employer-Sponsored Health Plans

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## EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (PPACA) creates a new framework for health insurance availability and health care delivery that affects all stakeholders, including providers, insurers, individuals and employers. The new paradigm gives employers strong incentives (through rules, subsidies, tax credits and financial penalties) to make health insurance available to all employees, make the coverage that is offered more affordable, and ensure that coverage meets certain minimum requirements. As the many changes wrought by PPACA roll into effect in the coming years, some employers may find it cost-effective to reevaluate the size and nature of their workforces and the benefits offered to those workers.

## BACKGROUND AND OVERVIEW

For decades, American businesses and workers have been accustomed to a health insurance system in which employers have been able to decide whether, and on what terms, to provide coverage to their employees. Through a combination of individual mandates, reforms in the insurance industry and markets, changes in employer responsibilities, and changes in health care payment and delivery systems, PPACA will significantly transform the current system of employer-sponsored health coverage. This transformation will affect health care providers large and small, both as providers and as employers themselves.

One of the cornerstones of PPACA is that, by 2014, virtually all U.S. citizens and legal residents will be required to have "minimum essential coverage" for themselves and their dependents or face monetary penalties. To help make this happen, many employers will have to "pay or play" by subsidizing health care coverage for their employees or paying monetary penalties for not providing affordable (or any) coverage. In addition, government subsidies, in the form of "premium assistance" tax credits, will be provided for lower-

income individuals through state health insurance "exchanges" – geographically-based markets where standardized insurance packages can be purchased by individuals and, initially, some small employers.

In addition to expanding the availability of coverage, PPACA imposes new substantive requirements on group health plans themselves, many of which are outlined below. However, PPACA also exempts health plans in existence as of the date of enactment (March 23, 2010) – called "grandfathered plans" – from a number of these new requirements, and it gives such plans delayed effective dates as to others. PPACA does not address whether plan amendments or other circumstances could cause a plan to lose its "grandfathered" status. Most employer-sponsored group health plans are grandfathered plans, so employers will want to be cautious with respect to making changes in their plans (except as required by law) until regulations are promulgated addressing this issue.

## RELEVANT PROVISIONS OF THE HEALTH CARE REFORM LAW

The employment-related changes made by PPACA go into effect at various times, with many not kicking in until 2014. However, some important changes took effect immediately upon enactment of the law or will become effective within the next year. What follows is a guide to the most significant changes that affect employers who sponsor group health plans, organized according to when the changes take hold.

### 1. Effective in the Near Term (2010 and 2011)

***Government-Funded Reinsurance for Early Retiree Coverage.*** By the end of June 2010, a temporary reinsurance program will be established by the U.S. Department of Health and Human Services (HHS) that will reimburse participating insured and self-insured health plans for a portion of the benefits paid to non-Medicare early retirees and their spouses and dependents during a plan year. This program will expire as of January 1, 2014 or when the $5 billion allocated to the program is spent, whichever occurs first. Once HHS establishes procedures for plans to apply for participation, early application is highly recommended due to the limited funding.

***Small Business Tax Credits.*** Starting this year, small employers (no more than 25 full-time equivalent employees and less than $50,000 in average wages) are eligible to receive payroll tax credits for amounts spent on health insurance for employees, provided the employer pays at least 50% of the premium cost. Notably, this credit is available for premiums paid in 2010, even if paid before PPACA became law. For the 2010 through 2013 tax years, the credit starts at 35% of the employer's contribution to the premiums (25% for tax-exempt entities), and gradually decreases as firm size and average wages increase. In 2014 and 2015, a tax credit of up to 50% will be available, but only to small employers that purchase coverage for employees through a state exchange. IRS guidance on this tax credit is available here.

***New Health Plan Mandates.*** Starting with the first plan year on or after September 23, 2010 (for most plans, January 1, 2011), group health insurance plans may not impose lifetime benefit limits (and after 2013, no annual limits), may not apply pre-existing condition exclusions to children under age 19, may not rescind policies except in cases of fraud or intentional misrepresentation, must cover preventive care and immunizations at no cost to the insured (except for grandfathered plans), and must allow non-dependent children up to age 26 to be covered on a parent's policy (even if the child does not live with the parent(s), is married and/or has a job).

***Federal Long-Term Care Insurance.*** The Community Living Assistance Services and Supports (CLASS) Act – embedded within the health care reform law – creates a new national long-term care coverage program commencing on January 1, 2011. The program is voluntary, but employees who elect this coverage will pay the monthly premiums (amount still to be determined) through payroll deduction. Workers must pay premiums into the program for five years before they become eligible to receive benefits. As the program is developed and rolled out, employers will need to educate employees about this option and update their payroll procedures to facilitate deductions for premiums.

***Flexible Spending and Health/Medical Savings Accounts.*** Beginning with the 2011 tax year, reimbursable expenses for FSAs, HSAs, and MSAs will no longer include over-the-counter medications without a prescription (except for insulin), and there are increased taxes levied for non-medical HSA and MSA distributions.

***Form W-2 Reporting.*** Starting with the 2011 tax year, the aggregate cost of employer-sponsored health plan coverage must be reported on each employee's Form W-2.

**2. Effective in 2012-2013**

***Standard Explanation of Coverage.*** By March 23, 2012, group health plans must begin distributing a standard summary explanation of benefits and coverage to enrollees at the time of enrollment. The standards will be developed by the Secretary of HHS over the next 12 months; among other things, the summary cannot exceed four pages and will have to use terminology understandable to the average plan participant. Insurers are responsible for distributing the summary for insured plans; for self-insured plans, the obligation falls to the plan sponsor or administrator. Failure to provide the summary may result in fines up to $1,000 per violation.

***Flexible Spending Accounts.*** Beginning in 2013, pre-tax contributions to FSAs will be limited to $2,500 (amount to be indexed for inflation).

***Increased Medicare Taxes on High-Income Taxpayers.*** Beginning in 2013, individuals earning more than $200,000 and couples earning more than $250,000 annually will pay additional Medicare taxes. Under current law, all wages are subject to a 2.9% Medicare payroll tax, paid equally by the employer and employee. The health care reform law increases the employee's share of the Medicare payroll tax by 0.9% on earnings above the threshold amounts (and employers need not account for spousal income when calculating an employee's withholding, so some taxpayers may end up owing additional taxes or getting refunds when they file their returns). In addition, for the first time ever, a Medicare tax will be levied on investment income, with net income above the $200,000/$250,000 thresholds subject to a 3.8% tax.

***Notice to Employees of Coverage Options.*** As of March 1, 2013, employers subject to the Fair Labor Standards Act will be required to provide new hires and existing employees with written notices relating to free choice vouchers and purchase of health insurance through an exchange. It is hoped that regulations to be issued by the Secretary of Labor will help clarify the somewhat obtuse statutory requirements regarding these notices.

### 3. Effective in 2014 and Beyond

***Employer "Pay or Play."*** The health care reform law does not require employers to offer health coverage to employees. However, beginning in 2014, employers will face penalties or excise taxes for providing no coverage, providing coverage that is "unaffordable" to employees, or for providing coverage that is too rich through "Cadillac plans." Note that the penalties described below are set forth as annual amounts, but they actually will be calculated and levied on a monthly basis (*i.e.,* for each month in which a penalty would be due, the amount owed would be 1/12 of the annual amount).

> ***No Coverage.*** Employers with more than 50 full-time employees must either provide health insurance coverage that meets "minimum essential coverage" standards or incur a monetary penalty. If any employee of an employer not providing coverage receives a federal subsidy for purchasing insurance through an exchange, the employer must pay the government a penalty of $2,000 per full-time employee in excess of 30 employees. For purposes of determining whether an employer has more than 50 full-time employees, a full-time employee is defined as one who works at least 30 hours per week.
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> ***Unaffordable Coverage.*** Employers with more than 50 full-time employees may also incur penalties if even one employee opts out and receives government-subsidized coverage. Employee eligibility for government-subsidized coverage depends on the availability and affordability of employer coverage. An employer's plan will be deemed "unaffordable," entitling its employees to opt out and elect government-subsidized coverage, if the employee has to pay more than 9.5% of his or her income. The penalty is equal to the lesser of (1) $3,000 times the number of full-time employees who receive the premium assistance tax credit, or (2) the penalty the employer would owe if it did not offer coverage at all.
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> ***Cadillac Plans.*** Beginning in 2018, group health plan coverage that is richer than the basic federal model will become subject to a non-deductible, 40% excise tax. The tax applies to coverage with premiums in excess of $10,200 for individuals and $27,500 for families ($11,850 and $30,950, respectively, for retirees and employees in high-risk occupations). The tax is on the amount exceeding the relevant threshold and would be paid by insurers or by employers where self insured.

***Automatic Enrollment Requirement.*** Large employers – defined for this purpose as employers with more than 200 employees – will be required to enroll employees automatically into one of the health insurance plans offered by the employer. Employees may then opt out. It is unclear when this enrollment requirement takes effect, but the effective date is likely to be addressed by regulations to be issued by the Department of Labor implementing this requirement.

***Free Choice Vouchers.*** Beginning in 2014, employers offering coverage must provide a "free choice voucher" to eligible employees to purchase insurance through the state-run exchanges. Eligible employees are those (1) who have income below 400% of the federal poverty level, and (2) whose premium contribution

would otherwise exceed 8%, but not 9.8%, of their income. The voucher amount is equal to what the employer would have paid to provide coverage for the employee under the employer's plan.

***Wellness Programs.*** Currently, HIPAA regulations permit financial incentives of up to 20% of the amount of an employee's health insurance premium to be given to employees who participate in the employer's wellness program. PPACA increases this maximum to 30% beginning in 2014, and gives the Secretary of HHS the authority to raise it further to 50%, although (perhaps unintentionally) the increase does not apply to grandfathered health plans. HIPAA rules notwithstanding, in designing wellness plans, employers and their health plans must be conscious of limitations imposed by the Genetic Information Nondiscrimination Act and the possibility that some incentives may be viewed by the U.S. Equal Employment Opportunity Commission as running afoul of the Americans with Disabilities Act.

***Reporting Obligations.*** Beginning in 2014, insurers (including employers who self-insure) who provide minimum essential coverage to at least one person during the year must file an information return with HHS reporting certain coverage information. In addition, every large employer and every employer offering free choice vouchers must file an information return with HHS providing detailed information about the health care coverage the employer offers. Failure to file may result in monetary penalties of up to $100,000 per calendar year. The information on these returns also must be provided to each employee by January 31 of the following calendar year.

***Waiting Periods.*** Beginning in 2014, employers cannot require a waiting period in excess of 90 days before an employee can enroll in health care coverage.

***Pre-Existing Condition Limitations and Cost Sharing.*** Effective with the first plan year on or after January 1, 2014, group health plans and insurers may not impose any pre-existing condition limitations and must comply with annual limits on insureds' out-of-pocket costs as established by PPACA. (Grandfathered plans are exempt from the latter requirement.)

## EMPLOYEE RIGHTS CREATED BY PPACA

In addition to all of the changes relating to health insurance plans and the health care delivery system, PPACA includes some lesser noticed, but potentially very important, provisions granting new rights to employees. These provisions do not specify any future effective date; thus, it is assumed they became effective upon enactment of the law.

***Whistleblower Protections.*** Section 1558 of PPACA amends the Fair Labor Standards Act to implement significant new protections for whistleblowers and for employees receiving health care subsidies. The law prohibits retaliation against an employee who has (1) received a health insurance tax credit or subsidy; (2) provided, caused to be provided, or is about to provide to an employer, the U.S. Government or a state Attorney General, information that the employee reasonably believes to be a violation of PPACA Title I; (3) testified, assisted or participated, or is about to do one of those things, in a proceeding concerning a violation of Title I; or (4) objected to or refused to participate in any activity that the employee reasonably believes to be a violation of Title I. Because Title I includes many key health reform provisions, Section 1558 will cover a wide range of protected activity, although it remains to be seen just how close someone has to be to disclosing a violation of the health care reform law to be "about to" make such a disclosure.

Section 1558 adopts the complaint procedures from the Consumer Product Safety Improvement Act of 2008. Those procedures include (1) a 180-day statute of limitations; (2) a requirement that any complaint first be filed with OSHA, which will investigate; (3) the option to litigate the claim before an OSHA Administrative Law Judge or remove the claim to federal court 210 days after filing the complaint; (4) the right to a jury trial of the claim in federal court; (5) a variety of remedies, including reinstatement, back pay, special damages, and attorney's fees; and (6) an employee-friendly causation standard and burden of proof.

***Breaks for Nursing Mothers.*** Section 4207 of PPACA amends the Fair Labor Standards Act to require employers to provide unpaid "reasonable" breaks for mothers to express breast milk for their infants up to one year old. (This is a departure from the general FLSA standard that breaks of 20 minutes or less must be paid.) Employers are also required to furnish a private space, other than a restroom, for mothers to express milk. Employers with fewer than 50 employees may be excused from these requirements if compliance would impose an undue hardship due to significant difficulty or expense.

## POTENTIAL FUTURE ISSUES

Even with its massive size (more than 2,500 pages), the health care reform law is frequently short on the details of how its provisions are to be carried out. Accordingly, many of the changes described above will be fleshed out in the months and years ahead through issuance of federal regulations by the Secretaries of HHS and Labor, among others. Some provisions also could be amended or even repealed.

It is difficult to predict how the combination of insurance market reforms, health plan rules, subsidies, tax credits and financial penalties will affect employer sponsorship of group health plans in the long term. Certainly a main goal of PPACA is to broaden the availability and affordability of coverage. As employers implement their new obligations and assess costs over time, however, larger employers, in particular, may find themselves reconsidering whether (and how much) to pay for employee health coverage versus paying the penalties for not providing coverage.

Employers may also consider ways to resize and reshape their workforces to account for the employee-count thresholds. For example, employers who are slightly under the 50 full-time employee threshold that triggers the "pay or play" requirement may decide to hold staffing levels steady in order to avoid being subject to substantial financial penalties. The linkage of certain requirements to the number of employees may also lead some employers to engage independent contractors or otherwise outsource functions. In doing so, however, employers should take care to ensure that any independent contractors are properly classified as such. Misclassification of employees as contractors can result in significant tax liabilities and penalties that could well negate any perceived savings on health care costs.

## FOR MORE INFORMATION, CONTACT A MEMBER OF OUR HEALTH CARE GROUP

This Client Alert is the fourth in the "Finding Your Way" advisory series, designed to assist our clients and other health care providers as they prepare to respond to health care reform. Future articles will include discussions regarding PPACA's criminal enforcement, civil fraud and abuse, accountable health organization, and health information technology provisions.

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