Health Care Reform:

Understanding the Impact On Your Clients' Bottom Line

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Tax Roundtable

September 21, 2010

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INTRODUCTION

Overview of the Act

The Patient Protection and Affordable Care Act (the "Act") was signed into law on March 23, 2010. The Act applies broadly to group health plans—including both insured and self-insured plans—and its provisions interact with or amend existing legislation, such as ERISA, the Fair Labor Standards Act and the Internal Revenue Code. Several federal administrative agencies, including the Department of Labor, the Department of Health and Human Services and the IRS, are involved in its implementation and enforcement.

The Act contains numerous provisions affecting employer-based health care plans, including new excise taxes, required plan provisions, required participant communications and plan sponsor reporting provisions. This handout will briefly describe the key provisions of the Act that impact employer-sponsored health care plans.

Mandates, Choices and Incentives

The Act imposes many new requirements on employers, health care providers, insurers and individuals. Some of its provisions are required, while others are structured as incentives (so-called "pay or play" options) in the form of tax credits and penalty taxes to motivate employers to offer, and individuals to obtain, certain levels of coverage.

Grandfathered Plans

The Act also provides special treatment to "grandfathered plans"—health plans that were in effect on the date the Act was passed (March 23, 2010). Grandfathered plans are exempt from some, but not all, of the Act's coverage-related requirements. But this exempt status does not come without a cost. In order for plans to maintain their grandfathered status, they must adhere to a number of conditions, such as caps on the amount of allowable premium increases. An employer or plan sponsor who had a plan in force on March 23, 2010, therefore needs to determine whether the advantages of maintaining grandfathered status outweigh the restrictions and limitations placed on those plans.

Staggered Effective Dates

The Act's provisions take effect in several stages. Some reforms are effective for plan years beginning on or after six months after the date of the Act—which means January 1, 2011, for calendar year plans. Many of the other reforms are effective for plan years beginning on or after January 1, 2014. Still other provisions take effect at other times. It is important for employers and plan sponsors to be aware of the myriad of effective dates applicable to their plans.

A Note On the Effective Dates Stated

Unless noted otherwise, the effective dates for the Act's provisions given in this handout are for plan years that begin on or after the date stated, e.g., a January 1, 2011, effective date means the provision is effective January 1, 2011, for a calendar year plan, but it would be effective July 1, 2011, for a plan with a June 30 plan year end.

Given the breadth of the Act and its countless effects, a thorough analysis of all of its provisions is well beyond the scope of this handout. Instead, this handout will address the questions we are hearing most often from employers and their health plan advisors. And it will do this in an easy to follow Q&A format.

QUESTION 1

ARE EMPLOYERS REQUIRED TO PROVIDE HEALTH INSURANCE TO THEIR FULL-TIME EMPLOYEES?

Answer: **No. The Act does not require employers to provide any health coverage at all. However, large employers will be hit with a series of excise taxes if they fail to provide health coverage that is both "adequate" and "affordable."**

Although there is no requirement for an employer to offer any health plan coverage to their employees, beginning January 1, 2014, large employers will be subject to a penalty tax if they fail to offer adequate coverage to their full-time employees or if they offer adequate coverage but it is deemed to be unaffordable. (The penalty taxes and the definitions of "affordable" and "adequate" coverage are discussed in the answer to Question 11 below.)

"Large employers" are those with 50 or more full-time equivalent employees ("FTEEs") in the preceding calendar year.

How to Calculate the Number of FTEEs

The number of FTEEs is the total of:

(1) The number of full-time employees (those working on average at least 30 hours per week); plus

(2) The total number of hours worked by part-time employees (those working on average under 30 hours per week) divided by 120.

For purposes of determining FTEEs, seasonal employees (those working less than 120 days) can be disregarded.

QUESTION 2

ARE EMPLOYERS REQUIRED TO PROVIDE HEALTH INSURANCE TO THEIR PART-TIME EMPLOYEES?

Answer: **No. The Act does not require employers to provide any health insurance coverage whatsoever to their part-time employees.**

Employers are not required to cover part-time employees (defined as those who work less than 30 hours per week on average). However, as discussed in the answer to Question 1 above, part-time employees have to be taken into account for purposes of determining how many Full-Time Equivalent Employees an employer has. An employer with 50 or more FTEEs is considered to be a "large employer." Large employers are subject to penalty taxes if they fail to offer their full-time employees health coverage that is both adequate and affordable. (These taxes are discussed in the answer to Question 11 below.)

QUESTION 3

CAN AN EMPLOYER REQUIRE ITS EMPLOYEES TO ENROLL IN ITS HEALTH CARE PLAN AND CHARGE THEM THE MONTHLY PREMIUMS?

Answer**: Yes. In fact, certain large employers will be required to automatically enroll their employees in their health plans.**

Subject to regulations which have not yet been issued by the Department of Labor, employers with at least 200 FTEEs (calculated the same way as in the answer to Question 1) who offer at least one health plan option will be required to automatically enroll all new full-time employees in one of those plans. In addition, the employer must continue the enrollment of its current employees. Employees can be charged the monthly premiums for their auto-enrolled coverage.

An employer must, however, give employees adequate notice of the automatic enrollment program and the opportunity to opt out of the health plan in which they have been auto-enrolled and either select another option (if one is available) or opt out of the employer's plans completely. (See Question 4 below.)

This auto-enrollment requirement is not yet in effect. It will become effective as of the date stated in the yet-to-be-released Department of Labor regulations.

QUESTION 4

CAN EMPLOYEES OPT OUT OF THEIR EMPLOYER'S PLAN?

> ***Answer*: Yes. Qualifying employees must be allowed to opt out of their employer's health plan.**

Employees may opt out entirely, but only if they have coverage under another plan, including their spouse's plan or coverage under one of the state Health Insurance Exchanges ("Exchanges")[1] which the Act requires every state to establish.

Employees who opt out of their employer's plan will not trigger a penalty for the employer, provided the employer's health plan is not "unaffordable" (see Question 11 below) and the employer provides the required "free choice vouchers" to qualifying employees (see Question 8 below).

QUESTION 5

CAN EMPLOYERS USE A LONG "WAITING PERIOD" TO KEEP NEW EMPLOYEES OUT OF THEIR HEALTH PLANS FOR AN EXTENDED PERIOD?

> ***Answer*: No. Starting January 1, 2014, the maximum allowable eligibility waiting period will be 90 days.**

Although employers are not required to provide health care coverage to their employees, starting January 1, 2014, if an employer has a health plan, that plan must cover full-time employees once they have been employed for 90 days.

QUESTION 6

DO "TEMPORARY EMPLOYEES" HAVE TO BE COVERED?

> ***Answer*: Yes, starting January 1, 2014, provided they are working on a full-time basis and they have satisfied the health plan's eligibility waiting period.**

Starting January 1, 2014, employees scheduled to work on the average of at least 30 hours per week can be subject to no more than a 90-day eligibility waiting period. The fact that the employer classifies these employees as "temporary," as opposed to "regular" or "permanent," is irrelevant.

[1] This handbook is focused on the Act's impact on employer-sponsored plans. So, an in-depth discussion of the health insurance exchanges and the Act's provisions on the related taxes/tax credits for individuals is outside its scope.

QUESTION 7

CAN EMPLOYERS DENY COVERAGE FOR PRE-EXISTING CONDITIONS?

Answer: **No. The Act bans "pre-ex conditions" in two stages.**

Starting January 1, 2011, pre-existing condition exclusions are prohibited for children under age 19. And, starting January 1, 2014, they are prohibited for all enrollees.

QUESTION 8

WHAT BENEFITS WILL A HEALTH PLAN BE REQUIRED TO PROVIDE? (AND WHEN DO THEY BECOME EFFECTIVE?)

Answer: **Under the Act, plans must offer "minimum essential coverage" and meet certain participant notice and reporting requirements. The new requirements start becoming effective in 2011 and will be fully in force in 2014.**

In order to provide the "minimum essential coverage" required by the Act, health plans will have to include the numerous features discussed below by the applicable dates.

NOTE: *The provisions that are labeled "GF Exempt" below do not apply to "grandfathered plans." The requirements and restrictions on grandfathered plans and how grandfathering status can be lost is discussed in the answer to Questions 14 and 15 below.*

Starting January 1, 2011

- **Prohibition on Annual and Lifetime Limits.** Plans may not impose ***any*** lifetime limits on "essential benefits" (see Question 9 below). Annual limits on essential benefits will be phased out completely by 2014 (see Question 10 below). Lifetime limits and unrestricted annual limits will be allowed only for benefits that are not "essential benefits."

- **Prohibition on Rescissions.** Coverage cannot be rescinded except for fraud or intentional misrepresentation.

- **Prohibition on Pre-Existing Conditions for Children.** No pre-existing condition exclusions are allowed for enrollees under age 19.

- **W-2 Reporting.** The aggregate value of employer-sponsored health plan coverage must be reported on employees' W-2s, starting with W-2s issued for 2011. Employers will be required to separately report the total premium cost (i.e., employer and employee portions) for all health plans (i.e., medical, dental, vision, etc.) excluding Section 125

health flexible spending accounts. For self-insured plans, the "premium" cost is the total employer and employee contributions.

This is simply a new reporting requirement. The value of the coverage will continue to be a tax-free benefit. The purpose of this requirement is to inform employees about the true cost of their employer-sponsored coverage, of which many employees are unaware. (Although some cynics believe that this is a means for the government to finally determine the actual amount of tax-free benefits that are being provided across the country and that this will be the first step in taxing health benefits.)

- **Uniform Explanation of Benefits and Coverage.** Employer-sponsored plans must distribute a summary of benefits and coverage to all applicants and enrollees at the time of initial enrollment and at each annual enrollment. This summary is in addition to the Summary Plan Description required by ERISA. The summary must be presented in a "culturally and linguistically appropriate manner," and it must follow a standardized format and use standardized terms all of which will be set out in regulations that are required to be issued by the Secretary of Health and Human Services no later than March 22, 2011. The first such summary of benefits and coverage is to be distributed no later than March 22, 2012.

- **60-Day Advance Notice of Plan Changes.** Participants must be given at least 60 days' advance notice of any proposed material change to a plan's benefits.

- **Coverage of Adult Children *(GF Exempt, but limited)*.** Plans must cover an enrolled employee's children until age 26, regardless of whether the child is a student, is married or qualifies as the employee's dependent for tax purposes. Plans must offer a special 30-day enrollment period for these adult children for the first plan year after September 30, 2010 (i.e., January 1, 2011 for calendar year plans). Until then, any dependents aging off of the plan will continue to have the ability to enroll in COBRA coverage. During the next open enrollment, employees will have the opportunity to re-enroll those dependents.

  ► ***Limited Grandfathered Plan Exception.*** Until January 1, 2014, a grandfathered plan does not have to provide this coverage for adult children who are eligible for their own employer-sponsored health coverage.

- **Coverage of Preventive Care *(GF Exempt)*.** Plans must provide first dollar coverage (no cost-sharing) for certain preventive care, such as women's screenings, well child care and certain immunizations.

- **Internal and External Claims Appeals *(GF Exempt)*.** Under interim final regulations that were issued on July 22, 2010, plans must establish an internal claims appeals process that includes providing participants notice in "a culturally and linguistically appropriate manner" of the review process. If the claim is denied in the internal appeal, the participant must have the right to appeal the denial to an external, independent reviewer.

- **Patient Protections *(GF Exempt)*.** If a plan requires or allows for the designation of a primary care provider, participants must be given the right to designate any primary care provider who is available to accept the participant. Plans must allow pediatricians to be designated as the primary care provider for children. In addition, plans must cover emergency and OB-GYN services without pre-authorization, referrals or in-network restrictions.

- **Prohibition on Discrimination Based on Salary *(GF Exempt)*.** A plan cannot base eligibility upon the levels of employees' salaries, nor can a plan otherwise discriminate as to eligibility in favor of "higher-wage employees."

- **Ensuring Quality of Care *(GF Exempt)*.** Plans will have to report annually to the Department of Health and Human Services and to enrollees (during open enrollment) regarding the benefits under the plan that improve health outcomes, such as case management, disease management and wellness and health promotion activities. The Secretary of Health and Human Services is to publish the reporting requirements by March 22, 2012.

- **Transparency in Coverage *(GF Exempt)*.** A plan must provide the Secretary of Health and Human Services, the applicable state Insurance Commissioner and "the public" (although it appears that disclosure to plan participants will satisfy the public disclosure requirement) with the following information:

    - Claims payment policies and practices;
    - Periodic financial disclosures;
    - Data on enrollment/disenrollment;
    - Data on the number of claims denied;
    - Data on rating practices;
    - Information on cost-sharing and payments regarding out-of-network coverage;
    - Information on participant rights; and
    - "Other information as determined appropriate by the Secretary."

    Note: It appears this requirement does not apply to self-insured plans; however, the language of the statute is unclear.

FOR THE 2012 THROUGH 2018 PLAN YEARS

- **Trust Fund Fee.** Employers sponsoring self-insured plans will be charged a per-head fee to help fund the new federal Patient-Centered Outcomes Research Trust Fund. For each self-insured plan, the fee will be $1 times the average number of lives covered under that plan (i.e., employees plus dependents) in the 2012 plan year. For 2013 and 2014, the fee increases to $2 times the average covered lives. Starting in 2015, the dollar amount of the fee is subject to cost-of-living adjustments based on the percentage increase in the projected per capita amount of National Health Expenditures. This fee will not be charged after the 2018 plan year.

BY MARCH 1, 2013

Notice to Employees of Benefits Available under an Exchange. No later than March 1, 2013, employers will be required to notify their employees of the existence of the Exchange in the state in which they are employed and, if the employer is paying less than 60 percent of the cost of plan coverage, the notice must also explain the benefits available to employees if they purchase coverage through the Exchange (such as tax credits and cost-sharing reductions). The Secretary of Health and Human Services is required to issue regulations regarding the content and form of this notice.

STARTING JANUARY 1, 2014

- **Coverage of Adult Children.** Adult children of covered employees must be covered until age 26, regardless of whether they are eligible for coverage under their own employer's plan.

- **Prohibition on Pre-Existing Condition Limitations.** Plans cannot impose pre-existing condition exclusions or limitations, regardless of the age of the enrollee. (See Question 7 above.)

- **Limitation on Maximum Waiting Period.** Plans cannot have an eligibility waiting period longer than 90 days. (See Question 5 above.)

- **Free Choice Vouchers to Qualifying Employees Opting Out of Employer Plan.** If an employer offers a plan providing "minimum essential coverage" and pays any portion of the plan costs, it will have to begin issuing "free choice" vouchers to qualifying employees who opt out of the plan.

  "Qualifying employees" are those:

  - Who do not participate in any of the employer's plans;
  - Whose required contribution to one of the employer plans would be more than 8 percent, but not more than 9.8 percent, of their household income; and
  - Whose household income does not exceed 400 percent of the federal poverty line for their family.

  The value of the voucher must be equal to the dollar amount of the employer contribution the employer would have made under the plan applicable to the employee. These vouchers can only be used to purchase health coverage through an Exchange. Employees who receive vouchers will not be eligible for any tax credits through their state Exchange. The value of free choice vouchers is excludible from the employee's income to the extent the amount of the voucher does not exceed the cost of coverage purchased by the employee and is deductible as compensation by the employer.

- **Cost-Sharing Limitations *(GF Exempt)*.** A plan's cost-sharing provisions (the total of deductibles, co-insurance, co-payments and similar charges) cannot exceed the maximum out-of-pocket expenses a participant would be required to pay for coverage under a high deductible health plan offered in connection with a health savings account. (For 2010, this maximum is $5,950 for single coverage and $11,900 for family coverage.)

- **Prohibition on Discrimination Based on Health Status *(GF Exempt).*** A plan cannot base an employee's or a dependent's eligibility (or continued eligibility) on any of the following health status-related factors:

    - Medical condition (including both physical and mental illnesses);
    - Claims experience;
    - Receipt of health care;
    - Medical history;
    - Genetic information;
    - Evidence of insurability (including conditions related to domestic violence);
    - Disability; or
    - Any other health status-related factor published by the Secretary of Health and Human Services.

- **Prohibition on Discrimination Against Providers *(GF Exempt)*.** A plan cannot discriminate against a health care provider who is acting within the scope of his or her license. However, this does not mean plans are required to contract with any willing provider.

- **Coverage for Clinical Trials *(GF Exempt)*.** Plans cannot prohibit enrollees who meet the protocols for clinical trials for cancer or another life-threatening disease or condition from participating in those trials, and they cannot deny or limit coverage for the routine patient costs for items and services provided in connection with those trials.

QUESTION 9

WHAT ARE "ESSENTIAL BENEFITS"?

Answer: **Basically, just about anything that is currently considered to be "major medical" coverage.**

Current regulations list the following "essential benefits":

- 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
- Pediatric services, including oral and vision care

Future regulations may (and probably will) add to this list.

QUESTION 10

HOW WILL THE BAN ON ANNUAL LIMITS BE PHASED IN?

Answer: **The allowable dollar cap will increase over the next three years and will finally be eliminated starting 2014.**

Three-Year Phase In. The ban on annual limits will be phased in as follows:

2011	$ 750,000
2012	$1,250,000
2013	$2,000,000
2014 and after	No limit allowed

Waiver Program. Because these restricted annual limits will have a devastating impact on limited benefit/"mini-med" plans, the regulations allow the Secretary of Health and Human Services to implement a waiver program that would grant relief if compliance with these limits would significantly decrease benefits or increase premiums. Guidance on the waiver application process is supposed to be issued "in the near future."

Limits Apply to Each Covered Individual. The phased-in annual limits described above apply to each individual covered under the plan (that is, a single annual limit is not applied to the employee and covered dependents).

QUESTION 11

WHAT PENALTIES ARE IMPOSED IF A PLAN IS OUT OF COMPLIANCE?

Answer: **The Act imposes different types of penalties and penalty taxes based upon the nature of the violation.**

Penalties for Coverage-Related Violations. Violations of the Act's coverage-related provisions are subject to civil enforcement suits under ERISA, as well as monetary penalties of $100 per participant per day during the period of noncompliance, up to an annual maximum of

$500,000 or 10 percent of the group health plan's expenses for the prior year, whichever is less. Additional penalties may be imposed for failure to meet the Act's information reporting requirements. None of these penalties are deductible.

Penalty Taxes on Large Employers Failing to Offer Adequate or Affordable Coverage. Beginning January 1, 2014, large employers (those with 50 or more FTEEs—see Question 1 above) are subject to two different "pay or play" penalty taxes, neither of which is deductible:

(1) Penalty for Failure to Offer Minimum Essential Coverage to Full-Time Employees. Large employers who fail to offer any of their full-time employees "minimum essential coverage" (see Question 9 above) must pay a penalty if any full-time employee enrolls in one of the new state Exchanges and receives subsidized coverage (a premium tax credit or a cost-sharing reduction).

The penalty is determined monthly and is calculated as follows:

$$\text{Penalty} = \frac{(\text{FTEs} - 30) \times \$2{,}000}{12}$$

"FTEs" are all employees who are employed on average at least 30 hours a week (including those who do not receive subsidized coverage through a state Exchange). As shown in the formula above, for purposes of calculating the penalty, the first 30 FTEs are disregarded.

Example: XYZ Inc. has 500 FTEs in January 2014 and does not offer a health plan that provides the required minimum essential coverage. XYZ Inc. will be subject to a penalty of $78,333.33 for that month calculated as follows:

$$\text{Penalty} = \frac{(500 - 30) \times \$2{,}000}{12}$$

$$= \$78{,}333.33$$

(2) Penalty for Offering Unaffordable Coverage to Full-Time Employees. A large employer offering "unaffordable coverage" (defined below) will be subject to a separate penalty if any of its full-time employees enrolls in a state Exchange and receives subsidized coverage.

The penalty is determined monthly and is the lesser of the amount calculated under Formula 1 or Formula 2 below:

Formula 1—

$$\text{Penalty} = \frac{(\text{Includible FTEs}) \times \$3{,}000}{12}$$

"Includible FTEs" are those FTEs who are receiving a tax credit available to persons enrolling in coverage through a state insurance Exchange.

Formula 2—

$$\text{Penalty} = \frac{(\text{All FTEs} - 30) \times \$2{,}000}{12}$$

"Unaffordable Coverage." Coverage is unaffordable if either:

(1) The employee's required premium for coverage exceeds 9.5 percent of the employee's household income; or

(2) The plan's co-insurance level is less than 60 percent.

If neither of these conditions is met, an employee is ineligible for a tax credit otherwise available to persons enrolling in coverage through a state insurance Exchange.

QUESTION 12

WHAT STEPS SHOULD EMPLOYERS TAKE IN PLANNING FOR THESE NEW "PAY OR PLAY" PENALTIES?

Answer: **Basically, employers will need to determine whether it is more cost effective to modify their plans to comply with the Act (or maintain their plans' grandfathered status) or simply pay the penalties. In addition to the economics, employers also need to address whether they need to offer health plan coverage to be competitive in their business environment.**

Cost Comparison. The penalty taxes discussed above essentially treat the provisions of health insurance as a "pay or play" mandate on employers. The Act's requirements are an added payroll cost to employers—either in the form of higher health plan costs or a penalty tax. For this reason, many employers are beginning to compare the cost of providing health insurance coverage (taking into account the tax deduction allowed to the employers) against the cost of

paying the nondeductible penalty for not providing any coverage, to see if it is cheaper to just pay the penalty rather than maintain a plan. Employers may be more likely to consider dropping coverage given the fact they will no longer need to be as concerned with being a source of health coverage since their employees will be able to obtain coverage through a state Exchange. The case for simply paying the penalty may become even more compelling should medical insurance costs escalate faster than the penalty rates are adjusted (which seems likely).

Societal Engineering? Whether, as some have claimed, this approach is part of a grand design to switch our nation's health care system from the present employer-sponsored system to a government-sponsored system remains to be seen. However, this "pay or play" approach gives employers (particularly smaller employers) an indirect financial motivation to drop their plans. Further, the additional plan compliance costs (legal and consultants' fees) will likely significantly increase the expense of maintaining a plan for many small companies.

Avoiding the Penalties. Generally, as explained in the answer to Question 11, the "pay or play" penalties can be avoided if an employer offers a plan that provides "minimum essential coverage" that is not "unaffordable." Employers can also avoid these penalties to the extent they provide employees with free choice vouchers (discussed in the answer to Question 8).

Action Steps. With all this in mind, employers should take several steps to analyze the potential cost impact of these penalties on their businesses.

First, employers should determine whether they are "large employers" with 50 or more FTEEs (see the answer to Question 1 for the calculation). If they're not, they are not subject to either of the penalty taxes. But large employer status is determined on a monthly basis, so it may be possible for some employers to be subject to the tax in some months but not subject to the tax in others, based upon fluctuations in their monthly workforce headcount. Businesses with fluctuating workforces could be particularly impacted by this rule.[2]

Second, employers should work with their advisors to determine whether their plans qualify for grandfathered status (discussed in the answer to Question 14 below) and what modifications are required under the Act.

Third, employers should work with their advisors to run cost projections in order to estimate the financial impact of the cost of offering plans with the increased benefits and fewer limitations required under the Act. Any analysis of the true cost of providing "minimum essential coverage" that is "affordable" versus the cost of the "pay or play" penalties should take into account factors such as:

- Employee demand for increased cash compensation if employer-paid health benefits are terminated; and
- The tax benefits accruing to employers and employees under employer-sponsored health plans.

[2] The rule excludes certain seasonal employees and retail holiday workers.

If an employer decides to terminate its health care plan and pay the penalty tax, it will probably need to increase employees' cash compensation (assuming the employer presently contributes to the cost of the plan). Presently, employers can deduct the cost of providing health care benefits, and such amounts are also excluded from employees' income. Higher cash wages to employees combined with the loss of the tax deduction on the employee-paid portion of the plan costs will likely result in a significantly higher tax bill for the employee. Because health care costs for individually purchased plans are not tax deductible, employees will generally find their premium dollars do not "go as far" as they did under the employer-sponsored plan.

QUESTION 13

HOW SHOULD AN EMPLOYER COMPARE THE COSTS OF COMPLIANCE VERSUS THE COSTS OF THE "PLAY OR PAY" PENALTIES?

Answer: **The following simplified example[3] illustrates the recommended analysis an employer should conduct if it is considering dropping its health care coverage and simply paying the "play or pay" penalty instead.**

Facts. Assume Employer X's health care plan premiums are $1,000 per participant per month, and Employer X pays 80 percent of the premiums and requires the participant to pay 20 percent. Thus, Employer X has a present deductible expense of $800 per participant per month, and each employee-participant pays $200 for coverage out of pre-tax wages.

After-Tax Premium Cost. If Employer X decides to drop its plan, it would pay a penalty tax of $166.67 per month per employee for not offering minimum essential coverage.[4] Assuming a 35 percent corporate tax rate, Employer X's after-tax premium cost is $520 per employee per month, calculated as follows:

$$\text{After-Tax Cost} = \$800 \times (1 - .35)$$

$$= \$520$$

[3] This example does not consider the impact of FICA taxes on employers or employees with respect to pre-tax employee contributions to health plan costs or increased wages. Employers and employees get the additional tax benefit of not paying FICA taxes on the amount of pre-tax employee contributions. In the absence of pre-tax contributions to an employer-plan, the employee's income subject to FICA increases and subjects both the employer and employee to their applicable share of FICA taxes. Additionally, any increased wage payments to assist employees in purchasing other coverage will be subject to FICA taxes.

[4] As discussed above, the penalty formula is ((FTEs − 30)× $2,000) / 12. Disregarding the 30 employee reduction, the marginal tax on each employee is $2,000/12, or $166.67 per month. Consequently, this example will use a penalty tax of $166.67 per month.

Equivalent Additional Wage. Assuming a 35 percent corporate tax rate, some more quick math reveals Employer X could drop its plan, pay the penalty tax, give each employee an additional $545 per month to obtain coverage elsewhere and come out essentially even, calculated as follows:

$$\text{Additional Payment} = \frac{\text{(Current After-Tax Premium Cost - Penalty Tax)}}{\text{(1 - tax rate)}}$$

$$= \frac{(\$520 - \$166.67)}{(1 - .35)}$$

$$= \$543.58$$

Other Savings. By dropping coverage, Employer X would also free itself of the administrative headaches and administrative costs to maintain the plan. Although this result may be palatable, a proper analysis requires delving into the economic impact on employees.

Tax Impact on Employees. From the standpoint of its employees, however, the benefits of Employer X's plan are greater than just Employer X's $800 per month contribution. Employees participating in the plan are not taxed on $1,000 of monthly income. (The $800 of employer-paid premium is excluded, and the $200 monthly premium the employee pays is paid with pre-tax dollars.) Consequently, assuming employees face a combined 30 percent federal and state income tax rate, they receive a tax break of $300 per month just by obtaining coverage under Employer X's health care plan.

If Employer X decides to terminate the plan, pay the penalty tax and give each employee an additional $545 per month to purchase insurance coverage elsewhere, employees would see their monthly taxable income increase by $745 ($545 in higher wages, and $200 due to no longer making pre-tax premium payments for coverage under Employer X's plan).

Consequently, assuming the same 30 percent tax rate, the $745 increase in taxable income (only $545 of which is increased wages), results in a $521.50 increase in after-tax take home pay, calculated as follows:

$$\text{Increase in Take Home Pay} = \$745 \times (1-.30)$$

$$= \$521.50$$

Thus, the employees in this example will effectively have $521.50 per month to purchase health insurance coverage in the individual market. Employees will almost certainly be unable to purchase the same level of health insurance coverage in the individual market as they had under Employer X's plan, given that they effectively have just over half of the amount they had available to purchase coverage under Employer X's plan. Although Employer X comes out virtually the same from a financial standpoint, its employees may end up worse off due to the loss of the significant tax benefits associated with employer-provided coverage. As a result,

Employer X may find itself suddenly offering a less competitive wage and benefits package, even though its tax-adjusted costs are essentially the same.

Competitive Wage/Benefits Package. As shown by the example above, a proper cost/benefit analysis of terminating a plan should consider the tax consequences to the employer and its employees as well, as those could impact the employer's ability to attract and retain workers with a competitive wage and benefits package. In addition, this could make the employer's workforce more receptive to unionization.

Recommended Analysis. Because of the myriad of variables impacting employers and employees, we recommend that employers work with their advisors to run cost-benefit analyses to estimate the financial impact of terminating their current plan(s) versus modifying the plan(s) to meet the Act's new coverage and benefits requirements. Employers may find that, although their costs will increase to modify their present plan to meet the Act's requirements, the increase is the lesser of two evils when facing the prospect of offering a less competitive wage and benefits package.

QUESTION 14

WHAT IS THE SIGNIFICANCE OF BEING A "GRANDFATHERED PLAN?"

Answer: **A grandfathered plan does not have to meet certain of the Act's coverage and reporting requirements at all, and it has a delayed effective date for some of the other requirements.**

Grandfathered Plan Status. Group health plans are eligible for grandfathered status if they were in effect on March 23, 2010, the date the Act was enacted. A plan's grandfathered status will continue as long as the plan's coverage is continuous since March 23, 2010. Employees who are hired after March 23, 2010, or are not participating in the plan prior to that date, can be enrolled in a grandfathered plan, along with their dependents, without adversely affecting the plan's grandfathered status.

Act Requirements Not Applicable to Grandfathered Plans. Grandfathered plans are exempt from the following requirements of the Act (discussed in detail in the answer to Question 8 above):

- Coverage of adult children (limited exemption until 2014)
- Coverage of preventive care
- Internal and external claims appeals
- Patient protections
- Prohibition on discrimination based on salary
- Ensuring quality of care
- Transparency of coverage
- Cost-sharing limitations
- Prohibition on discrimination based on health status

- Prohibition on discrimination against providers
- Coverage for clinical trials

Act Requirements Applicable to Grandfathered Plans. Grandfathered plans are not exempt from the following requirements of the Act, discussed in detail in the answer to Question 9 above, which are all effective for plans beginning January 1, 2011, except as noted:

- Prohibition on lifetime limits
- Restricted annual limits (only through 2013)
- Prohibition on pre-existing conditions for enrollees under age 19
- Prohibition on rescissions
- W-2 reporting
- Uniform explanation of coverage
- 60-day advance notice of plan changes
- Coverage of adult children regardless of eligibility for other coverage (effective 2014)
- Prohibition on pre-existing conditions for enrollees of any age (effective 2014);
- Prohibition on annual limits (effective 2014)
- Limitation on maximum waiting period (effective 2014)

QUESTION 15

WHAT DOES A PLAN HAVE TO DO TO MAINTAIN ITS GRANDFATHERED STATUS?

Answer: **Maintaining grandfathered plan status requires employers to follow strict rules with regard to benefit and cost-sharing provisions.**

Actions That Will Lose Grandfathered Status. It's disturbingly easy to lose grandfathered status. Under the interim final rules (the Grandfather Rules) issued on June 14, 2010, by the Department of Health and Human Services, the Department of Labor and the Treasury Department, any of the following changes to a grandfathered plan will cause the plan to lose its grandfathered status:

(1) ***Converting to Insured Plan.*** Converting a self-insured plan to an insured plan, even if the benefits provided under the plan do not change.

(2) ***Eliminating/Reducing Certain Benefits.*** Eliminating all or substantially all of the benefits to treat or diagnose a particular condition, including eliminating any one element required to treat or diagnose a particular condition. (For example, eliminating coverage for mental health counseling if the plan previously covered prescription drugs and counseling to treat a mental health condition.)

(3) ***Increasing Co-Insurance.*** Increasing the co-insurance percentage borne by participants by any amount (i.e., increasing participants' co-insurance from 10 percent to 20 percent).

(4) ***Increasing Cost-Sharing.*** Increasing a fixed-amount cost-sharing requirement, other than a co-payment, (e.g., deductibles and out-of-pocket limits) by more than the rate of medical inflation plus 15 percentage points. (Medical inflation is based upon the overall medical care component of the Consumer Price Index for All Urban Consumers, unadjusted.)

(5) ***Increasing Co-Payments.*** Increasing a fixed-amount co-payment by more than the greater of:

(a) $5, increased for medical inflation; or

(b) The rate of medical inflation plus 15 percentage points.

(6) ***Decreasing Employer Contributions.*** For any class of similarly situated individuals, decreasing the employer contribution rate by more than 5 percentage points below the contribution rate in effect on March 23, 2010.

(7) ***Changing Annual Limits.*** Changing a plan's annual limits by:

(a) Imposing an overall annual limit on the dollar value of benefits if, on March 23, 2010, the plan did not impose an overall annual or lifetime limit;

(b) Adopting an overall annual limit on benefits at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010, if, on that date, the plan imposed an overall lifetime limit on the dollar value of benefits but no annual limit on the dollar value of benefits; or

(c) Decreasing the dollar value of the annual limit on benefits (regardless of whether the plan also imposed an overall lifetime limit on March 23, 2010) if, on March 23, 2010, the plan imposed an overall annual limit on the dollar value of all benefits.

(8) ***Transferring Employees to Different Plan.*** Transferring employees from one grandfathered plan to another grandfathered plan if the transfer does not have a bona fide employment-based reason and the transfer results in a reduction in benefits or an increase in cost-sharing to the participant that would otherwise result in a loss of grandfathered status under the Grandfather Rules.

(9) ***Failing to Maintain Records.*** Failure to maintain the necessary records to document grandfathered status (see Question 16 below).

(10) ***Failing to Provide Employee Notice.*** Failure to provide participants with the required notice of the plan's grandfathered status (see Question 16 below).

Loss of Grandfathered Status Probably Inevitable. The challenge facing many employers will be to maintain their plans' grandfathered status for as long as possible as rising medical costs will make it difficult for many employers to stay within the cost-sharing limitations imposed on grandfathered plans. Given medical cost trends, it is predicted that most plans will lose their grandfathered status at some point in the next several years. (The government estimates that 70 percent of plans currently qualify for grandfathered status, but this will drop to less than one-third over the next several years.)

Consequences of Losing Grandfathered Status. As discussed above, when plans lose their grandfathered status, the Act requires them to provide additional benefits, and it restricts their cost-sharing features. All of this will, of course, only serve to further drive up the costs of maintaining health plans. If plans lose grandfathered status, employers should assess the costs and benefits of maintaining the plans under the Act's requirements or dropping the plans entirely and paying the "pay or play" penalty instead (see Question 11 above).

QUESTION 16

ARE GRANDFATHERED PLANS SUBJECT TO SPECIAL REPORTING RULES?

Answer: **Yes. Grandfathered plans have to comply with special rules regarding document retention/disclosure and notices to participants.**

Employers maintaining grandfathered plans will have to comply with the following administrative requirements in order to preserve a plan's grandfathered status:

- **Plan Document Maintenance.** Employers must maintain all records necessary to document the terms of the plan and the applicable costs to participants in effect as of March 23, 2010, and make those records available for examination on request; and

- **Participant Notices.** Employers must also include a statement in any plan materials provided to participants (such as Summary Plan Descriptions and Summaries of Material Modifications) that describes the plan's benefits and notes that the plan believes it is a grandfathered health plan. The Grandfather Rules include a model notice that employers can use for this purpose. The model notice is not exactly employer-friendly and may cause some employee-relations problems. For example, it includes the following statement:

> Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to

other plans, for example, the requirement for the provision of preventive health services without any cost sharing.

QUESTION 17

HOW DOES THE ACT AFFECT SECTION 125 PLAN HEALTH FSAs?

Answer: **The Act impacts Section 125 health flexible spending accounts ("FSAs") in two major ways: First, as of January 1, 2011, over the counter ("OTC") medicines and products will no longer qualify for reimbursement without a prescription. Second, as of January 1, 2013, a $2,500 annual cap is placed on health FSAs.**

Rx Required for OTC Medicines. Effective January 1, 2011, OTC medicines and products will no longer be reimbursable through participants' Section 125 health FSAs unless they are prescribed by a medical practitioner. Under this new rule, participants will be required to include a copy of their medical practitioner's written prescription when they submit a claim for reimbursement for an OTC medicine or product.

Effect on 2010 FSA Balances. While the new OTC rule goes into effect January 1, 2011, it does have some impact on FSA balances carried over from 2010:

- ***2010 Claims Submitted During 2010 Run-Out Period.*** Participants may continue to submit reimbursement claims against their 2010 health FSA balances for OTC medicines or products purchased without a prescription before January 1, 2011. The rules regarding run-out claims under Section 125 plans have not been changed, so these claims will need to be submitted before the run-out period expires under the terms of the employer's health FSA plan (generally, March 31, 2011).

- ***2011 Claims Submitted During 2010 Grace Period.*** Participants who purchase OTC medicines or products after January 1, 2011, but want them reimbursed from their 2010 FSA balances during the grace period for the 2010 plan year, must submit a written prescription with their reimbursement claim.

Example. Here's an illustration of how the transition rule will work for 2010 OTC reimbursement claims:

> Let's say an employer's health FSA plan allows for a claims grace period (that is, participants can use up their remaining balance from the prior year during a limited time in the beginning of the following year). If a participant purchases an OTC allergy medicine in February 2011 and wants that reimbursed from the carried over balance of the participant's 2010 FSA, that participant will have to submit a written prescription along with the claim form in order to be reimbursed. However, the participant does not need a prescription if the medicine was purchased in

December 2010, and the reimbursement claim was merely submitted in February 2011.

New $2,500 Annual Limitation. Under pre-Act law, there was no dollar limit on the amount an employer could allow employees to contribute to a Section 125 health FSA plan. (As a practical matter, however, to limit the employer's exposure on the Section 125 plan "Uniform Coverage Rule,"[5] most plans had a dollar limit, typically not more than $5,000.) Effective January 1, 2013, the Act imposes a $2,500 limit on employee pre-tax salary reductions into a Section 125 health FSA. This limit will be indexed for inflation annually, rounded down to the next lowest $50 increment.

Plan Amendments/Employee Notices. Employers will need to amend their Section 125 health FSA plan documents to address these changes. Moreover, participants need to be made aware of these new rules, because they will affect participants' decisions on how much to contribute into their FSAs for 2011 and whether they should pay for OTC drugs and items in 2010 or in the 2011 grace period. We recommend that the packet going out to participants for the 2011 open enrollment include a brief, easy-to-understand notice describing the effects of the new rules and the steps they must follow to be reimbursed for OTC drugs and other items starting January 1, 2011.

QUESTION 18

ARE THERE ANY TAX INCENTIVES AVAILABLE TO EMPLOYERS PROVIDING HEALTH COVERAGE TO THEIR EMPLOYEES?

Answer: **Yes. There's a tax credit for certain small employers who pay for at least 50 percent of the cost of coverage they provide to their employees.**

Sliding Scale Credit. Effective January 1, 2010, employers with no more than 25 full-time equivalent employees (see below) and whose average annual wages are no more than $50,000 may receive a tax credit of up to 35 percent of the employer's cost to provide group health insurance (up to 25 percent in the case of tax-exempt employers). The credit is based on a sliding scale calibrated to the number of employees and their average annual wages. The employer must contribute at least 50 percent of the total premium cost. Beginning in 2014, eligible employers may purchase coverage through an Exchange and receive a credit of up to 50 percent of the cost for up to two years (up to 35 percent in the case of tax-exempt employers).

[5] Under the Uniform Coverage Rule, the full amount that participants have elected to contribute into their Health FSAs for a plan year has to be available on day one of that year to pay claims. So, if a participant elects to contribute $5,000 for the year, that participant can submit a claim for the full $5,000 on, say, January 2 even though there is nothing in the participant's Health FSA at that time. The risk is that the participant will quit after being paid and the employer will not be able to recoup the full $5,000 from the Section 125 contributions that would have been taken out of the participant's salary.

Tricky Definitions. Although simple in theory, this credit contains extremely complex definitions and rules, many of which differ from those under other parts of the Act. For example, for purposes of determining the number of full-time equivalent employees, all members of an employer's controlled group are included, and the aggregate hours of part-time employees are converted to full-time equivalents based on 2,080 hours of service per year. This definition differs from the definition of FTEEs used for purposes of the penalty taxes (see Question 1). In addition, there are a number of limitations and phase-outs. Consequently, employers who may potentially qualify for this credit should carefully review these rules with their advisors.

New Form Released. The IRS has recently issued a draft of the new form which employers will use to claim the credit.[6]

QUESTION 19

WHAT IMPACT WILL THE "CADILLAC PLAN TAX" HAVE?

Answer: **In an effort to get health insurers to offer (and employers to purchase) policies that cost less than certain threshold amounts, beginning in 2018, the Act imposes a 40 percent excise tax on coverage providers providing plans which cost over a certain threshold amount. The tax is on the amount of the "excess benefit" over the annual threshold amount.**

40 Percent Excise Tax. Effective January 1, 2018, a 40 percent nondeductible excise tax is imposed on each coverage provider for its applicable share of the excess benefit with respect to employer-sponsored coverage during the applicable tax period.

"Covered Provider." A "coverage provider" is:

- The health insurance issuer, if the applicable coverage is insured group coverage;
- The employer, if the applicable coverage is an HSA or Archer MSA arrangement under which the employer makes contributions; or
- The plan administrator, in all other cases.

How the Tax Is Calculated. In plain English, the tax is imposed monthly on the amount by which the monthly cost of the applicable employer-sponsored coverage for the employee exceeds $1/12^{th}$ of the applicable annual limit.

"Applicable Annual Limits." For 2018, the "annual limits" will be:

- For Employee-only coverage: $10,200 multiplied by the applicable "health cost adjustment percentage"; and

[6] IRS News Release 2010-96 (September 7, 2010) discusses the credit and includes a draft of Form 8941. A final version of the form with instructions will be issued later this year.

- For Family coverage:[7] $27,500 multiplied by the applicable "health cost adjustment percentage."

"Health Cost Adjustment Percentage." The "health cost adjustment percentage" is a formula designed to increase the two annual limits in case the actual cost of health care between 2010 and 2018 outpaces projected growth in health care costs during the period.[8] There is also a separate age and gender adjustment under which the annual limits are increased based upon the cost of the standard Blue Cross/Blue Shield benefit option under the federal employee health plan for the type of coverage provided if priced for the age and gender characteristics of the employer's workforce. In addition, the annual limits are also increased for qualified retirees and employees in certain "high-risk professions" such as law enforcement, firefighting, paramedics, longshoremen, construction, mining, agriculture, forestry and fishing. These limits will be indexed for inflation in future years.

Burden on the Employer. The Act requires each employer to calculate the amount of the excess benefit subject to the tax and the applicable share attributed to each coverage provider. Employer must also notify the IRS and each coverage provider of the amounts allocated. The IRS has been charged with drafting regulations discussing these calculations and information reporting requirements.

QUESTION 20

SO WHAT DOES THE FUTURE HOLD FOR HEALTH CARE REFORM?

Answer: **That's easy – much, much uncertainty.**

Some Predictions. Gazing into the crystal ball, we foresee—

- Grandfathered plans will lose that status sooner rather than later
- Covering more people under health plans and providing them with more and better coverage (mandated benefits, elimination of pre-existing conditions and annual/lifetime limits) will drive up the costs of coverage
- Advances in medical technology will continue to drive up costs
- Insurance companies will increase their health plan premiums
- Increased costs (including compliance costs) will cause many employers, particularly smaller-sized employers, to drop their health plans
- Increased medical costs will inevitably lead to some form of rationing (although it will go by some other, less callous sounding term)

[7] Family coverage is any coverage other than employee-only coverage.

[8] The health cost adjustment percentage equals 100 percent, plus the excess (if any) of: (a) the percentage by which the per-employee cost of the standard Blue Cross/Blue Shield benefit option under the federal employee health plan for 2018 exceeds the cost of such coverage for 2010; over (b) 55 percent.

- There's an outside chance that health care reform may not survive the constitutional challenge that has been launched by a number of states regarding the individual mandate (which is one of the linchpins of the entire health care reform system)
- Health care reform is unlikely to escape the upcoming Congressional and presidential elections unscathed

In Closing. As can be seen from just this brief discussion, the Act will have a sweeping effect on the way employer-based health care is provided and paid for in the U.S. There are many unanswered questions, and the various government agencies charged with oversight are hurriedly drafting regulations and other guidance. Time will tell what the true impact will be and whether the Act will survive in the form originally envisioned by its drafters. Meanwhile, employers and their advisors should keep up to date on changes that will affect their plans and the deadlines to implement the changes. As with so many other things in the tax and benefits arena, proper planning and execution will prevent potential problems before they arise.

HEALTH CARE REFORM GUIDANCE

Important Websites

- **IRS Guidance:** http://www.irs.gov/newsroom/article/0,,id=222814,00.html
- **Healthcare.gov Home Page:** http://www.healthcare.gov/
- **DOL Guidance:** http://www.dol.gov/ebsa/healthreform/

Present IRS Guidance

News Releases

- IR-2010-96, IRS Releases Form to Help Small Businesses Claim New Health Care Tax Credit
- IR-2010-95, IRS Issues Guidance Explaining 2011 Changes to Flexible Spending Arrangements
- IR-2010-79, IRS Requests Public Input on Expanded Information Reporting Requirement
- IR-2010-76, IRS Begins Accepting Applications for Qualifying Therapeutic Discovery Project Program
- IR-2010-74, Affordable Care Act Provides Expanded Tax Benefit to Health Professionals Working in Underserved Areas
- IR-2010-73, IRS Issues Regulations on 10-Percent Tax on Tanning Services Effective July 1
- IR-2010-69, Recent Legislation Offers Special Tax Incentives for Small Businesses to Provide Health Care, Hire New Workers
- IR-2010-63, Offers Details on New Small Business Health Care Tax Credit
- IR-2010-53, Tax-Free Employer-Provided Health Coverage Now Available for Children under Age 27
- IR-2010-48, IRS Reaches Out to Millions of Employers on Benefits of New Health Care Tax Credit
- IR-2010-38, New for 2010: Tax Credit Helps Small Employers Provide Health Insurance Coverage

Legal Guidance

- Notice 2010-59, IRS Issues Guidance Explaining 2011 Changes to Flexible Spending Arrangements
- Revenue Ruling 2010-23 obsoletes Rev. Rul. 2003-102, prior guidance on reimbursing expenses for over-the-counter drugs from employer health plans.
- Notice 2010-51, Information Reporting Under the Amendments to Section 6041 for Payments to Corporations and Payments of Gross Proceeds and With Respect to Property
- REG 118412-10, Group Health Plans and Health Insurance Coverage Rules Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act

- TD 9489, Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act
- TD 9486, Indoor Tanning Services; Cosmetic Services; Excise Taxes
- Notice 2010-39, Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals
- TD 9482, Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under the Patient Protection and Affordable Care Act
- Notice 2010-44, Tax Credit for Employee Health Insurance Expenses of Small Employers
- Notice 2010-38, Tax Treatment of Health Care Benefits Provided With Respect to Children Under Age 27
- Revenue Ruling 2010-13, Section 45R—Average premium for small group market for determining the small employer health insurance credit

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