Claremont Management Group Presents
Employers and the New Healthcare Bills
May 20, 2010

By

DAVID D. SCHEIN, President and General Counsel,
Claremont Management Group, Inc.

Patient Protection and Affordable Care Act (PPACA), HR 3590, March 23, 2010, and the Health Care and Education Tax Credit Reconciliation Act of 2010, HR 4872 (Sidecar Bill), March 30, 2010.

Major changes to healthcare system in the US. Expect $10B to $20B impact on taxes over ten years. While "Affordable" is in the title, PPACA is almost certain to increase the cost of healthcare itself.

Very complex and one way to review the bill is a timeline of expected impact on employers.

2010:

Bill signed on March 23, 2010. So, immediate issues follow:

- "Grandfathered" plans are in effect on this date. Do not make major changes to your plan or you may lose this status and will have to comply with more mandates at an earlier date.
- Small business tax credit – Must pay at least half of premium, have no more than 25 FTE employees with average wages less than $50,000. Maximum credit for employers with 10 or fewer employees. Must include all related businesses of employer. Partners, sole proprietors, 2% owners of S corp. or 5% of other corps are not eligible. Credit is 35% of the premiums or 25% for non-profit businesses. Compare to deduction.
- Break time and separate area for recent mothers to express breast milk required. Cannot be the bathroom. Up to one year following birth of child. Employers with less than 50 employees may plead "undue hardship."
- Bars excessive waiting periods – over 6 months suggested as example.

- Amends FLSA to add Section 18c for whistle-blower protection for compliance issue with PPACA.
- No rescission of coverage except where fraud or intentional misrepresentation occurs.

June 21, 2010:

- Uninsured for six months or more with pre-existing condition have immediate access to healthcare insurance, although this ends when state exchanges are operating. Cannot drop coverage to get this new coverage.
- Early Retiree health care reimbursement of 80% of the cost where it exceeds $15,000 up to $90,000 per year for ages 55-64 and not eligible for Medicare. Ends in 2014 or when $5B has been used up.

July 1, 2010:

- 10% Indoor tanning parlor tax.

September 23, 2010:

"Plan years" starting after this date. (May not be "policy year.")

- All plans, including Grandfathered plans:
- No Lifetime plan limits on "Essential Benefits" – Still undefined, but we know it includes:
    - Emergency services
    - Hospitalization
    - Ambulatory patient services
    - Maternity and newborn care
    - Mental health and substance abuse services
    - Prescription drugs
    - Rehabilitative services
    - Laboratory services
    - Preventive and wellness services
    - Chronic disease management
    - Pediatric services – including oral and vision care for children

- Annual limits are restricted to non-essential benefits.
- No rescission of coverage except where fraud or intentional misrepresentation occurs.

- If a plan covers dependent children, it must continue to do so for unmarried and married children until age 26. For Grandfathered plans, the age 26 limit only applies if the child is not eligible for other coverage. This exception ends in 2014.

  PPACA added to Internal Revenue Code Section 105 dependents that may now be covered under a group health plan on the same non-taxable basis — any son, daughter, stepson, stepdaughter, eligible foster child, or adopted child of the employee who is age 26 or younger for the entire calendar year unless they have employer-provided coverage already.

- For children under age 19, plans cannot have a pre-existing condition exclusion.

For plans that are not Grandfathered, additional requirements:

- The non-discrimination tests that previously applied only to self-insured plans now apply to fully-insured plans.
- First-dollar coverage must be available for preventive care.
- If emergency services covered, must not require pre-approval and must cover them at the in-network level of benefits.
- If “primary care providers” required, covered person may designate any doctor available to accept that person. For child, must be able to designate an in-network pediatrician.
- Ob/Gyn – no pre-certification needed for services, nor requirement that an Ob/Gyn provide referral.
- Watch signing CBA’s that run into 2014, when full effect of the PPACA is felt.
- New appeals procedure for plan and undefined external review.

2011:

- Over-the-counter medicines or drugs are not eligible for reimbursement under a Health FSA, HRA or HSA without a doctor's prescription.
- The excise tax for non-medical HSA distributions increases from 10 percent to 20 percent.
- Cafeteria plan rules changed to make it easier for small businesses to implement them. The Subsection 125 nondiscrimination rules do not apply for cafeteria plans. Eligible employers must have 100 or less employees during either of the two preceding years.

- Employers report on W-2 employer cost of healthcare premiums.

2012 (March 23):

- The plan administrator (self-insured plans) or the insurance carrier (fully-insured plans) must give a coverage summary to all applicants and enrollees, at initial enrollment and open enrollment. This is in addition to the Summary Plan Description (SPD). HHS will provide standards by March 23, 2011. The document can be no more than four pages long and address covered benefits, exclusions, cost sharing and continuation. A $1,000 penalty applies for each failure to provide.

2013:

- Contributions are capped at $2,500 each year for Flexible Spending Accounts.
- Employees with annual income of $200K, or couples with $250K, have increased FICA tax of 0.9% of wages.
- Elimination of 28 percent subsidy on the costs for Medicare Part D that employers have received.
- Health insurance company executive compensation will not be deductible over $500K per year, had been $1MM previously. Covers all insurers, private and public.

2014:

- Group health plans and insurance carriers may not impose any annual limit. Lifetime limit already in place.
- Each state to set up a health insurance exchange
- Small employers of up to 100 employees may participate in the Health Exchange until 2017. Before 2016, a state may cap participation to employers with 50 or fewer employees.
- Plans cannot have any Pre-existing condition exclusions.
- The PPACA basically codifies existing HHS HIPAA regulations regarding wellness programs. The maximum incentive amount for a wellness program is increased from 20 percent to 30 percent of plan cost, and the government has discretion to increase it to 50 percent.
- Out-of-pocket (OOP) expenses and deductibles cannot exceed those applicable with the HSA-eligible high-deductible health plans.

- Maximum coverage waiting period is 90 days or less.
- Individuals who do not enroll in qualifying coverage are subject to an excise tax. They generally pay the greater of a flat dollar amount (2014: $95, 2015: $325, 2016 and beyond: $695) or a percentage of income (2014: one percent, 2015: two percent, 2016 and beyond: 2.5 percent). There is a hardship exemption for those with incomes below a certain level.
- Employers with 200 or more full-time employees must automatically enroll all new hires. All employers must provide an Exchange-related notice to new hires. Failure to provide health coverage results in a monthly penalty equal to 1/12 of $2,000 after disregarding the first 30 employees. Premium credit penalty is $3,000 or $2,000 per employee.
- Free choice vouchers introduced for employees with incomes less than 400% of poverty level. Allows them to take voucher to buy alternative insurance from exchanges to be established. The money from employer will be tax deductible as if paid for health insurance.

2018:

- A 40 percent tax is imposed on the monthly value of coverage over 1/12 of $10,200 (single) and 1/12 of $27,500 (family) coverage, indexed to the CPI plus one percent in 2019, then simply CPI thereafter. Allowances are made for retiree coverage, multiemployer plans and high cost states.