



Health Care Reform and What it Means For Your Business

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Presented by:
Mark A. Smith, Esq.
msmith@barley.com
(717) 399-1526

Impact of the Patient Protection and Affordable Care Act (PPACA) on Employers and Employer Plans

- Establishment of State-by-State Exchanges
- Individual Responsibility
- Employer Responsibility
- Plan Coverage and Insurance Reform Mandates
- Tax Law Changes - \$437 Billion in new taxes, fees & penalties



Health Care Exchanges

- PPACA requires that by January 1, 2014, each state must establish an “American Health Benefits Exchange”
- The Exchange is to be a governmental or non-profit entity established to facilitate the purchase of “Qualified Health Plans” by eligible individuals and small employers (100 or fewer employees)
 - Beginning in 2017, states may open up Exchanges to large employers



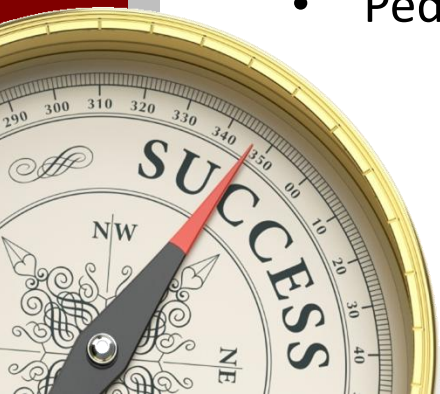
A “Qualified Health Plan” is a Plan That...

- Is certified by the Exchange through which it is offered
- Provides what PPACA defines as an “Essential Health Benefits Package”
- Is offered by a health insurance issuer that satisfies various requirements
- Provides limits on patient cost sharing keyed off of the HDHP annual out-of-pocket limits (\$5,950/\$11,900 single/family in 2010)
- Offers at least two tiers of plans,
 - a “silver” plan that covers at least 70% of the costs of the benefits
 - and a “gold” plan that covers at least 80% of the costs of the benefits
 - and may also offer a “bronze” (60%) plan and a “platinum” (90%) plan



Essential Health Benefits Include...

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn services
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitation services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including oral and vision care



Individual Responsibility

- Effective January 1, 2014, individuals who do not maintain “minimum essential coverage” for themselves, their spouses and dependents will be assessed a “shared responsibility penalty”, collected through the annual income tax return
- What will constitute minimum essential coverage?
 - Coverage under eligible employer-sponsored plans
 - Coverage purchased in the individual market (e.g., through an Exchange)
 - Certain governmental programs (Medicare, Medicaid, CHIP, TRICARE, VA)



Exceptions to the Applicability of the Shared Responsibility Penalty

- Household income less than threshold for filing a Federal return (e.g., \$26,000 for joint filer, two children in 2010)
- Cost of coverage exceeds 8% of household income
- Coverage gaps of <3 months
- Prisoners, certain religious groups, persons not lawfully present in U.S., Indian tribe members



What is the individual penalty?

The penalty will actually be calculated monthly for each month without coverage, but on an annual basis the penalty for not having minimum essential coverage will be the greater of:

- A flat dollar amount per individual 18 and older (\$95 in 2014, \$325 in 2015, \$695 in 2016, adjusted for inflation thereafter); plus 50% of the flat dollar amount per individual under 18, but capped at 300% of the flat dollar amount; or
- A percentage of household income in excess of the income threshold for having to file a federal return for the applicable family size

- The percentage of household income is 1% in 2014, 2% in 2015, and 2.5% thereafter. But the penalty cannot exceed the national average premium for a “bronze” level plan



Individual Penalty Example

- So, once the penalty is fully phased in, a husband, wife, and two minor children, with household income of \$60,000 and with no coverage, will pay a penalty equal to \$2,085, which is the greater of
 - 300% of \$695 (=\$2,085), or
 - 2½% of (\$60,000 - \$26,000) (=\$850)
- Note: the penalty cannot exceed the national average cost of bronze level coverage



Federal Premium Assistance Tax Credit for Low Income Individuals

- Beginning in 2014 when the above shared responsibility penalty begins to apply, PPACA also creates a new premium assistance tax credit to assist low income individuals in paying for coverage obtained through an Exchange
- The premium tax credit is available to those whose household incomes are below 400% of the Federal Poverty Level (FPL)



2010 FPL Guidelines

Family Size						
% of FPL	1	2	3	4	5	6
100%	\$10,830	\$14,570	\$18,310	\$22,050	\$25,790	\$29,530
133%	\$14,404	\$19,378	\$24,352	\$29,326	\$34,301	\$39,275
200%	\$21,660	\$29,140	\$36,620	\$44,100	\$51,580	\$59,060
300%	\$32,490	\$43,710	\$54,930	\$66,150	\$77,370	\$88,590
400%	\$43,320	\$58,280	\$73,240	\$88,200	\$103,160	\$118,120



Federal Premium Assistance Tax Credit for Low Income Individuals

Continued

- The concept on which the credit operates is that the low income individual is expected to devote a certain percentage of household income to paying for health insurance
 - This percentage increases as the level of income increases.
 - The amount of the credit an individual will receive is the cost of silver coverage under the Exchange, minus the dollar amount the individual is expected to be able to devote to health care coverage
- Example:
 - Persons with household incomes up to 133% of FPL are expected to devote 2% of income to health insurance, whereas persons with household incomes between 300% and 400% of FPL are expected to devote 9.5% of their income to pay for health insurance



More Examples

- If silver family coverage costs \$10,000 per year, and family of four has household income of \$29,325, putting it at 133% of the FPL, it would be expected to devote 2% of \$29,325, or \$586.53, to pay for the coverage, and the balance of the cost, \$9,413.47, would be paid as a tax credit
- If the same family of four has household income of \$66,150, putting it at 300% of the FPL, it would be expected to devote 9.5% of \$66,150, or \$6,284.25, to pay for coverage, and the balance of the cost, \$3,715.75, would be paid as a tax credit



Federal Cost Sharing Reduction for Low Income Individuals

- Cost sharing refers to the amounts the insured pays out of pocket for insured care—e.g., co-payments, co-insurance, deductibles
- Under PPACA, the federal government will subsidize a portion of these cost sharing amounts for low-income individuals
- To be eligible for the cost sharing subsidy, the individual must:
 - enroll in a silver level plan (i.e., one where the plan covers 70% of the costs) through the state Exchange
 - have household income between 100% and 400% of FPL



Federal Cost Sharing Reduction for Low Income Individuals

Continued

- The effect of the cost sharing subsidy is that the eligible individual, though enrolled in a silver plan where 30% of the costs are to borne by the insured and 70% by the plan, will in fact have the plan bear more than 70% of costs
- The size of the subsidy decreases as income increases from 100% of FPL to 400% of FPL
- The subsidy is paid to the insurer by HHS, to, in effect, “buy down” the cost sharing level



Employer Responsibility

- An employer (determined by combining separate businesses under common ownership or control) with less than 50 full time equivalent (FTE) employees is subject to no penalty if it does not provide health care plan coverage
- In fact, a small employer, with less than 25 FTE employees and average annual wages less than \$50,000 may qualify for a tax credit (beginning in 2010) of up to 35% of the employer cost of coverage if it offers, or continues to offer, health care coverage to employees.



What is a full time employee?

- A full time employee is an employee working 30+ hours per week. In any month, an employer's FTE employee count is its number of full time employees plus the total hours in the month worked by part time employees divided by 120
- FTE Calculation Example: In a given month, Employer A has 40 employees who worked in excess of 30 hours per week, and 20 employees who worked part time putting in a total of 1800 hours. This employer's FTE workforce for the month is $40 + (1800/120)$, which totals to 55



Employer “Free Rider” Penalty

- Beginning in 2014, an employer with 50 or more FTE employees that does not provide health care coverage to full time employees must pay an annual non-deductible excise tax penalty if any full time employee not offered coverage receives a federal cost sharing reduction or premium assistance credit to purchase coverage in an Exchange
- Employees not eligible for workplace coverage and who have household incomes up to 400% of the federal poverty level will most likely qualify for one or both of these sources of federal assistance to help pay for coverage through an Exchange



Employer Free Rider Penalty Calculation

- The “Free Rider” penalty is calculated monthly, but on an annual basis it is \$2,000 x the number of FTE employees in excess of 30
- Example: Employer A has 60 FTE employees and provides no coverage, and has at least one employee who qualifies for federal premium assistance or cost sharing reduction. The annual non-deductible excise tax penalty Employer A must pay is $\$2,000 \times 30 = \$60,000$



Employer “Opt Out” Penalty

- In addition, beginning in 2014, employers with 50 or more FTE employees that do offer their health care plan coverage, may nonetheless have to pay a non-deductible excise tax penalty if:
 - An employee opts out of the coverage because it is too expensive (i.e., it costs the employee more than 9.5% of the employee’s income)
- or*
- An employee opts out of the coverage because the portion of the cost borne by the employer is less than 60% of the total cost, and the opt-out employee gets Federal premium assistance or cost sharing reduction to help him/her buy coverage through an Exchange



In such opt out cases, what is the employer penalty?

- The penalty is determined monthly, but on an annual basis it is $\$3,000 \times$ the number of opt-out employees who get a tax credit or a cost sharing subsidy to buy Exchange coverage (but in no case could the penalty be more than what the employer would have paid if it offered no coverage, i.e., $\$2,000 \times$ the number of FTE employees in excess of 30)
- Example:
 - Employer A has 100 FTE employees and offers them coverage that costs 50 of them more than 9.5% of income. These 50 all opt out of the employer coverage and qualify for a tax credit to buy Exchange coverage. The employer annual opt out penalty would ordinarily be $50 \times \$3,000 = \$150,000$. However, this is in excess of $\$2,000 \times 70 = \$140,000$ (the penalty had there been no coverage offered at all), so the applicable penalty will be $\$140,000$



Free-Choice Vouchers

- Finally, beginning in 2014, if an employer of any size offers coverage and it has employees who meet three requirements:
 1. The employee contribution for the employer coverage is greater than 8% of household income and not greater than 9.8%
 2. The employee's household income is not greater than 400% of the FPL
 3. The employee declines the employer coverage,
 - then the employer is required to make available to the employee a "voucher" that the employee can use to buy coverage in the Exchange



Free-Choice Vouchers

Continued

- The monthly amount of the voucher is the monthly amount the employer would have paid for the employee's coverage had he/she enrolled in the employer plan where the employer pays the largest portion of the plan costs
- The amount of the voucher is tax deductible by the employer and excludable from the employee's income
- The voucher amount is paid by the employer to the Exchange, where the employee uses it to "buy" Exchange offered coverage
 - Any excess is refunded to the employee



Small Employer Tax Credit

- PPACA also provides an incentive to small employers to offer coverage to their employees—a tax credit to cover part of the employer cost
 - The credit is available now, beginning in 2010
 - An eligible small employer is one with fewer than 25 FTE employees, and average annual wages less than \$50,000, and that pays at least 50% of the cost of the coverage



Small Employer Tax Credit

Continued

- The maximum credit currently is 35% of the employer's cost of providing the coverage (25% for a tax-exempt employer)
 - This maximum is available to employers with 10 FTE employees and average annual wages of \$25,000
- Employer's cost of coverage cannot exceed what employer would have paid if all employees were in a plan that had the average premium in the state for small group market plans
 - (For PA for 2010, \$5,039 for single coverage; \$12,471 for family coverage)
- As the FTE employee count ranges from 10 to 25, and the average wage ranges from \$25,000 to \$50,000, the size of the available credit decreases proportionately
- The credit is not a refundable credit for a taxable employer, so it can only be realized as an offset against income taxes owed
 - For tax exempt small employers, it is a refundable credit



Automatic Enrollment by Large Employers

- Employers with more than 200 full time employees must automatically enroll eligible full time employees in the employer plan at end of any permitted waiting period
- But, at same time, the employee has to be given the right to opt out and opportunity to do so
- Effective date is March 23, 2010; but statute states this requirement applies “in accordance with regulations” promulgated by the DOL. So as a practical matter, this will not apply until implementing regulations are issued



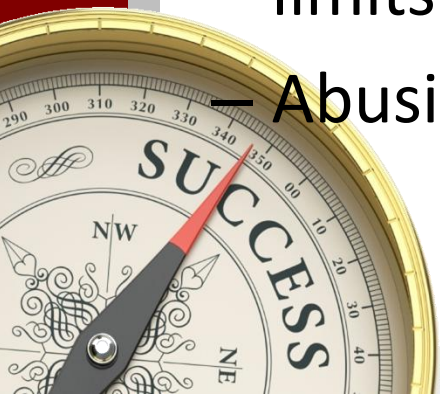
Plan Coverage and Insurance Reform Mandates

- PPACA treats employer health plans in effect on March 23, 2010 as “grandfathered.” The initial concept was that grandfathered plans would be exempt from having to adopt the new law’s coverage and benefits mandates and rules that follow below
- This grandfathered plan concept was materially eroded as the legislation developed, with the end result that many of the mandates apply to all plans, grandfathered (“GF”) and non-grandfathered (“non-GF”) alike. The summary below indicates when a grandfathered plan exemption applies



Grandfathered Plan Status

- What is a Grandfathered Plan? – must be in existence as of March 23, 2010
- What causes a plan to lose its grandfathered status?
 - Elimination of benefits, Increase in cost-sharing
 - Decrease in contribution rate, Changes in annual limits
 - Abusive transactions,



Effective for Post-9/22/10 Plan Years

- Coverage of adult children to age 26
 - Applies generally to GF and non-GF plans
 - Extends even to married children, up to age 26
 - Does not extend to children of children or to spouses of children
 - A GF plan, until 2014, need not cover adult children if they are eligible for another employer plan
 - There is also a change in the tax treatment of employer-provided coverage to adult children who are not tax dependents. Effective now, such coverage is excludable from the parent's income up to age 27



Effective for Post-9/22/10 Plan Years

Continued

- For enrollees under age 19, no pre-existing condition exclusions permitted
 - Applies to GF and non-GF plans
 - Beginning in 2014, this expands to a blanket prohibition on pre-existing condition exclusions
- Lifetime and annual dollar limits prohibited
 - Applies to GF and non-GF plans
 - Plans cannot place a life lifetime dollar cap on the value of essential health benefits to any enrollee
 - 2011-2013 annual dollar limits on essential benefits will continue to be permitted on a limited basis, to be defined by HHS
 - After 2013, annual dollar limits on essential benefits will be prohibited



Effective for Post-9/22/10 Plan Years

Continued

- Rescinding the coverage of an enrollee (other than for fraud or misrepresentation) is prohibited
 - Applies for GF and Non-GF Plans
- Required coverage for certain “preventive care” – with no cost sharing (deductibles, co-insurance, co-pays)
 - GF plans are exempt from this requirement
 - Examples include immunizations, child/well baby care, mammography
- Highly compensated employee non-discrimination rules for self-insured plans to also apply to insured plans
 - GF insured plans are exempt from this requirement
 - The penalty for this insured plan discrimination, however, will be \$100/day participant, rather than the taxation of discriminatory medical reimbursements that applies to discriminatory self-insured plans



New Mandated Patient Rights Effective for Post-9/22/10 Plan Years

- If emergency services are covered, they cannot be subject to special requirements and costs different from those applied to in-network participating providers
- If OB/GYN services are covered, female participants are required to have direct access without requirement of referral or authorization
- Where there is a requirement that a participant have a primary care provider, the participant cannot be assigned; must be given a choice among any participating primary care provider who is available; must also permit participant choice of pediatrician for covered children among all available participating pediatricians; must also permit female participant choice of participating OB/GYN as primary care provider

- Does not apply to GF Plans



New Mandated Patient Rights

Continued

- Plans must have internal and external claims review process, with an external “ombudsman” office set up specifically to assist claimants with appeals of denied claims
 - Does not apply to GF plans



Effective in 2012...

- New “Uniform Explanation of Coverage” requirement
 - Applies to GF and non-GF plans
 - In addition to ERISA SPD requirement; must be provided at time of enrollment
 - Requires “culturally and linguistically appropriate” language be used
 - Maximum – 4 pages
 - Penalty - \$1,000 per failure per enrollee



Effective in 2012...

Continued

- Advance Notice of Material Modifications
 - Applies to GF and Non-GF plans
 - Not later than 60 days before becoming effective, any material modification to coverage must be communicated to covered individuals
 - Applies in addition to ERISA SMM requirement
 - Same penalties as for Uniform Explanation of Coverage



Effective in 2012...

Continued

- Quality Reports
 - Applies to Non-GF plans
 - Plan is to prepare an annual report for HHS (and to be delivered to enrollees at open enrollment) on plan quality initiatives and efforts, such as programs to improve outcomes and reduce re-admissions, and proactive wellness initiatives
 - HHS required to provide implementing regulations no later than March 23, 2012, so actual effective date could be earlier or later



Effective in 2013...

- New Employee Health Care Notice Required by FLSA
 - Effective date is March 1, 2013; applies to GF and non-GF plans
 - Notice must inform employees of:
 - Available (or to be available) health care Exchanges
 - The employee's rights to possible federal premium tax credit or cost sharing reduction to help with coverage through the Exchange if the employer covers less than 60% of the cost of coverage for employees



Effective in 2014...

- No pre-existing condition exclusions (in 2011, this began to apply for children under 19)
 - GF and non-GF plans
- Maximum enrollment waiting period of 90 days
 - GF and non-GF plans
- Employers with a health care plan required to provide “Free Choice” vouchers to eligible employees
 - GF and non-GF plans



Effective in 2014...

Continued

- Annual Cost Sharing Restrictions (Deductibles, Co-pays, Co-Insurance)
 - Cannot exceed \$11,900 for family coverage; \$5,950 for single (these are 2010 \$; will be indexed)
 - Non-GF plans only
- Clinical Trial Coverage
 - Requires coverage for participation in clinical trials relating to life threatening diseases
 - Non-GF plans only



Effective in 2014...

Continued

- Wellness Program Participation Cost Sharing Discounts
 - Employer can offer employees up to a 30% premium share discount for participation in wellness initiatives
 - By regulation, HHS can increase this permitted discount to 50%
 - Non-GF plans only



Tax Law Changes Effective in 2010 and 2011

- W-2 Reporting of Employer Health Care Coverage
 - The value of employer provided health care coverage must be reported as an informational item on the employee's W-2
 - Does not mean the value is now part of the employee's taxable income; merely that the value must be computed and reported
- OTC Drugs no longer reimbursable under FSAs, HRAs, HSAs
- Excise tax for nonmedical withdrawals from HSAs and Archer MSAs, increased to 20%
- Employer provided coverage of non-dependent adult children up to age 27 is excludable from the employee's income (effective in 2010)



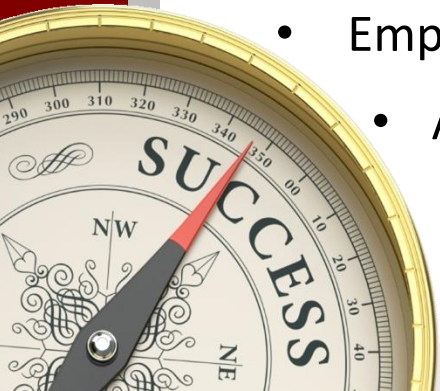
Effective in 2012...

- For policy years/plan years ending after 9/30/12, a fee is imposed on plans to fund “Participant Centered Outcomes Research Trust Fund” for study of comparative effectiveness research
 - For first applicable year, fee is \$1 times average number of covered lives
 - For second applicable year, fee is \$2 times average number of covered lives
 - Thereafter, up to 2019, fee is indexed under a statutory formula
 - For insured plans, payable by the insurer; for self-insured plans payable by the plan sponsor (typically the employer)



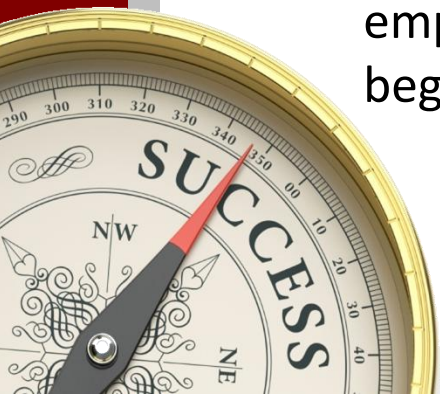
Effective in 2013...

- Additional Medicare payroll tax to be paid by high income employees
 - For wages in excess of \$200,000 (single filers) or \$250,000 (married filing jointly), Medicare tax jumps to 2.35% from 1.45%
 - Employer Medicare tax stays at 1.45% on all income
- New Medicare Tax on investment income
 - Tax is 3.8% of the lesser of net investment income or the excess of modified adjusted gross income over \$200,000 for single filers; over \$250,000 for joint filers
- Employer deduction for Medicare Part D subsidy eliminated
- Annual Cap on Salary Reduction Health FSAs reduced to \$2,500



Effective in 2014...

- New detailed financial reporting to IRS and individual about health care coverage
 - Applies to employers with plans and to insurers
 - Reported information to include portion of premium paid by employer
 - Separate reporting requirement relating to any situation where required employee contribution exceeds 8% of employee's wages
- Employer "Free Rider" excise tax, imposed on 50 FTE employers with no coverage, begins to apply
- Employer "Opt Out" excise tax, imposed on employers with 50 FTE employees with coverage that is unaffordable or inadequate, begins to apply



Effective 2018...

- New “Cadillac Plan” tax
 - If aggregate value of the health plan coverage to an employee exceeds \$10,200 (single) or \$27,500 (family), the excess is subject to a 40% non-deductible excise tax value
 - Tax paid by insurer for insured coverage and by plan administrator or employer otherwise



Other PPACA Provisions Worthy of Note

- Early Retiree Medical Reinsurance
 - Of interest to employers covering early retirees under retiree medical plans
- Part D Subsidy Deduction Phase-out
 - Employers getting subsidy for retiree prescription coverage lose deduction in 2013 for subsidy amount
- “Simple” Cafeteria Plans
 - Employers with ≤ 100 employees can set up a safe harbor cafeteria plan beginning in 2011
- Community Living Assistance Services and Supports (CLASS) Act
 - National voluntary long term care insurance program established effective in 2011
 - Employers to elect whether they will offer it via payroll deduction

