

# Health Reform

## How Will Health Reform Impact Employers Through 2012?

Know the provisions that impacted employers in 2010 and provisions that will impact employers through 2012.

President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which is transforming the current model for employer-sponsored health coverage. Below is a summary of provisions that impacted employers in 2010 and provisions that will impact employers through 2012.

### March 23, 2010

#### Nursing Mothers

Employers must provide a reasonable break time for employees who are nursing mothers to express breast milk, for a period of one year following the birth of the child. The employer must provide a place that is shielded from view and free from intrusion from co-workers and the public. A bathroom is specifically excluded as an appropriate place. Employers are not required to pay employees during the time they are expressing breast milk unless mandated under state law; however, nursing mothers must be compensated for break time in the same manner as other employees are compensated for break time. Also, employers with fewer than 50 employees may be exempt from this requirement if it causes an “undue hardship.” This is determined by looking at the difficulty or expense of compliance for a specific employer in comparison to the size, financial resources, nature or structure of the employer’s business.

### March 23, 2010

#### Small Business Tax Credit

For taxable years beginning March 23, 2010, through Dec. 31, 2013, small employers will receive a tax credit of up to 35 percent of the employer’s contribution toward the employee’s health insurance premium if the employer contributes at least 50 percent of the total premium cost or 50 percent of a benchmark premium. If the small business is a nonprofit, the tax credit equals 25 percent instead of 35 percent.

A small employer is defined for purposes of the tax credit as an employer with fewer than 25 full-time equivalent (FTE) employees with an average annual wage amount of less than \$50,000. FTE employees include leased employees, but do not include seasonal workers (unless the seasonal workers work more than 120 days per year).

There are other types of employees who are not included, including a sole proprietor, a partner in a partnership, a shareholder owning more than 2 percent of an S corporation and any owner of more than 5 percent of other businesses. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. The credit phases out as firm size and average wage increases, resulting in a partial credit for employers exceeding 10 employees and average annual wages exceeding \$25,000.

## June 29, 2010

### Retiree Reinsurance Program

The U.S. Department of Health and Human Services (HHS) established a temporary reinsurance program to provide reimbursement to employment-based plans for a portion of the cost of providing health insurance coverage to early retirees who are age 55 and over, but not eligible for Medicare. An employer must submit an application to HHS for participation in the program. Claims between \$15,000 and \$90,000 will be reimbursed, with certain conditions. The program will end upon the earlier of Jan. 1, 2014, or when the funding runs out. Due to limited funds, HHS is not accepting applications for the program after May 5, 2011.

## September 23, 2010

### Insurance Reforms

Effective for plan years beginning on or after Sept. 23, 2010, the following insurance reforms should be included within the policy.

**Lifetime limits** — All fully insured, self-insured and grandfathered plans must remove lifetime limits on the dollar value of essential benefits for any participant or beneficiary. A plan is required to give written notice that lifetime limits on benefits no longer apply, and that an individual to whom the limits had applied, if still covered, is once again eligible for benefits under the plan. Further, if the individual is not enrolled in the plan, or if an enrolled individual is eligible for, but not enrolled in, any benefit package under the plan, then the plan must also give this individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notice and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after Sept. 23, 2010.

**Annual limits** — All fully insured, self-insured and grandfathered group plans will be restricted as to the annual limit that can be placed on the dollar value of essential health benefits. The minimum annual limit in 2010–2011 is \$750,000. The amount increases in 2012 and 2013 to \$1.25 million and \$2 million respectively. Annual limits will be completely prohibited in 2014.

**Ban on rescissions of coverage** — All fully insured, self-insured and grandfathered plans are prohibited from rescinding coverage, except in the case of fraud or an intentional misrepresentation of a material fact.

**Adult dependent coverage to age 26** — All fully insured, self-insured and grandfathered plans that provide dependent coverage must provide coverage for dependents until the age of 26. The dependent may be married or unmarried, and there is no requirement that the dependent be a student or live with the parents. The coverage requirement does not apply to spouses of adult dependents or their children (i.e., grandchildren of employee). For grandfathered plans only until 2014, the coverage requirement applies to dependents who do not have another source of employer-sponsored coverage. Plans may not vary benefits based on the age of a dependent except for dependents over the age of 26. Tax-exempt status of dependent coverage is extended through the end of the calendar year in which the dependent turns 26.

**Pre-existing condition coverage for individuals under 19 years of age** — The pre-existing condition coverage requirement applies to all fully insured, self-insured and grandfathered plans and applies to individuals under 19 years of age. This includes employees who may themselves be under age 19 and dependents of employees under age 19. PPACA also eliminated the ability of non-federal government plans to opt out of certain HIPAA requirements including pre-existing condition limitations, but HHS has announced that these will not be enforced for plan years beginning before April 1, 2011.

**Emergency services** — Fully insured and self-insured plans (other than grandfathered plans) must cover emergency services at in-network rates regardless of whether the provider is in-network or out-of-network and without prior authorization.

**Primary care physician** — Fully insured and self-insured plans (other than grandfathered plans) must permit enrollees to choose any in-network primary care physician or pediatrician when the plan requires a participant to designate a primary care physician.

**New coverage appeal process** — The new claims and appeals procedures apply to all non-grandfathered group health plans and have various effective dates depending on the appeal requirement. These changes will require all sponsors of non-grandfathered plans to revise their plan documents, summary plan descriptions (SPDs) and other communications to participants and beneficiaries. The claims and appeals procedures under Section 503 of ERISA will now apply to all non-grandfathered group health plans, regardless of whether a plan is subject to ERISA. The ERISA claims and appeals procedures are, however, modified. Additionally, plans must now have an external review process for claimants who have exhausted internal review procedures. The external review process must meet certain requirements as outlined in the regulations and in other recent guidance issued by the U.S. Department of Labor (Technical Release 2010-01). The specific requirements for state and federal external review processes are detailed and require coordination with independent review organizations.

**Preventive services mandates** — Fully insured and self-insured plans (other than grandfathered plans) must provide coverage for, and may not apply cost-sharing requirements for, certain preventive services, including: preventive items or services with an "A" or "B" rating in the current recommendations of the U.S. Preventive Services Task Force; immunizations; infant, children and adolescent screenings; and certain preventive screenings and care for women. To view a list of mandated preventive services, visit [www.healthcare.gov](http://www.healthcare.gov).

## September 23, 2010

### Nondiscrimination for Highly Compensated Individuals

This provision applies the Internal Revenue Code § 105(h) nondiscrimination rules (currently applicable to self-funded plans) to non-grandfathered fully insured plans. The effective date has been delayed until further guidance is released. At that time, the implementation will be prospective. Section 105(h) prohibits plans from establishing eligibility or benefit rules that discriminate in favor of highly compensated employees. Under Section 105(h), highly compensated individuals are those who are: among the five highest paid officers, shareholders owning more than 10 percent of the employer, and the highest paid 25 percent of employees. This provision prohibits fully insured executive-only carve-out plans that exclude lower-wage employees from eligibility. A fully insured plan found to be discriminatory under Section 105(h) of the Code will result in an excise tax equal to \$100 per day per individual discriminated against.

## 2011

### Wellness Grant Program

Employers with fewer than 100 employees who work 25 hours or more per week may be eligible for a federal grant to implement a wellness program. The employer must not have had an existing wellness program in place on the date of enactment, March 23, 2010. The employer must implement a wellness program that includes health awareness initiatives, efforts to maximize employee participation, initiatives to change unhealthy behaviors and lifestyle choices, and supportive environment efforts. The grant program runs through 2015 or until the \$200 million appropriation is exhausted. The grant program was initially slated to begin October 2010. As of the date of this publication, no grant program information has been released.

## January 1, 2011

### OTC Ineligibility for Reimbursement

Over-the-counter (OTC) drugs, medicines and biologicals will be ineligible for reimbursement from flexible spending accounts unless prescribed by a doctor. The change to OTC reimbursement applies to tax years (not plan years) beginning after Dec. 31, 2010. The effective date applies to when expenses are incurred.

## January 1, 2011

### Penalty for HSA Distributions Increases

Distributions from a Health Savings Account (HSA) that are not considered a qualified medical expense will be penalized at 20 percent, up from 10 percent, on an individual's income tax return.

## January 1, 2011

### Simple Cafeteria Plan Safe Harbor

As of Jan. 1, 2011, small employers (generally those with 100 or fewer employees) are allowed to adopt new "simple cafeteria plans." Plans may choose to exclude employees working less than one year, those younger than age 21, collectively bargained employees or nonresident aliens from participation. In exchange for satisfying minimum participation and contribution requirements, these plans will be treated as meeting the nondiscrimination requirements that would otherwise apply to the cafeteria plan. An employer must contribute a uniform percentage of a qualified employee's compensation (not less than 2 percent) or the lesser of 6 percent of the employee's compensation or twice the employee's contribution. A qualified employee is one who is not a key or highly compensated employee.

## January 1, 2012

### W-2 Reporting Requirement

Employers are required to report the aggregate cost of coverage under a group health plan, whether paid by the employer or the employee, in box 12 of Form W-2 using code DD. For most employers, the reporting requirement will apply to compensation earned in 2012 that is reported on W-2s furnished to employees in and after January 2013. The reporting requirement has no effect on the taxability of employees' coverage. Employers filing fewer than 250 W-2s in 2011 will not be required to comply with the reporting requirement before January 2014, but transitional relief for these employers may stretch beyond 2014. For fully insured plans, the aggregate cost is the total premium paid. For self-insured plans, the aggregate cost is determined using rules similar to those used for determining COBRA premiums. Aggregate costs include employer contributions to an HRA, but do not include employer or employee contributions to Archer MSAs or HSAs. They also do not include employee contributions to medical FSAs, long-term care, coverage provided under a multi-employer plan, coverage provided under a stand-alone dental or vision plan, and coverage provided under a self-insured plan that is not subject to any federal continuation coverage requirements (certain governmental entities, church plans or small employers not subject to COBRA).

## March 23, 2012

### Summary of Benefits

By March 23, 2012, plan administrators, sponsors and insurers must provide a summary of benefits and coverage explanation to participants prior to enrollment. The summary must be presented in a culturally and linguistically appropriate manner. The content and format is prescribed by statute, and standards will be developed by the Secretary of Health and Human Services. The summary must provide information about whether the plan meets the requirements of “affordability” and “qualified” for purposes of the tax credit available in 2014. Additionally, the summary must include uniform definitions of standard insurance terms and medical terms; a description of coverage and cost-sharing under the plan; exceptions, reductions and limitations on coverage; the plan’s cost-sharing provisions, including deductible, coinsurance, and copayment obligations; renewability and continuation of coverage provisions; a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions; a statement that the outline is a summary and that the plan document should be consulted to determine governing contractual provisions; and contact numbers and Web addresses where the actual group certificate or policy may be obtained.

## March 23, 2012

### Notice of Material Modification

If a group health plan or issuer makes any material modification in any of the terms of the plan or coverage involved that is not reflected in the most recently provided Summary of Benefits, the plan or issuer must provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

## March 23, 2012

### Employer Annual Reporting Requirements Regarding Quality of Care

Group health plans must provide an annual report to participants at open enrollment and to the Secretary of Health and Human Services regarding group health plan and health care provider reimbursement structures that improve the quality of care, including wellness and health promotion activities. The Secretary of Health and Human Services is required to develop reporting requirements and issue regulations by March 23, 2012.

## September 30, 2012

### New Federal Premium Fee

Effective for plans/policies ending after Sept. 30, 2012. Group health plans (self- and fully insured) will be assessed a fee of \$2 (\$1 in the case of plan years during fiscal year 2013) per average number of insured lives to finance a comparative effectiveness research program. This fee will be paid by the plan sponsor, which is the employer in the case of a single employer plan, an employee organization in the case of a plan established by such an organization, or associations, committees or trustees in the case of a VEBA, MEWA or other multiple employer plan. This fee will be indexed annually, and sunset for plan years ending after Sept. 30, 2019.

## Notice Requirements

In addition to the implementation dates described above, employers have notice obligations to consider. Employers should evaluate their plans to ensure the following notices are provided:

**Dependent coverage to age 26** — Children who become eligible for coverage due to the new extension of coverage to age 26 must be given at least a 30-day enrollment period following written notice of their eligibility. The notice must be sent no later than the first day of the plan year following Sept. 23, 2010, with coverage effective the first day of the plan year. This notice must be distributed with other enrollment materials (e.g., in an enrollment packet) and applies to both grandfathered and non-grandfathered plans. For more information, visit [www.dol.gov/ebsa/dependentsmodelnotice.doc](http://www.dol.gov/ebsa/dependentsmodelnotice.doc).

**Lifetime limits** — The Lifetime Limits Model Notice is to be used to provide written notice to participants informing them that a lifetime limit on the dollar value of all benefits no longer applies, and individuals whose coverage ended by reason of reaching a lifetime limit under the plan must be notified that they have 30 days in which to re-enroll. The notices and enrollment opportunities, similar to the Patient Protection Model Notice (see below), must be provided by the first day of the first plan year beginning on or after Sept. 23, 2010. Note, however, that the notice can be included with a plan’s enrollment materials (as opposed to in the SPD), provided the statement is prominent. This applies to both grandfathered and non-grandfathered plans. For more information, visit [www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc](http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc).

**Patient protections** — The Patient Protection Model Notice can be used to satisfy the requirement that non-grandfathered health plans and insurers provide notice to participants of their rights to choose a primary care provider or pediatrician from within the plan’s network, or obtain obstetrical or gynecological care without prior authorization. This notice must be provided whenever the plan provides a participant with an SPD or other summary of benefits, starting no later than the first day of the first plan year beginning on or after Sept. 23, 2010. This is not required to be sent as a separate communication. For more information, visit [www.dol.gov/ebsa/patientprotectionmodelnotice.doc](http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc).

**The grandfathered health plans model notice** — This is sufficient for use by non-grandfathered plans to meet the requirement that employers include a statement that describes the benefits provided and the fact that the plan or coverage considers itself grandfathered under PPACA, and includes contact information that a participant can use to ask questions or lodge a complaint. The notice must be included in the SPD or in any other plan materials provided to participants or beneficiaries describing the benefits provided under the plan or health insurance coverage. For more information, visit [www.dol.gov/ebsa/grandfatherregmodelnotice.doc](http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc).

**Internal appeals and external review procedures** — This must be included in the SPD. It only applies to non-grandfathered plans. The model notice for non-grandfathered self-funded plans to include in the SPD has not yet been released. The model notice for non-grandfathered fully insured plans has been released. It is on Page 32, Appendix A, of the NAIC Model Act: [www.dol.gov/ebsa/pdf/externalreviewmodelact.pdf](http://www.dol.gov/ebsa/pdf/externalreviewmodelact.pdf).

**Mini-med waiver notification** — This must be provided with any plan materials, including the SPD, and must be in bold, 14-point font. This notice applies to a group health plan that received a waiver from the annual limits requirement. Thus it could apply to both grandfathered and non-grandfathered plans. For more information, visit [www.healthcare.gov/center/regulations/guidance\\_limited\\_benefit\\_2nd\\_supp\\_bulletin\\_120910.pdf](http://www.healthcare.gov/center/regulations/guidance_limited_benefit_2nd_supp_bulletin_120910.pdf).

PPACA does not require notification regarding the prohibition on pre-existing condition exclusion periods for individuals under age 19, certain preventive care services with no cost-sharing (only applies to non-grandfathered plans) or nondiscrimination rules (only applies to non-grandfathered plans). Thus there are no model notices for such. However, under ERISA, the SPD should be revised to reflect any plan changes in regards to these items or other items. Additionally, ERISA requires a summary of any plan changes be sent to participants summarizing how the plan's eligibility or benefits have changed. This is called a Summary of Material Modification. There is no model language for such notices. They simply need to explain the changes in plain language so that the average participant can understand.

## Distribution Timeline

The Adult Children Model Notice, the Lifetime Limits Model Notice and the Patient Protections Notice (if applicable) must be distributed by the first day of the first plan year beginning on or after Sept. 23, 2010. The Internal Appeals and External Review Procedures, Grandfathered Health Plan Notice and Mini-med Waiver Notification must be distributed with the revised SPD.

**For more information about the employer impacts for 2010 through 2012, contact your NFP advisor.**

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