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The Patient Protection and Affordable Care Act was signed into law on March 23, 2010. Amendments to the PPACA were included in the Health Care and Education Reconciliation Act of 2010, which was enacted on March 30, 2010 (these two Acts are collectively referred to as the "PPACA").

Health Care Reform: Are You Prepared? A Timeline for Employers to Follow

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The Patient Protection and Affordable Care Act was signed into law on March 23, 2010. Amendments to the PPACA were included in the Health Care and Education Reconciliation Act of 2010, which was enacted on March 30, 2010 (these two Acts are collectively referred to as the "PPACA"). The legislation will impose significant new responsibilities on employers, some of which are already effective. While further guidance is expected on the application of these requirements, the following provides a summary and timeline of key provisions of the PPACA. As employers look ahead to the implementation of the PPACA, Littler Mendelson will be providing additional publications to provide employers with compliance strategies in connection with various components of the new law.

Provisions Effective on the Date of Enactment (March 23, 2010) or with No Specified Effective Date

- **Grandfather Provision**: The health care reform law contains health insurance market reforms that will impact employers sponsoring group health plans and health issuers offering group and individual policies. "Grandfathered" plans, those in existence on the date of enactment of the PPACA, are exempt from some, but not all, of the new insurance market reform requirements. Although the statute explicitly allows grandfathered plans to enroll new employees and family members and maintain "grandfathered" status, it is silent about what changes to the plan would cause a plan to lose this status. Therefore, uncertainty exists regarding the scope of permissible changes employers can make to a plan in this regard.
  - In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements that were ratified before the date of enactment of the PPACA, a plan will remain "grandfathered" until the date on which the last of the collective bargaining agreements relating to the coverage terminates.
- **Small Business Tax Credits**: Employers with no more than 25 full-time equivalent

employees and annual average wages of less than $50,000 can receive a tax credit for purchasing health insurance for their employees. To receive this credit, employers are required to cover at least 50% of the total premium cost. The number of full-time equivalent employees is determined by dividing (1) the total hours for which the employer pays wages to employees during the year (but not more than 2,080 hours for any employee) by (2) 2,080.

  - For tax years 2010 through 2013, the tax credit will be up to 35% of the employer's contribution, with the full credit of 35% available to employers with 10 employees or less and average annual wages of $25,000 or less.
  - Beginning in tax year 2014, the credit will be increased to 50% of the employer's contribution.

- **Automatic Enrollment**: Employers with more than 200 full-time employees that offer health coverage must automatically enroll new full-time employees in a plan. An employee may opt-out of coverage. The PPACA does not specify an effective date; however, there has been speculation that the automatic enrollment requirement will become effective upon the issuance of regulations.
- **Reasonable Break Time for Nursing Mothers**: The PPACA amends the Fair Labor Standards Act to require employers to provide nursing mothers, up to one year after the birth of their child, a reasonable break time each time the employee needs to express milk. Employers must provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which nursing mothers may be use. An employer with less than 50 employees is not required to comply if the requirements would impose a significant difficulty or expense. The PPACA provides that an employer is not required to compensate an employee receiving such reasonable break time for any work time spent for such purpose. The new federal requirement, which became effective on the date of enactment, does not preempt state law.
- **Protections for Employees**: The PPACA amends the Fair Labor Standards Act to prohibit employers from discharging or discriminating against any employee because the employee:
  - received a federal tax credit or cost-sharing subsidy to purchase health insurance;
  - provided or is about to provide to the employer, federal government, or state attorney general information relating to a violation, or what the employee reasonably believes to be a violation, of Title I of the PPACA;
  - testified or is about to testify in a proceeding about such violation;
  - assisted or participated, or is about to assist or participate, in such a proceeding; or
  - objects to or refuses to participate in any activity the employee reasonably believes to be a violation of Title I of the PPACA

The complaint procedure for retaliation claims follows that of the whistleblower protection provisions of the Consumer Product Safety Improvement Act of 2008.

- **Nutrition Labeling of Standard Menu Items at Chain Restaurants**: The PPACA includes a provision that creates a national, uniform nutrition-disclosure standard for chain restaurants and food retail establishments. The statute does not include a specific effective date. However, the mandatory requirements are not expected to take effect until after Food and Drug Administration (FDA) finalizes its regulations. The legislation directs the FDA to propose regulations within one year of the PPACA enactment date of March 23, 2010.

Provisions Effective 90 Days After Enactment (June 23, 2010)

- **Retiree Reinsurance**: By no later than June 23, 2010, a federal reinsurance program must be established to reimburse sponsors of employment-based plans that provide health benefits to retirees age 55 or older who are not Medicare eligible. Sponsors can apply for reimbursement of 80% of claims paid between $15,000 and $90,000. The sponsor must implement cost-saving programs for high-cost and chronic conditions. Reimbursement must be used to reduce costs for participants. The $5 billion in funds for the

program will only be available until the earlier of 2014 or when the funds are depleted. Plan sponsors that are interested in receiving reimbursement under this program should recognize that it is temporary and should prepare to apply for the reimbursement soon.

- **Temporary High Risk Pool**: A temporary high risk pool must be established to provide coverage for individuals with preexisting conditions who have been uninsured for at least six months. Insurers or employers who are found to have encouraged individuals to disenroll and enroll in the high risk pool must reimburse the pool. The program will exist until January 1, 2014.

Plan Years Beginning on or After Six Months Post-Enactment (September 23, 2010 Or January 1, 2011 for Calendar Year Plans)

- Insurance Market Reforms that Apply to New and Grandfathered Plans
  - Extension of Dependent Coverage up to Age 26. Group health plans and insurers that provide dependent health coverage must extend that coverage to dependents up to age 26. Prior to 2014, a grandfathered group health plan must only extend dependent coverage to age 26 if the dependent is not eligible for other employer-sponsored coverage. Children of the adult dependents (grandchildren of the covered employee) do not have to be offered coverage under the plan. The coverage is not taxable to the employee or dependent. (Before the PPACA, adult dependent coverage was generally taxable with limited exceptions.).
  - Prohibition on Rescissions: Group health plans and insurers are prohibited from rescinding, or canceling, health coverage of an enrollee except in the case of fraud or intentional misrepresentation of material fact.
  - Prohibition on Pre-existing Condition Exclusions: Group health plans and insurers are prohibited from imposing pre-existing condition exclusions for children under the age of 19. Beginning in 2014, plans are prohibited from including a pre-existing condition exclusion for any participant.
  - Prohibition on Lifetime Benefit Limits: Group health plans and insurers are prohibited from imposing a lifetime dollar limit on essential health benefits.
  - Restriction on Annual Benefit Limits: Prior to 2014, group health plans may impose annual limits on the dollar value of essential health benefits only as determined by the Secretary of Health and Human Services. Beginning in 2014, annual dollar limits are prohibited for all essential health benefits.
- Insurance Market Reforms that Apply to New Plans, but Do Not Apply to Grandfathered Plans
  - Preventative Care: Group health plans and insurers must cover certain preventative care services without cost-sharing, including preventative services rated A or B by the U.S. Preventative Task Force, recommended immunizations, preventative care and screenings for infants, children, and adolescents, and additional preventative care and screenings for women. Appeals Process: A new appeals process that includes both internal and external reviews will be required to be provided by employers to employees for appeals of coverage determinations and claims.
  - Non-discrimination in Favor of Highly-Compensated Employees: The requirements of Section 105(h) of the Internal Revenue Code will be extended to fully-insured plans. The restriction currently only applies to self-insured plans.
  - Emergency Services: Group health plans and insurers must cover emergency services without prior authorization and in-network requirements.
  - Physician Selection: Group health plans and insurers that provide for or require the designation of a participating primary care provider must permit each participant to designate any participating primary care provider who is available to accept such individual. The plan must permit a participant to designate a pediatrician as the primary care provider for a child. Plans are prohibited from requiring authorization or referral for an OB-GYN.

Provisions Effective in 2011

- **W-2 Reporting**: Beginning in 2011, employers must report the value of employer-provided health coverage on an employee's W-2. This requirement does not change the tax treatment of employer-provided health coverage.
- **Qualified Medical Expenses**: Beginning in 2011, over-the counter drugs will not be eligible for reimbursement from a flexible spending account (FSA), health savings account (HSA), health reimbursement account (HRA) or Archer medical savings accounts (MSAs).
- **Increased Penalty for Nonqualified Withdrawals**: Effective January 1, 2011, the penalty for withdrawals from HSAs that are not used for qualified medical expenses will increase from 10% to 20%, and the penalty for unqualified withdrawals from Archer MSAs will increase from 15% to 20%.
- **Drug Manufacturer and Importer Fee**: An annual fee on manufacturers and importers of branded drugs will be imposed beginning in 2011.
- **CLASS Act**: A voluntary federal insurance program for employees to purchase long-term care becomes effective beginning January 1, 2011. Employers may elect to automatically enroll employees in the CLASS program, and employees may opt-out.

Provisions Effective in 2012

- **Form 1099**: Effective January 1, 2012, businesses must provide a Form 1099 for all corporate service providers receiving more than $600 per year for services or property, not just for non-corporate service providers.
- **Uniform Explanation of Coverage Documents**
  - Upon application, enrollment and re-enrollment, all health insurance issuers and sponsors of self-insured group health plans (*including grandfathered plans*) must provide a summary of benefits and coverage to enrollees and applicants.
  - By no later than 60 days prior to the effective date of any mid-year change, group health plans also must provide notice of any material changes to the plan coverage. The Secretary of Health and Human Services will establish the format for this summary description, which must begin to be issued no later than March 23, 2012.
- **Quality of Care Reporting**: Not later than March 23, 2012, the Secretary of Health and Human Services must develop reporting requirements for use by plans and insurers regarding plan benefits and reimbursement structures, including those that improve health outcomes and implement wellness and health promotion activities (*Not applicable to grandfathered plans*).
- **Comparative Effectiveness Research Fee**: For the plan year ending after September 30, 2012, there will be a $1 per enrollee tax on fully-insured and self-funded group health plans to fund comparative effectiveness research. For plan years ending after September 30, 2013, the fee increases to $2 per enrollee. This fee sunsets after 2019.

Provisions Effective in 2013

- **FSA Limits**: Effective January 1, 2013, annual contributions to FSAs will be limited to $2,500. This amount will be indexed to CPI.
- **Medicare Part D Retiree Subsidy**: The employer's deduction for the amount of the Medicare Part D retiree drug subsidy will be eliminated.
- **Device Manufacturer and Importer Fee**: An excise tax on manufacturers and importers of medical devices will be imposed.
- **Medicare Payroll Tax**: An additional 0.9% Medicare tax will be imposed on employees with wages over $200,000 ($250,000 for joint filers).

- **Medicare Contribution on Investment Income**: A 3.8% tax on unearned income will be imposed on those with income over $200,000 ($250,000 for joint filers).
- **Executive Compensation**: Beginning in 2013 and only with respect to services performed after 2009, the deduction for current and deferred compensation paid to officers, directors, employees, or services providers of health insurance issuers is limited to $500,000 per year.
- **Employer Notice Requirements**: Beginning on March 1, 2013, employers must provide employees written notice: (1) of the existence of the health insurance exchange; (2) of potential eligibility for federal assistance if the employer's health plan is "unaffordable" based on criteria under PPACA and if employee household income is below certain thresholds; and (3) that they may lose the employer's contribution to health coverage if they purchase health insurance through the health insurance exchange.

Provisions Effective in 2014

- **Health Insurance Exchanges**: State-established health insurance exchanges (Exchanges) must begin to operate on January 1, 2014. The Exchanges are virtual marketplaces that allow individuals and eligible employers to purchase health insurance. Initially in 2014, only employers with up to 100 employees can purchase insurance for their employees through the Exchange. Prior to 2016, states can limit this to businesses with up to 50 employees. Beginning in 2017, states can allow employers with more than 100 employees to purchase health insurance for their employees through the Exchange.
- **Individual Responsibility – Penalty**: Individuals generally will be required to obtain "minimum essential coverage" or pay a penalty.
  - For 2014, the penalty is $95 for each uninsured adult in household or 1% of household income over filing threshold.
  - For 2015, the penalty increases to $325 or 2% of household income over filing threshold.
  - For 2016 and after, the penalty increases to $695 or 2.5% of household income over filing threshold.
- **Federal Tax Credits and Cost-Sharing Subsidies**: Individuals with household incomes up to 400% of the federal poverty level (currently approximately $88,000 for a family of four) may be eligible for federal premium tax credits or cost-sharing subsidies to purchase insurance through an Exchange. Individuals with employer-sponsored coverage may still be eligible for federal assistance if such coverage is either: (1) unaffordable because the employee's required contribution is more than 9.5% of their household income; or (2) the plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs.
- **Employer Responsibility – Penalty**: The new health care reform law does not require employers to offer health coverage to their employees. However, large employers will be subject to a penalty beginning in 2014 if they do not: (1) offer coverage; (2) offer coverage that is affordable; or (3) offer coverage that meets the minimum value standards.
  - Large Employers: For purposes of the penalty, a *large employer* is an employer who has 50 or more full-time employees and full-time equivalents. Full-time employees are defined as those that work 30 or more hours a week calculated on a monthly basis. Full-time equivalents are also counted in the determination of whether an employer is a large employer for purposes of the penalty. The monthly number of hours worked by part-time employees is aggregated and divided by 120 for this purpose. To determine whether an employer is deemed a large employer subject to the penalty, the number of full-time employees is added to the number of full-time equivalents. If that number is 50 or more, the employer is subject to a penalty as described below. Employers falling below the threshold will not be subject to a penalty.

    Even though the hours of part-time workers are counted for purposes of determining whether an employer is a large employer, the penalty only applies with respect to full-time employees. An employer is not considered a large employer if it employs more than 50 people for 120 days or less during the calendar year and the employees in excess of 50 employed during such 120 day

period were seasonal workers. The controlled group rules (*i.e.*, the rules under Sections 414(b), (c), (m), and (o) of the Internal Revenue Code of 1986) that apply to qualified retirement plans will similarly apply in determining whether an employing entity is a large employer.

- Large Employers that Do Not Offer Health Coverage: A large employer that does not offer to its full-time employees (and dependents) an opportunity to enroll in minimum essential coverage will pay a penalty if at least one of its full-time employees receives federal assistance to purchase insurance through an Exchange. The penalty will be equal to $2,000 multiplied by the total number of full-time employees, subtracting 30 from the total number of full-time employees.
- Large Employers that Do Offer Health Coverage: A large employer that offers minimum essential coverage to full-time employees (and dependents) will also be subject to a penalty if the health coverage offered is either: (1) unaffordable because the employee's required contribution is more than 9.5% of their household income; or (2) the actuarial value of the employer's plan is less than 60%, meaning the plan pays for less than 60% of covered health care expenses. In either case, the employer will pay a penalty that is the lesser of $3,000 for each full-time employee receiving federal assistance to purchase health insurance through an Exchange **or** $2,000 multiplied by all full-time employees (subtracting 30 from the total number).
- Free Choice Vouchers: Beginning in 2014, employers that offer health coverage to their employees may also have to provide "free choice vouchers" for certain employees that would rather purchase health insurance through the Exchange instead of through the employer. This requirement is not limited to large employers. Employees with household incomes at or below 400% of the federal poverty level and whose premium payment is between 8% and 9.8%[1] of their household income are eligible for the free choice vouchers. The amount of the free choice voucher is the amount the employer would have contributed toward such employee's coverage (or family coverage at the employee's option) with respect to the plan to which the employer pays the largest portion of the cost. The employee can keep the difference, if any, between the amount of the voucher and the cost of purchasing insurance through the Exchange. The amount of the voucher is deductible to the employer. No penalties are imposed for employees who receive free choice vouchers.
- Employer Reporting Requirements: Employers must annually report to the federal government whether they offer health coverage to their full-time employees and dependents, the total number and names of full-time employees receiving health coverage, the length of any waiting period, and other information about the cost of the plan.

- **Insurance Market Reforms and Benefit Mandates**
  - Essential Health Benefits: Qualified health plans and insurers in the individual and small group markets must offer coverage that includes the "essential health benefits package." A *small group* is defined as one with no more than 100 employees. A health plan providing the essential health benefits package will be prohibited from imposing an annual cost-sharing limit that exceeds the thresholds applicable to Health Saving Accounts (HSAs). Small group health plans providing the essential health benefits package will be prohibited from imposing a deductible greater than $2,000 for self-only coverage, or $4,000 for any other coverage (*Does not apply to grandfathered plans*).
  - Excessive waiting periods: For plan years beginning on or after January 1, 2014, self-insured group health plans and insurers are prohibited from imposing a waiting period greater than 90 days. The waiting period is the time period that must pass before an individual is eligible to use health benefits (*Applies to grandfathered plans*).
  - Prohibition on pre-existing condition exclusions: For plan years beginning on or after January 1, 2014, self-insured group health plans and insurers are prohibited from including a pre-existing condition exclusion for any participant (*Applies to grandfathered plans*).
  - Prohibition on annual benefit limits: Group health plans and insurers are prohibited from imposing a lifetime dollar limit on essential health benefits (*Applies to grandfathered plans*).

- Health Status: Group health plans and insurers are prohibited from basing eligibility on health-status related factors (*Does not apply to grandfathered plans*).
- Clinical trials: Group health plans and insurers cannot deny coverage for participation in clinical trials for life-threatening diseases. The benefits must otherwise be covered by the plan and may be subject to out-of-network provider restrictions (*Does not apply to grandfathered plans*).
- Wellness Program Incentives: The PPACA codifies the existing HIPAA rules allowing wellness programs to offer an incentive, such as a premium reduction, for achieving a health standard. However, the maximum amount of the incentive is increased from 20% to 30% of the cost of employee-only coverage under the plan, with Secretarial discretion to increase the cap to 50%.

- **Health Insurer Fee**: Beginning in 2014, an annual fee on health insurance providers will be imposed.

Provisions Effective in 2018

Excise Tax on High-Cost Insurance Plans: Beginning in 2018, and with respect to employer-sponsored health plans that provide coverage where the value of such coverage exceeds $10,200 for single coverage and $27,500 for family coverage, a 40% excise tax will be imposed on health insurance issuers and persons that administer plan benefits. The excise tax is imposed on the value of coverage in excess of the threshold. For retirees and employees in high-risk professions, the threshold is $11,850 for single and $30,950 for families. The amount of coverage includes both employer and employee premium payments. The threshold may be adjusted for age and gender demographics that are different from a national pool. It may also be adjusted if actual health inflation exceeds the government's estimate of health inflation between now and 2018. The threshold will then be periodically adjusted for inflation subsequent to 2018.

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[1] The Health Care and Education Reconciliation Act reduced the affordability threshold for a federal subsidy from 9.8 to 9.5% of household income. However, the Act did not make a corresponding change to the free choice voucher provision.