A Littler Mendelson Report

InSight

An Analysis of Recent Developments & Trends

In This Issue:

March 2011

One year after the Patient Protection and Affordable Care Act was signed into law, employers have already begun to feel the impact of the sweeping health care reform legislation, even though key provisions are still years away from becoming effective. The following summary is an updated timeline of the law's requirements, reflecting regulations and guidance issued to date.

Health Care Reform One Year Later: The Status of the Patient Protection and Affordable Care Act Implementation

By Ilyse Schuman, Steven Friedman and David Sawyer

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 "PPACA"). One year later, employers have already begun to feel the impact of this sweeping legislation, even though key provisions are still years away from becoming effective. The law imposes significant new responsibilities on employers. However, the statute itself offers little in the way of clear guidance to employers about their compliance obligations. The task of implementing the health care reform law largely rests with the federal regulators at the Departments of Health and Human Services (HHS), Labor (DOL) and Treasury. The flurry of regulatory activity over the past year has generated some clarity, but also challenges and questions for employers.

The following is an updated summary and timeline of key provisions of the PPACA, reflecting the regulations and guidance issued to date. Much of the PPACA regulatory activity has come in the form of interim final regulations. Unlike the normal rulemaking process, the agencies have issued binding rules prior to consideration of public comments. This expedited rulemaking process has led to a continuing stream of rules, modifications, and, in some cases, delays in enforcement. Employers can expect more changes ahead as existing interim regulations are finalized and new regulations are released amidst challenges in Congress and the courts. Those taking a long-term strategic approach to health care reform and the health and productivity of their workforce will be better positioned to navigate the ever-evolving regulatory, legislative and legal landscape of PPACA.

Date of Enactment (March 23, 2010) or 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. While 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. The statute itself was silent about what changes would cause a health plan that was in place on March 23, 2010, to lose its grandfathered status. However, interim final regulations published on June 17, 2010, set forth strict criteria for maintaining grandfathered status.[1] Any one of the following six changes, measured from March 23, 2010, will cause a plan to cease to be grandfathered:

- Elimination of all or substantially all benefits to diagnose or treat a particular condition.
- Increase in a percentage cost-sharing requirement (*e.g.*, raising an individual's coinsurance requirement from 20% to 25%).
- Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points.
- Increase in a co-payment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, $5 plus medical inflation).
- Decrease in an employer's contribution rate towards the cost of coverage by more than 5 percentage points.
- Imposition of annual limits on the dollar value of all benefits below specified amounts.

The regulations also contain an anti-abuse feature to stop employers from certain business reorganizations or transfers among divisions or between employers to avoid losing grandfathered status. Grandfathered plans must provide written notice to all participants and beneficiaries about the grandfathered status of the plan. Insurance reforms applicable to grandfathered health plans apply to collectively bargained plans with no delay in effective date. However, insured health plans maintained pursuant to one or more collective bargaining agreements that were ratified before the date of enactment of PPACA can be modified before the last expiration date without losing grandfathered status at that time. The regulatory requirements for maintaining grandfathered status significantly restrict plans from making cost-saving changes, which may well outweigh the value of maintaining such status.

- **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: (i) 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 (ii) 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.[2]
- **Automatic Enrollment**: The PPACA amended the Fair Labor Standards Act (FLSA) to require employers with more than 200 full-time employees that offer health coverage to 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, the DOL issued question-and-answer guidance indicating that until regulations are issued and effective, employers are not required to comply with the automatic enrollment requirement. The DOL announced that it intends to issue final regulations by 2014.[3]
- **Reasonable Break Time for Nursing Mothers**: The PPACA amended the FLSA to require employers to provide nursing mothers, for 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 nursing mothers a place to express milk, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public. An employer with less than 50 employees is not required to comply if the requirement would impose 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 that provides greater protection. DOL has issued a fact sheet on the new requirement[4] and has solicited information from the public on its application.[5]

- **Protections for Employees**: The PPACA amends the FLSA 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.

90 Days After Enactment (June 23, 2010)

- **Retiree Reinsurance**: Effective June 1, 2010, a federal reinsurance program was established to reimburse sponsors of employment-based plans that provide health benefits to retirees age 55 or older who are not Medicare eligible. The interim final regulations[6] implementing the provisions of the Early Retiree Reinsurance Program (ERRP) were issued on May 5, 2010. 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. As of December 31, 2010, more than 5,000 employers had been accepted into ERRP, and more than $535 million in health benefit costs had been reimbursed through the program.[7]
- **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 in existing plans and enroll in the high risk pool must reimburse the pool. The program will exist until January 1, 2014. A total of 27 states have decided to run their own state programs, while 23 states deferred to HHS-run plans.[8]

Plan Years Beginning On or After Six Month Post-Enactment (September 23, 2010, or January 1, 2011, for Calendar Year Plan)

- **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 children up to age 26. Prior to 2014, a grandfathered group health plan must only extend dependent coverage to age 26 if the child is not eligible for other employer-sponsored coverage. Children of 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 child. (Before the PPACA, adult dependent coverage was generally taxable with limited exceptions.) On May 13, 2010, the DOL issued interim final regulations[9] implementing the dependent coverage provisions of the Affordable Care Act. Prior to the child's 26th birthday, the plan may not restrict coverage of dependents based on financial dependency, residency, student status, or employment status, nor may plans vary the level or terms of dependent coverage based on age. The regulation creates a special enrollment opportunity and notice requirement for children who lost coverage or were not eligible for coverage under the plan's existing age limits as of the effective date.
  - 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. The IRS, DOL and HHS issued interim final regulations on June 28, 2010, which clarified that rescissions refer to retroactive cancellation of coverage.[10]

- 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. This issue is addressed in the IRS, DOL and HHS interim final regulations.[11]
- Prohibition on Lifetime Benefit Limits: Group health plans and insurers are prohibited from imposing a lifetime dollar limit on essential health benefits. PPACA lists broad categories of benefits and services deemed "essential health benefits." The interim final regulations did not provide further guidance on the definition of "essential health benefits."[12] Plans that had imposed lifetime limits must provide special notice and reenrollment opportunities.
- 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. The agencies issued interim final regulations[13] setting the threshold for annual limits as follows: $750,000 for the plan year on or after September 23, 2010; $1.25 million for the following plan year; and $2 million for plan years after that. Limited benefit or so-called mini-med plans can apply for a waiver from the annual restrictions if they can demonstrate that meeting the requirements would result in a significant decrease in access to benefits or cause a significant increase in premiums. As of March 1, 2011, HHS has granted a total of 1,040 one-year annual benefit limit waivers.[14]

- **Insurance Market Reforms that Apply to New Plans, but Do Not Apply to Grandfathered Plans**
  - Preventive 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. The agencies published interim final regulations on July 19, 2010, clarifying that plans are not required to provide coverage for recommended out-of-network preventive services and that cost-sharing can be imposed on out-of-network preventive services.[15]
  - 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. On July 23, 2010, the IRS, DOL and HHS issued interim final regulations modifying or expanding existing internal claims requirements for ERISA plans.[16] On September 20, 2010, the DOL issued a technical release document that gives health insurance issuers a grace period until July 1, 2011, to comply with certain new internal claims and appeals procedure requirements. Self-funded plans can follow an interim "safe harbor" procedure for external review until further guidance is issued.[17]
  - Nondiscrimination in Favor of Highly-Compensated Employees: Section 105(h) of the Internal Revenue Code prohibits discrimination in favor of highly compensated individuals with respect to plan eligibility and benefits by self-insured plans. The PPACA extends this restriction to non-grandfathered fully-insured plans. Under the PPACA, an excise tax of $100 per day applies for each individual to whom the violation relates, up to an annual cap of the lesser of 10% of the cost of the plan or $500,000. On December 22, 2010, the IRS announced that enforcement of this provision was delayed until further guidance is issued.[18]
  - Emergency Services: Group health plans and insurers must cover emergency services without prior authorization and in-network requirements. The agencies issued interim final regulations on patient protections on June 28, 2010, which included guidance on the emergency services requirement.[19]
  - 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. Interim final regulations require non-grandfathered plans to provide participants notice of these protections.[20]

2011

- **W-2 Reporting**: Starting in tax year 2011, PPACA requires employers to report the value of the health insurance coverage they provide employees on each employee's annual Form W-2. This reporting requirement does not change the tax treatment of employer-provided health coverage. To provide employers the time they need to make changes to their payroll systems or procedures in preparation for compliance with this requirement, the IRS will defer the reporting requirement for 2011, making that reporting by employers optional for 2011 Forms W-2 (furnished to employees in January 2012).[21] The IRS provided further relief for smaller employers filing fewer than 250 W-2 forms by making this requirement optional for them at least for 2012 Forms W-2 (furnished to employees in January 2013) and continuing this optional treatment for smaller employers until further guidance is issued.[22]
- **Qualified Medical Expenses**: Over-the-counter drugs are no longer eligible for reimbursement from a flexible spending account (FSA), health savings account (HSA), health reimbursement account (HRA), or Archer medical savings accounts (MSAs) unless a prescription in obtained. The change does not affect insulin, even if purchased without a prescription, or other health care expenses such as medical devices, eye glasses, contact lenses, co-pays and deductibles. The new standard applies only to purchases made on or after January 1, 2011.[23]
- **Increased Penalty for Nonqualified Withdrawals**: Effective January 1, 2011, the penalty for withdrawals from HSAs that are not used for qualified medical expenses was increased 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 is imposed beginning in 2011.
- **CLASS Act**: A voluntary federal insurance program for employees to purchase long-term care became effective on January 1, 2011; however, HHS has until October 1, 2012, to designate a final benefit plan. Employers may elect to automatically enroll employees in the CLASS program, and employees may opt-out. Faced with questions about the fiscal sustainability of the program, HHS announced it is exploring areas within its statutory flexibility to strengthen the CLASS program to help enrollees plan for their future while ensuring program solvency.[24]

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 goods, not just for non-corporate service providers. This provision has generated significant controversy, and repeal is considered likely. The House and Senate have each approved different bills to repeal the requirement.
- **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.

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 service 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: (i) of the existence of the health insurance exchange; (ii) 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 (iii) that they may lose the employer's contribution to health coverage if they purchase health insurance through the health insurance exchange.

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 reduce this limit 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 a 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.

  This so-called individual mandate is at the heart of the legal challenges to PPACA. With federal courts differing on whether the provision is constitutional, the decision will ultimately rest with the U.S. Supreme Court.[25]
- **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: (i) unaffordable because the employee's required contribution is more than 9.5% of their household income; or (ii) 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: (i) offer coverage; (ii) offer coverage that is affordable; or (iii) 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 Section 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: Large employers that do not offer to 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: Large employers that offer minimum essential coverage to full-time employees (and dependents) will also be subject to a penalty if the health coverage offered is either: (i) unaffordable because the employee's required contribution is more than 9.5% of their household income; or (ii) 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 of full-time employees.
- 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. Employees with household incomes at or below 400% of the federal poverty level and whose premium payment is between 8% and 9.8%[26] 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 plans 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 an annual 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%, as the current HIPAA rules allow, to 30% of the cost of employee-only coverage under the plan, with Secretarial discretion to increase the cap to 50%. The agencies released guidance in the form of frequently asked questions stating that they intend to propose regulations that use existing regulatory authority under HIPAA to raise the percentage for the maximum reward that can be provided under a health-contingent wellness program to 30% before the year 2014. The agencies are also considering what accompanying consumer protections may be needed to prevent the program from being used as a subterfuge for discrimination based on health status.[27]

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

2018

Excise Tax on High-Cost "Cadillac" Health 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.

Next Steps for Employers

One-year after becoming law, the Patient Protection and Affordable Care Act remains both overwhelming and uncertain for many employers. While questions about many of its provisions still exist, the magnitude of the law's impact on employers has become more clear. Employers have responded to the initial flurry of insurance reforms and other mandates. However, the bigger challenges still lie ahead with the employer "play or penalty" that begins in 2014 and the "Cadillac plan" excise tax in 2018.

With health care costs continuing to rise, navigating health care reform becomes even more complex and critical. A recent employer survey by Towers Watson and the National Business Group on Health found that employers expect average costs for active health care benefits to increase by 7% in 2011, up from a 6% increase in 2010.[28] Rising health care costs and the anticipated impact of health care reform are driving many employers toward bolder health care benefit design decisions, according to the survey. While employers should ensure they are in compliance with the short-term changes mandated by PPACA, they cannot afford to ignore its longer-term implications. This includes taking the following actions:

- Review plan documents and summaries for compliance with near-term insurance market reforms and ensure timely distribution of required notices.
- Evaluate whether any post-March 23, 2010, or proposed plan changes would cause a loss of grandfathered status and consider advantages of retaining grandfathered status versus advantages of plan changes.
- Revise health FSA, HSA and HRA open enrollment materials.
- Consider effective use of wellness programs.
- Begin to evaluate benefit and employment policies in light of the 2014 "play or pay" penalty:
  - How does the cost of coverage compare to penalty?
  - Does your plan provide "minimum value?"
  - Is your plan likely to be "affordable?"
- Determine whether your plan is a "Cadillac plan."

Ilyse Schuman is a Shareholder in Littler Mendelson's Washington D.C. office, Steven Friedman is a Shareholder in the New York City office, and David Sawyer is a Shareholder in the Pittsburgh office. If you would like further information, please contact your Littler attorney at 1.888.Littler, info@littler.com, Ms. Schuman at ischuman@littler.com, Mr. Friedman at sfriedman@littler.com, or Mr. Sawyer at dsawyer@littler.com.

---

[1] 75 Fed. Reg. 34,538 – 34,570 (June 17, 2010). For more analysis, see Ilyse Schuman & Melissa Kurtzman, *Healthcare Reform: Long-Awaited "Grandfathered" Regulations Released - What Do Employers Need to Know?*, LITTLER ASAP, June 2010, *available at* www.littler.com/PressPublications/Pages/ASAPs.aspx.

[2] For more information on the small business tax credits, *see* www.irs.gov/newsroom/article/0,,id=220839,00.html.

[3] *See* Q&A-3 of the FAQs issued on December 22, 2010, available on the EBSA website at www.dol.gov/ebsa/healthreform/.

[4] U.S. Department of Labor, Wage and Hour Fact Sheet #73: Break Time for Nursing Mothers, *available at* www.dol.gov/whd/regs/compliance/whdfs73.pdf.

[5] 75 Fed. Reg. 80,073 (Dec. 21, 2010).

[6] 75 Fed. Reg. 24,450 – 24,470 (May 5, 2010).

[7] HHS New Release March 2, 2011, *available at* www.hhs.gov/news/press/2011pres/03/20110302a.html.

[8] *See* www.pcip.gov/StatePlans.html.

[9] 75 Fed. Reg. 27,122 140 (May 13, 2010).

[10] 75 Fed. Reg. 37,188 (June 28, 2010).

[11] *Id*.

[12] *Id*.

[13] *Id*.

[14] *See* http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html.

[15] 75 Fed. Reg. 41,726 (July 19, 2010).

[16] 75 Fed. Reg. 43,330 – 43,364 (July 23, 2010).

[17] 75 Fed. Reg. 52,597 (Aug. 26, 2010).

[18] Internal Revenue Service Notice 2011-1, *available at* www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6.

[19] 75 Fed. Reg. 37,188 (June 28, 2010).

[20] *Id*.

[21] Internal Revenue Service Notice 2011-1, *available at* www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6.

[22] Internal Revenue Service 2011-28, *available at* www.irs.gov/newsroom/article/0,,id=237870,00.html.

[23] Internal Review Service Notice 2010-59, *available at* www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6.

[24] *See* Statement by Kathy Greenlee, Assistant Secretary for Aging, HHS before the Committee on Energy and Commerce, Subcommittee on Health, U.S. House of Representatives (March 17, 2011), *available at* www.hhs.gov/asl/testify/2011/03/t20110317b.html.

[25] For more information, *see* www.healthcareemploymentcounsel.com/healthcare-reform/insurance-reform/florida-judge-orders-stay-of-his-decision-finding-affordable-care-act-invalid/.

[26] 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, such Act did not make a corresponding change to the free choice voucher provision.

[27] *Available at* www.dol.gov/ebsa/faqs/faq-aca5.html.

[28] Employers are expected to pay approximately $8,516 per active employee in total health care costs, up from an average of $8,000 in 2010. *See* 16th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care, *available at* www.towerswatson.com/united-states/research/3946#.