

Hub International Health Care Reform Questions & Answers April 6, 2010



Effective Dates

What are the various effective dates for the provisions of the new health reform law?

Hub International has prepared a chart on effective dates of employer obligations under the new law; it also addresses grandfathered plans. Contact your HUB representative for a copy of the chart.

Delays Available to Grandfathered Plans

We currently offer a group health plan, as of the date the new law was signed. We heard we can continue that plan as a “grandfathered plan.” What does that mean?

Some provisions of the law are inapplicable to existing plans in which an individual was enrolled on the date of enactment. Grandfathered coverage can be renewed, and family members and new employees are allowed to enroll without destroying grandfathered status. However, the Reconciliation Act applies a number of mandates in the new law to grandfathered health plans. We will be following the grandfather issue particularly closely, but note that the relief the grandfather rule appears to offer is somewhat illusory, especially in light of “essential” plan mandates and related penalties.

The new law is careful to state in several provisions that simply because a grandfathered plan is modified to comply with the new law, it will not lose grandfathered status. That raises the question – will *other* modifications to the plan cause the plan to lose grandfathered status? If the plan is modified to change deductibles and co-pays, for example, or to revise eligibility or covered benefits, will that make the plan lose grandfathered status? The new law does *not* define how a plan sponsor must or must not act to maintain a plan as grandfathered. Employers will need to consider whatever standards the agencies eventually develop on this issue when considering future plan changes. Some congressional intent discussions and provisions in the law imply no plan changes are allowed to a grandfathered plan -- other than the changes specifically allowed by the new law.

What are the plan provisions that are not going to be applicable to such a grandfathered plan?

The following provisions in the new law are not applicable to a grandfathered plan until it loses grandfathered status:

- Primary care provider designation (any contracted provider)
- Access to obstetrical and gynecological care
- Access to pediatric care (allopathic or osteopathic pediatric specialist as child’s primary provider)
- Non-discrimination based on compensation or hourly/salaried status (insured plans)
- Emergency room (no prior authorization; no network benefit differential)

- No cost sharing on minimum preventive benefits
- Appeals process revisions
- Renewals guaranteed – to be addressed with carrier
- Rating restrictions (age, tobacco, community rating, etc.) – to be addressed with carrier
- Guarantee issue – to be addressed with carrier
- Clinical trial coverage

What about the other provisions that will apply, even to a grandfathered plan?

The following is a list of provisions that apply even if a plan is maintained as a grandfathered plan:

- Pre-existing condition exclusion eliminated (including for children under age 19)
- No lifetime limits
- No annual limits
- Prior notification of plan changes (mid-year and at enrollment)
- No rescissions
- Dependents covered until age 26
- Minimum loss ratio and rebate rules
- Four-page plan disclosure
- No waiting period over 90 days

Are there other provisions where grandfathering is not even an applicable concept?

The following are additional areas where no grandfathering applies; the concept is not applicable:

- Reporting on plan information
- Form W-2 reporting of health coverage
- Wellness plan design guidelines
- Individual mandate
- Employer mandate
- Automatic enrollment
- Vouchers
- Notice to employees about coverage options and exchanges

Union Plan Issues

How does the effective date of the new law apply to collectively bargained plans?

If health insurance coverage is maintained due to collective bargaining agreements between employee representatives and one (or more) employers, compliance can be delayed. If the agreement was ratified before March 23, 2010, then portions of the new law do not apply to that plan. The plan is considered to be “grandfathered,” and compliance may not yet be required. The new rules apply when the agreement(s) relating to the plan terminate(s). See above for the list of provisions which are not applicable on the usual effective date when a plan is grandfathered.

What is the employer mandate?

An employer with over 50 employees must *offer* all full-time employees an essential health plan. The new law contains a tricky rule for counting the number of employees. More detail on these rules is provided below. An employer first must look to the *prior* calendar year to determine if it has over 50 employees and then must comply with the mandate in the current year, starting in 2014. An employer will have to offer benefits to all full-time workers (including full-time seasonal workers, discussed below) if its workforce exceeded 50 full-time employees on over 120 days in the prior calendar year.

An employer with over 200 employees must automatically enroll employees, but the employees may still choose to opt out of coverage. If an employee chooses not to take coverage for himself or herself or for any family members, the employee opt out will not affect the employer's compliance with the mandate. The employer is simply required to *offer* the coverage. (A lack of affordability may trigger other obligations, however, explained below and in other Q&As.)

Is a small employer with fewer than 25 employees required to offer a group health plan?

No. The employer mandate is only applicable for employers with more than 50 employees. The mandate, and the associated penalty, will not apply to such a small employer. (Small employers are eligible for a tax credit if they have fewer than 25 employees and do offer their employees health insurance; see the section of this Q&A document entitled [Small Employer Tax Credit](#).)

What is an essential health plan? Do we know what the essential health plan benefit design will be?

The specific plan design is yet to be determined; provisions are supposed to be based on a typical employer-sponsored health plan design.

We do know some of the benefits that must be included in the "essential" plan:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance abuse treatment, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Wellness and preventative services,
- Chronic disease management, and
- Pediatric services including oral and vision care.

Bronze, silver, gold, and platinum coverage levels are to be offered at benefit payment levels of 60%, 70%, 80%, and 90%, respectively.

Is there a minimum contribution employers must make to the cost of the health care plan they offer employees?

Many questions are arising on employer contributions toward coverage. The law does *not* directly require the employer to pay a certain dollar amount or percentage of premiums toward the cost of coverage.

However, due to the indirect operation of an “affordability” standard, an employer may consider whether it *should* pay a certain amount toward the cost of coverage so its employees do not seek vouchers, discussed separately in these Q&As, and so employees do not obtain coverage under a governmental credit, subsidy, or risk pooling arrangement that may trigger additional penalties for the employer.

What is the definition of “full-time employees”?

“Full-time employees” are defined as those persons working 30 or more hours per week. The definition does not exclude seasonal or temporary employees. Further, the law does not say “scheduled” to work, presumably meaning “actually” worked.

Are part-time employees counted in determining if we have 50 or more employees?

No, but their full-time equivalents will be added up, based on 120 hours/month, to determine whether an employer meets the 50-employee threshold. Part-time employees are not counted when assessing the actual penalty.

Do we have to offer coverage to part-time employees?

No - the law does not require employers to offer coverage to anyone but full-time employees and their dependents.

Do small construction companies have to comply with the employer mandate, even if they have fewer than 50 employees?

No, construction companies are subject to the same rules as other employers. Although the House first added language to the original Senate bill stating that the employer mandate would apply to employers in the construction industry if they had more than 5 full-time employees with annual payroll expenses exceeding \$250,000 (the Merkley Amendment), the Reconciliation Act amended the final bill and took this language out.

Can seasonal workers be excluded from the employee count when determining whether the employer has 50 employees?

Yes, seasonal workers can be excluded if they meet certain criteria. Whether they can be excluded will depend on how many days the employer has a large number of seasonal workers. Note: you look to the *prior* calendar year to determine if the employer has to comply with the mandate law in the *current* year. The key question is whether the seasonal workers work more than 120 days per year. Employers will have to offer benefits to all workers (*including* the seasonal workers) if their workforce exceeded 50 full-time employees on over 120 days in the prior calendar year.

The employer needs to calculate regular *and* seasonal worker count for each day in the prior calendar year, and determine if the days it had employed more than 50 employees total (seasonal and non-seasonal) was 120 or less days per calendar year.

The law does not allow an employer to disregard seasonal workers who are rotated in and out of employment. If there was a group of tulip workers who worked for three months, and then the employer replaced them with another group of tulip workers who worked for another 2 months, the employer must count the total number of employees on those days to get employee count, not the specific identities of the workers as being the same or different people.

Example: In 2013, an employer has 42 full-time employees, then hires 200 seasonal workers to cut tulips and take care of bulbs in March and April for **39 days**, and then hires 192 workers to plant tulips in October and November for **60 days**. The seasonal workers work full-time, but they are not working for the employer for over 120 days – they are only working there for 99 days (**39 days + 60 days = 99 days**). The employer has fewer than 50 full-time

employees on 120 days or fewer in the year. So, the mandate/ penalty will not apply in 2014. The employer does not need to offer the seasonal workers or its regular workers health plan coverage.

On the other hand, assume in 2013, the employer has 42 full-time employees, and hires 200 seasonal workers starting in early January through March for **88 days**. The employer releases those workers and hires 200 different workers for March and April, for an additional **57 days**. The identity of the workers does not matter – in this case the employer had workers for over 120 days (**88 days + 57 days = 145 days**) in 2013, so it is treated as a large employer subject to the mandate/penalty for 2014. The employer must offer its full-time seasonal and regular workers health plan coverage.

At the end of employment, the seasonal workers would be offered COBRA just like any other employee losing coverage, and the federal COBRA subsidy, if still in effect, would be available.

What are seasonal workers ?

The law says a “seasonal worker” for this purpose is a worker who performs services on a seasonal basis as defined by the Secretary of Labor (including retail workers during the holiday season). The reference to Department of Labor interpretations would also include the following rule on who is a “seasonal worker”: “where, ordinarily, the employment pertains to or is of the kind exclusively performed at certain seasons or periods of the year and *which, from its nature, may not be continuous or carried on throughout the year*. A worker who moves from one seasonal activity to another, while employed in agriculture or performing agricultural labor, is employed on a seasonal basis even though he may continue to be employed during a major portion of the year.” (The new law does not address temporary employees. Presumably, if a temporary employee is full-time, working over 30 hours per week, the temporary worker would have to be offered medical coverage if the waiting period is satisfied.)

If seasonal workers are full-time and satisfy the waiting period, do they need to be offered benefits?

The seasonal workers who work the required 30 hours are full-time employees. As full-time employees, the employer must offer health benefits to any seasonal worker who satisfies the waiting period of 90 days or less. Seasonal employees also are counted for penalty calculation purposes.

What if we do not offer essential health plan coverage to our full-time employees and their dependents?

If you do not offer coverage to your full-time employees and their dependents, you must pay a fine of \$2,000 per employee. (A separate penalty of \$3,000 per affected person is assessed if an employee or dependent who might have obtained coverage through your plan enrolls in the exchange using a tax credit or if a cost-sharing reduction is allowed or paid for that person.)

How does the penalty apply? We only offer coverage to some of our full-time employees. If we continue that practice, are we taxed/penalized based on all employees, all full-time employees, or only those employees to whom we offer no coverage?

The penalty is assessed based on *all full-time employees*, whether or not they are offered coverage. If you have 500 full-time employees and 100 part-time employees and only offer coverage to 300 of the full-time employees, you generally would have to pay the \$2,000 penalty on all 500 of the full-time employees. See the next question on the calculation process. (There is a special rule for the \$3,000 penalty; that one is on a person-by-person basis, based on whether people are using a credit or getting government support for cost sharing).

I heard we do not have to pay the penalty on a certain number of employees. How does that rule work?

Under a rule added to health reform late in the process, an employer can deduct 30 employees when calculating the penalty. In the prior question, the employer had 500 employees and did not offer coverage to all its full-time workers. The special rule allows the employer to deduct 30 employees, so the penalty is calculated as follows: 500 employees – 30 employees, which is 470 employees. Those 470 employees are multiplied by \$2,000, resulting in a penalty of \$940,000.

Will the penalty apply if coverage is offered to all full-time employees but some waive coverage?

No. The legal requirement is only to *offer* the coverage.

However, if you offer an incentive to waive coverage, you may face a penalty equal to incurred claims if that person incurs claims while covered under certain high risk pools. An employer facing that penalty generally will not be protected or compensated by either its health insurance plan or its stop loss contract (if it is self-funded with reinsurance). It is strongly suggested that no incentives be offered unless government guidance creates more flexibility in this rule prior to 2014.

What if employees waive coverage because it is not affordable?

They can claim a voucher from their employer.

What if an employer decides to pay the penalty to the IRS rather than offer an essential health plan? Are there other penalties that might apply?

For some employers, it will be cheaper to pay the tax penalty, especially if they have a large amount of lower paid employees.

What is the maximum exposure an employer might face?

An employer's maximum exposure to penalties depends on its number of full-time employees, as explained above, in addition to other issues and factors that are not easily anticipated or estimated.

- The \$2,000 per full-time worker penalty applies if no coverage is offered.
- If any of those employees use a credit or get government support for cost-sharing, there is \$3,000 per employee penalty for each affected person (not based on all full-time employees). Knowing to whom the \$3,000 penalty would apply may not be possible, but an employer may be able to estimate how many employees might fall into that category based on their income from the employer.
- An employer offering an incentive to opt of its plan would face potentially unlimited exposure for high risk pool claims incurred.

Restructuring Strategies

Can an employer restructure its businesses to create a number of companies all under 50 lives so the entities are all exempt from the penalty tax, and hence exempt from the mandated coverage rule?

Reorganizing the employer's structure would not be a work-around, based on the wording in the law. The IRS rules at Code section 414, subparagraphs (b), (c), (m), and (o), are to be used under Health Reform to aggregate (join together) various subgroups when there is common ownership between the entities. These rules generally cross

reference Section 1563(a), which consider common ownership, and which will trump how the structure of a group of related employers might be split apart.

What about restructuring to create numerous small employers eligible for the small employer tax credit?

Carving a single firm into 10 LLCs or 10 other types of companies, for example, with under 25 each, would not work if the common ownership rules are met.

Covering Dependents

Is there a requirement that plans provide dependent coverage?

There is no requirement that plans provide dependent coverage prior to December 31, 2013. After that date, the employer mandate penalty applies to an employer with over 50 full-time employees that fails to offer its full-time employees and their dependents the opportunity to enroll in a plan that satisfying the “essential” benefits package. Prior to that date, no dependent coverage needs to be offered. After that date, an employer failing to offer dependent coverage would be subject to the \$2,000 per full-time employee penalty. Although the term is not defined in the new law, dependent coverage generally means coverage for a spouse and children.

Must we provide an extension of coverage to dependents up to age 26?

For the extension to apply, group health plans and insurance issuers offering group or individual health insurance coverage must already provide dependent coverage. If an employer does not already provide dependent coverage, it would not be required to do so. Coverage is required to be extended for an adult child *until the child turns age 26*; thus, once the child is 26, coverage will cease. Coverage is not required to be provided to children of the adult child. This provision goes into effect for plan years beginning on or after October 1, 2010. For calendar year plans, this would not take effect until January 1, 2011.

While there is not a lot of guidance regarding this rule yet, the Secretary of HHS will issue regulations which should include a definition of “dependent.” What we do know now is that coverage must be extended without regard to the child's dependent status, student status, marital status or work status. In other words, it does not matter if the child is (a) a dependent under the IRS guidelines, (b) a student, (c) married, or (d) eligible to enroll in an eligible employer-sponsored health plan.

Prior to January 1, 2014 plan years, if a plan has grandfathered status, the grandfathered plan can refuse to offer coverage for a dependent who is eligible to enroll in an employer-sponsored health plan. After that date, eligibility for other employer coverage must be disregarded.

The new law also modifies tax treatment of dependents, allowing employer coverage to be non-taxable until the child reaches age 27 (designed to allow tax favored treatment for the taxable year in which the child turns age 26).

How does the age 26 rule apply to self-funded plans?

Self-funded plans would be required to comply with the age 26 extension.

Some employees want to add their children to coverage right away under the new age 26 rule. Is there a special enrollment for dependent children to join an employer's group health plan?

Employees should be advised about the effective date; plans will not be required to cover these children up to age 26 until the first plan year after October 1, 2010. Employees will be permitted to add these adult children at that time. No special enrollment is required or necessary because of this effective date.

Individual Mandate

Is there an exemption from the individual mandate on the basis of religious beliefs?

Yes, four groups of persons are able to claim an exemption from the mandate on individuals, including on the basis of religious beliefs:

- Members of an exempt *religious* sect or division
- Members of a health care sharing ministry (these are organizations that share each others health care costs, and must have been established for some time – since 1999; new members presumably could join, though)
- Indians
- People eligible for hardship exemption

Classing Out Employees

We offer an insured health plan; can we continue to classify employees by hourly versus salaried status when determining eligibility for benefits?

Generally, no. Under the new rules, an insured health plan cannot make distinctions in eligibility based on income, including on hourly versus salaried status.

Insurance carriers seem to be implementing this rule for upcoming renewals despite employers' positions on grandfathering. Health insurance carriers already are interpreting the rule literally and strictly.

Do these rules apply to self-funded plans?

No, but self-funded plans are already subject to Section 105 non-discrimination rules in the Internal revenue Code; the implication of this rule is that Congress believes self-funded plans are already regulated by that rule and are in compliance. This Administration's pressure may signal increased IRS interest in defining the scope of the non-discrimination rule and enforcing it similarly to the insured rule as disallowing distinctions on hourly versus salaried and perhaps other similar distinctions.

Advance Disclosure of Plan Changes

Does the 60-day advance disclosure rule apply to mid-year changes only, or is it also applicable to changes at annual enrollment?

Both types of changes trigger the disclosure requirement. A plan sponsor must now give 60 days' prior notice if it makes a material modification to its plan, regardless of when the change is made.

What triggers the advance notice – what is a “material” change to a health plan?

While there is no exact definition of what constitutes a “material modification,” the DOL has stated that “material modification or change” would be construed to mean those changes that are most important to plan participants. The DOL has listed the following information as material: name and address of plan sponsor or administrator; structure, name and type of plan; agent for service of process, and persons performing functions for the plan; plan requirements; and disposition of employee's contributions. An example of a change triggering an advance notice is dividing retirees into two groups which are charged different premiums for health coverage. Also, a change that increases deductibles, copayments of other amounts to be paid by a participant or beneficiary would likely be a material reduction in covered services or benefits.

Do we still have to issue a Summary of Material Modifications for material reductions in covered services or benefits?

Yes, technically, you do. If a modification or change to a group health plan produces a material reduction in covered services or benefits under the plan, the plan may still be required to furnish an SMM to participants and beneficiaries no later than 60 days *after* the modification or change is adopted. However, it is likely the DOL may take the position that the prior notice requirement eliminates the need to prepare and distribute the SMM.\

Incentive to Waive Coverage

It sounds like we will no longer be able to provide a reimbursement plan to those opting out of our health insurance plan?

That is correct. After 2014, if the employer provides an incentive for employees to opt out of the plan, the employer will be responsible to pay any claims for those employees and dependents that are paid out of the high risk pool.

Will the termination of a plan be considered an “incentive” that would result in the employer being responsible for claims under a high risk pool? What if the employer increases the wages or salaries of persons who were formerly eligible for coverage?

No, terminating a plan would not be considered an “incentive,” even if some or all employees receive a wage increase. No incentive to opt out is provided – there is no element of choice -- where the employer simply stops offering the plan.

However, if the employer has over 50 employees, the employer will not satisfy the mandate to offer coverage as applicable to an employer with over 50 employees. The employer would have to pay the \$2,000 penalty for each full-time employee, but the employer would not be responsible for any risk pool claims because terminating the plan did not create an incentive.

What about a plan that does not allow spouses to be eligible if the spouse has coverage elsewhere? What if the plan conditions the spouse’s eligibility on proof of other coverage?

The eligibility rule would not appear to be an incentive that triggers the risk of claims being paid through a pool. However, if the employer has over 50 employees, the plan probably will not satisfy the employer mandate requirement starting with January 1, 2014 plan years. The law does not make an exception for spouses or dependents with coverage available elsewhere.

Additional guidance from HHS *may* be less strict than the language of the new law and may allow this type of eligibility rule after the mandate takes effect for plan years starting in 2014. Given the current regulatory

environment, however, it is not likely HHS will take a position that favors a plan sponsor over an employee's spouse.

Employees Terminating All Group Health Plan Coverage

If an employer decides to terminate its group health plan, how will its employees get coverage, ranging from blue collar through white collar workers?

Individual policies will be available, on more favorable entry terms than currently available. Premiums may not be affordable for these persons. Even with more intensive oversight of premium rates, it may take some time for rates to be settled and even then affordability may be an issue. After January 2014, individual health insurance policies will be available to individuals in each state through state-level insurance exchanges. Individuals may be able to enroll through other programs such as multiple state insurance programs or co-ops. Lower paid individuals may receive tax credits or other subsidies for single or family coverage, depending on their specific situations.

Exchanges

How will insurance exchanges operate?

Insurance exchanges will be internet portals that enable individuals, and eventually employers, to evaluate and select health insurance coverage on-line. The federal law sets certain standards for the types of plans that can be offered through exchanges, and permits existing exchanges to continue to operate in states where they are currently in place. The concept of an exchange is designed, in part, to decrease administrative expense and complexity in comparing policies and requesting quotes for the various policies that are offered. The federal government will establish an exchange in any state not offering an exchange by 2014.

Exchanges have met with mixed results. Using an exchange is not always easy initially, due to a learning curve and possibly due to exchange design and glitches. Using an exchange does not always result in lower rates. In some situations, in states with exchanges, insurance plan costs are higher in an exchange than on the outside, traditional market. While exchanges are new, underwriters will be learning how to correctly price the policies offered by their insurance carriers.

The exchange concept also will permit the federal government to more closely monitor enrollment in insurance policies and to revise the offerings in the exchanges. The federal government also will use the exchange as a channel for the use of employer-provided vouchers for employees who are not offered affordable coverage at the workplace.

Annual and Lifetime Benefit Caps

When are the annual and lifetime caps no longer allowed?

This is effective for plan years beginning on or after October 1, 2010. For plan years beginning prior to January 1, 2014, a group health plan may have annual limits on only the dollar value of benefits that are "essential benefits." For plan years beginning in 2014, cost sharing cannot exceed the limits in Code Section 223(c)(2)(A)(ii) of the Internal Revenue Code (a high-deductible health plan standard, to be indexed).

Do the rules apply to insured plans and self-funded plans?

Yes. Both insured plans and self-funded plans will not be permitted to have annual and lifetime caps after the effective date.

Executive Medical Plans

Will insured executive medical plans be permissible under health care reform?

Insured executive benefit programs will no longer be allowed under the non-discrimination rule, starting with plan years beginning on or after October 1, 2010.

What if the employer taxes the plan coverage – does that change the analysis?

The law simply prohibits the offering of an insured plan that discriminates in this manner. Taxing the value of the coverage does not appear to allow the employer to avoid this rule. Insurance carriers already are refusing to issue policies that discriminate in this manner.

An employer could self-fund the benefit, and treat claims paid as a discriminatory, taxable benefit under Section 105. However, the individual will be taxed on funds that are actually paid to a third party, such as to a hospital, or that as reimbursements of amounts the executive has paid. An executive covered by such a program would be paying the tax out of income received, and without a gross up for taxes, the executive would receive a diminished benefit. For an executive who incurs a large claim that is not covered by the plan on a tax-favored basis, such as for surgery for a condition not covered by the plan, the difference in taxation will be significant.

Cadillac Plan Excise Tax

How will the Cadillac tax operate, assuming a plan has a value putting it into that category of coverage?

The Cadillac plan excise tax applies starting with the 2018 tax year. Employers must place a value on employer-provided health coverage offered at the workplace. If the value of that coverage is over a certain dollar amount set by the law, then a 40% excise tax applies to the excess value of the coverage.

The employer will calculate the value of coverage and will report the value of the coverage on each employee's Form W-2. An insurance carrier for an insured plan is responsible for remitting the tax, and the employer is responsible in the self-funded plan context. The law is not entirely clear on how that tax amount is to be passed through to participants, though it likely will be. The law is also not clear on how the tax is to be paid and reported to the IRS such that the tax will correspond to the W-2 information for each affected individual.

Over the Counter Drugs

When is the effective date of the new rule stating over-the-counter drugs are no longer reimbursable?

The rule applies to expenses incurred in plan years beginning January 1, 2011.

Are over-the-counter (OTC) drugs reimbursable if the individual has a doctor's note or prescription requiring the OTC medication?

The law reads as follows: reimbursement for expenses incurred for a medicine or drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin. If a doctor prescribes something, whether or not it is actually available without a prescription, it would qualify as a medical expense that is reimbursable.

Preexisting Condition Exclusions and Limitations Forbidden

Does the preexisting condition rule apply to:

- ***Carriers?***

Yes.

- ***Fully-insured group health plans?***

Yes.

- ***Self-funded plans?***

Yes.

Small Employer Tax Credit

What is the small employer tax credit?

Under federal health care reform as enacted in March 2010, a small employer (fewer than 25 full-time employees as discussed below) will be eligible for a tax credit within certain guidelines, starting with the 2010 tax year. All amounts paid toward health insurance premiums in 2010 are taken into account, not just the amounts paid for health insurance after the new law was enacted.

Some employers with more than 25 employees may qualify for the credit if they have a large number of part-time employees. Employers that may fall into that category should evaluate the number of full-time equivalent employees.

The income tax credit is part of the Internal Revenue Code Section 38(b) general business credit. The credit is claimed on the employer's annual income tax return. The IRS is providing additional guidance to tax-exempt employers on how to claim the refundable credit. Unused credits may be carried forward, according to the IRS. After the 2014 tax year begins, the credit may be claimed for two tax years.

If an employer is otherwise able to take a deduction for health insurance coverage expenses as a business expense, the amount of the deduction is reduced by the amount of the credit.

Eligibility for the Tax Credit

A small employer must satisfy all three of the following conditions:

- The employer must have fewer than 25 full-time equivalent employees (explained below)

- The employer must have “average wages” for its employees that do not exceed twice a certain dollar amount. (“Average wages” are explained below.) The current amount is \$25,000, so the average wages cannot exceed \$50,000 for the 2011. This figure will be indexed beginning with the 2014 calendar year.
- The employer must make an employer contribution toward health insurance coverage which is at least 50% of the premium cost. (Starting in 2014, the coverage must be obtained through an exchange.) (The IRS is indicating the 50% requirement is based on single coverage, regardless of the level of coverage individuals elect.)

Initially, an employer will exclude certain employees from the employee count, as allowed by law. Excludable persons include:

- Self-employed persons (as defined in Code Section 401(c)(1))
- 2% shareholders of eligible small businesses that are S corporations
- 5% owners for an eligible small business
- Persons who are dependents of persons in the above three categories of persons (cross-referencing Code Section 125(d)(2)(A) – (H))

Based on IRS interpretations on its website, the employer would not consider wages earned by such excluded persons when calculating average wages.

Leased employees are *included*.

“Full-time equivalent employees” are determined by determining the total number of hours worked by all employees (capped at 2,080 hours per person) for which wages were paid, and dividing that number by 2,080. (Seasonal workers’ hours may be excludable, as explained below.) (Note: This calculation is different from that used to determine full-time equivalent employees for purposes of the employer mandate to provide coverage starting with January 1, 2014 plan years.)

By “wages,” the new tax credit rule generally means amounts paid to both hourly and salaried workers. The department of Health and Human Services will work with the Department of Labor to address other types of payment, likely including payments for piecework; we will provide additional guidance as these rules are issued. If the number is not a whole number, the number is rounded down to the next lowest whole number.

“Average wages” are determined by determining all wages paid to employees by the employer during the taxable year (with seasonal hours excluded when possible -- see below), and then dividing that amount by the number of full-time equivalent employees for the taxable year. The average wages must be rounded to the next lowest multiple of \$1,000 (if it is not already a multiple of 1,000).

Seasonal Workers -- Seasonal workers’ hours and wages are excluded from the calculations of hours of service and from wages in the above calculations, but only if the seasonal worker works for the employer for 120 days per year or less. In other words, if the seasonal employee works more than 120 days per year, that person’s hours and wages apply to these determinations. The employer also needs to make sure the worker is actually a seasonal employee. The law says a “seasonal worker” for this purpose is a worker who performs services on a seasonal basis as defined by the Secretary of Labor (including retail workers during the holiday season). The reference to Department of Labor interpretations would also include the following rule on who is a “seasonal worker”:

“ where, ordinarily, the employment pertains to or is of the kind exclusively performed at certain seasons or periods of the year and *which, from its nature, may not be continuous or carried on throughout the year.* A worker who moves from one seasonal activity to another, while employed in agriculture or performing agricultural labor, is employed on a seasonal basis even though he may continue to be employed during a major portion of the year.”

If a seasonal worker, for example a summer resort employee, works in one position during the on-season as a seasonal employee, then in a maintenance position in the off-season, that person would be considered a seasonal worker. The days on which that person works will count toward the 120 days.

Tax Credit Amount

For tax years starting in 2010 and prior to the 2014 tax year, the tax credit amount generally is 35% of the lesser of:

1. the total amount of contributions the employer makes on behalf of its employees during the taxable year for premiums paid for health insurance coverage, or
2. the total amount of contributions the employer would have made if each employee had enrolled in a qualified health plan which had a premium equal to the average premium for the small group market in the state in which the employer is offering the coverage. (Note: The IRS is expected to publish these State-by-State figures on its website by the end of April.)

“Health insurance coverage” for this purpose means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

The IRS includes the following example on their website:

For the 2010 tax year, a qualified employer has 9 FTEs with average annual wages of \$23,000 per FTE. The employer pays \$72,000 in health care premiums for those employees (which does not exceed the average premium for the small group market in the employer's State) and otherwise meets the requirements for the credit. The credit for 2010 equals \$25,200 (35% x \$72,000).

For tax years starting with the 2014 tax year, the tax credit amount generally is 50% of the lesser of:

1. the total amount of contributions the employer makes on behalf of its employees during the taxable year for premiums for qualified health plans offered through an exchange, or
2. the total amount of contributions the employer would have made if each employee had enrolled in a qualified health plan which had a premium equal to the average premium (determined by the federal government) for the small group market in the rating area in which the employee enrolls in coverage.

Tax aggregation rules apply, so an employer that is part of a controlled group generally cannot strategically separate into smaller companies to take advantage of the tax credit. (The law cross-references Sections 414(b), (c), (m), and (o), as well as Section 52(c), (d), and (e).)

Only the employer’s contributions are taken into account; the employee’s contributions are not counted as part of the contributions even if the employee pays his or her portion through a payroll deduction under a cafeteria plan.

The IRS does not provide any insight into the transition for group health plans between the 2013 plan year and the 2014 tax year, at which time the employer must purchase coverage from an exchange. A concern exists that an employer with a plan year other than a January 1 plan year may not be able to claim the credit for some portion of the 2014 tax year. If there is no transitional relief, small plans wishing to claim the credit may wish to change to a January 1 plan year prior to 2014.

Tax-Exempt Small Employers -- The tax credit is 25% (35% for tax years starting in 2014) for tax exempt eligible small employers. A “tax-exempt eligible small employer” is any 501(c) exempt organization exempt from taxation under Section 501(a). Tax aggregation rules apply, so an employer that is part of a controlled group generally cannot strategically separate into smaller companies to take advantage of the tax credit. (The law cross-references Sections 414(b), (c), (m), and (o), as well as Sections 52(c), (d), and (e).)

The credit is treated as a credit under Subpart C of the Internal Revenue Code, not the subpart containing Section 45R. Also, for a tax-exempt small employer, the credit is the lesser of the amount of credit calculated under the usual rules (discussed in this document), or the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins. "Payroll taxes" as used in this context means:

- Withholding under Section 3401(a),
- Withholding required by Section 3101(b), and
- Amounts of taxes imposed on the eligible small employer under Section 31111(b).

A rule similar to the rule in Section 24(d)(2)(c) applies for purposes of determining payroll tax withholding.

As with other employers, only the employer's contributions are taken into account; the employee's contributions are not counted as part of the contributions even if the employee pays his or her portion through a payroll deduction under a cafeteria plan.

The credit cannot exceed the total amount of income and Medicare (i.e., Hospital Insurance) tax the employer is required to withhold from employees' wages for the year and the employer share of Medicare tax on employees' wages.

The IRS website contains the following example:

For the 2010 tax year, a qualified tax-exempt employer has 10 FTEs with average annual wages of \$21,000 per FTE. The employer pays \$80,000 in health care premiums for those employees (which does not exceed the average premium for the small group market in the employer's State) and otherwise meets the requirements for the credit. The total amount of the employer's income tax and Medicare tax withholding plus the employer's share of the Medicare tax equals \$30,000 in 2010.

The credit is calculated as follows:

- (1) Initial amount of credit determined before any reduction: $(25\% \times \$80,000) = \$20,000$
- (2) Employer's withholding and Medicare taxes: \$30,000
- (3) Total 2010 tax credit is \$20,000 (the lesser of \$20,000 and \$30,000).

Reduction of Credit

The full amount of the credit is only available to employers with 10 or fewer full-time equivalent employees, and whose employees have average annual wages from the employer of less than \$25,000.

The credit is reduced for any eligible employer, depending on the number of employees and average wages. The amount of the credit is reduced as follows, as described on the IRS website:

If the number of FTEs exceeds 10 or if average annual wages exceed \$25,000, the amount of the credit is reduced as follows (but not below zero). If the number of FTEs exceeds 10, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the number of FTEs in excess of 10 and the denominator of which is 15. If average annual wages exceed \$25,000, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the amount by which average annual wages exceed \$25,000 and the denominator of which is \$25,000. In both cases, the result of the calculation is subtracted from the otherwise applicable credit to determine the credit to which the employer is entitled. For an employer with both more than 10 FTEs and average annual wages exceeding \$25,000, the reduction is the sum of the amount of the two reductions. This sum may reduce the credit to zero for some employers with fewer than 25 FTEs and average annual wages of less than \$50,000.

Example. For the 2010 tax year, a qualified employer has 12 FTEs and average annual wages of \$30,000. The employer pays \$96,000 in health care premiums for those employees (which does not exceed the average premium for the small group market in the employer's State) and otherwise meets the requirements for the credit.

The credit is calculated as follows:

- (1) Initial amount of credit determined before any reduction: $(35\% \times \$96,000) = \$33,600$
- (2) Credit reduction for FTEs in excess of 10: $(\$33,600 \times 2/15) = \$4,480$
- (3) Credit reduction for average annual wages in excess of \$25,000: $(\$33,600 \times \$5,000/\$25,000) = \$6,720$
- (4) Total credit reduction: $(\$4,480 + \$6,720) = \$11,200$
- (5) Total 2010 tax credit: $(\$33,600 - \$11,200) = \$22,400.$

Where can I find additional information?

The IRS has a discussion of the new tax credit on its website at:

<http://www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6>

Waiting Periods Limited to 90 Days

If an employer has a provision stating a new hire is eligible for coverage the first of the month following 90 days of employment, does that satisfy the 90-day waiting period established by health reform? Or does the plan need to allow employees to join the plan the first of the month following 60 days of employment, so all employees are eligible within the 90-day period?

The law literally states the maximum waiting period can be no more than 90 days. Until we get further agency guidance, we will not know if a plan satisfies this requirement with a provision for “eligibility starting the first of the month following 90 days of employment.” Please note that in at least one state with a similar rule, the state took the position that this type of rule was permissible, even though it might operate to delay coverage a little longer for some persons.

New Flexible Spending Account Limit

When is the \$2,500 cap on health flexible spending accounts effective?

The new rule for \$2,500 being the maximum FSA contribution will apply to taxable years starting with the 2013 tax year. The tax year is generally the calendar year for individuals.

What if we do not have a calendar year cafeteria plan, and employee health FSA elections are effective for parts of two calendar years?

We do not yet have any guidance on how to deal with cafeteria plan/FSA plan years that straddle the calendar year, such as July 1 plan years, but we assume the IRS will require the \$2,500 to apply as the maximum for 2013 as a whole, so employers may have to require odd elections for amounts deducted and claims incurred prior to 12/31/12, with a separate amount for the 2013 portion, perhaps.

Reinsurance Program for Early Retirees

When is the new reinsurance program for early retirees effective?

March 23, 2010, with standards to be developed and program “live” by 90 days after that date. The program ends on 1/1/14, or earlier if the funds run out.

How does an employer qualify for the reinsurance program for early retirees?

To be an *employment-based plan* that can participate in the program, the plan must:

1. Provide health benefits to early retirees,
2. Implement programs and procedures to generate cost savings with respect to people with chronic or high-cost conditions (presumably case and care management programs will qualify, but the scope is uncertain yet),
3. Provide documentation of the actual cost of medical claims involved, and
4. Be certified by the Secretary of HHS. (This last condition and another provision indicate an application and approval process will be part of the regulations and criteria to be issued by the June 21, 2010 timeframe.)

The program is available to plans providing early retiree benefits and sponsored by state and local governments and agencies or instrumentalities of these governments. This program is also available to other, non-governmental employers, employee organizations, VEBAs, a plan’s committee or board, or multiemployer plans as defined in Section 3(37) of ERISA. (These multiemployer plans described in ERISA Section 3(37) are collectively bargained plans with more than one employer being required to contribute.)

How does the employer apply to participate in the program; what is the process?

We will not know more about the process until HHS issues guidelines, due by June 21, 2010.

What must an employer do administratively – track individual claims, etc.?

To be reimbursed, a participating employment-based plan will submit claims to the Secretary of HHS. The claims documentation must contain information on the actual costs of the items and services for which each claim is being submitted. This means the cost will be the actual amount expended by the plan (so, not billed charges – the HHS staff will be looking for discounted amounts and likely proof of payment as well – check copies/cancelled checks). The law specifically requires that claims submitted for reimbursement take into account any negotiated price concessions including discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations. The plan must include amounts incurred by the covered early retirees, spouses, and dependents (including survivors). Deductibles, coinsurance, and copayments should be included in the calculation of the amount paid by the plan. For example, if an entity is a university that takes advantage of special deals with its own hospital system, those deals would have to be considered to the extent they affect the claims incurred and submitted for reimbursement. Further, it appears that for prescription drug charges, the plan would have to consider and allocate pharmaceutical company rebates.

The amount of the claim will include amounts incurred by the covered early retirees, spouses, and dependents (including survivors), so deductibles, coinsurance, and copayments are included in the calculation of the amount paid by the plan. HHS will conduct annual claims audits, to review the amounts plans have submitted.

The amounts submitted should be for the entire plan year in question; there will be some overlap and some employers may report claims for a partial plan year (in 2010 as well as in 2013, if their plan year is an August 1 plan year, for example).

If the Secretary determines the plan's claim is valid, the amount of the reimbursement will be approximately 80% of the amount the plan pays toward an individual's claim amount over \$15,000 but less than \$90,000. (Presumably, if a plan has a lower attachment point for stop loss coverage, the \$90,000 figure should be reduced to reflect the fact that stop loss insurance moneys were received, but the law does not specifically address this issue. The law does not explain how this new program works in the fully-insured context, as mentioned above.) These amounts will be indexed. The Secretary will establish a formal appeals process for denied claims.

How can reinsurance reimbursements be used? Are they employer general assets?

If a plan receives a reinsurance reimbursement from the federal agency, the plan is required to use the money to lower costs for the plan. The reimbursements may be used:

- To reduce premium costs for the employer, VEBA or other sponsor, or
- To reduce premiums or other out-of-pocket costs for the plan participants. (The law says "plan participants," not retirees, so if the plan covers active and retired workers, the money reimburse through this program presumably can reduce costs for active workers as well.)

These moneys cannot be used as the general revenues of the plan sponsor. HHS will monitor use of the funds, perhaps through reporting, a certification, or audits – the means to monitor compliance with this rule will be set in regulations, most likely. The plan sponsor does not treat these reimbursements as income.

Comparative Research Fee

When and how is the fee for comparative research calculated?

The fee is calculated at the end of the policy year, based on the average number of covered lives.

The fee is \$1 per covered life for plan years or policy years ending in 2013. For policies and plan years ending in 2014 and beyond, the fee is \$2 per covered life, with an adjustment in the projected amount of National Health Expenditures.

It is an annual fee. It will be calculated based on the average number of covered lives during the year (not just the number of covered employees). The law does not address how an employer determines the average number of persons covered by the plan – whether the employer is expected to take the number covered on each day and divide by 365, or whether some other method is used. Finally, we do not yet know where the employer reports this information/what tax form is used to transmit the fee; the new law does not address this issue.

Is it per employee or per covered life?

The fee is not a per employee fee, and it is not a fee calculated on the number of covered employees. It is calculated based on covered lives, which means the plan sponsor or carrier will include dependents and spouses.

What is the fee used for?

The fee is used to fund the Patient-Centered Outcomes Research Trust Fund (PCORTF). The Institute funded by these amounts (as well as transfers from the Medicare program) will assist patients, clinicians, purchasers, and

policymakers in making informed health decisions by advancing quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can appropriately and effectively be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations and the dissemination of research findings with respect to relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services and items described in another subsection of the law. (In other words, we don't know!)

Vouchers from Employers

What is a voucher?

Special voucher rules apply if an employer's plan is determined not to be "affordable" for a worker (if the cost exceeds 8% to 9.8% of the person's income which must be 400% or less than federal poverty level). If that employee does not qualify for a tax credit, the employee can obtain a voucher from the employer equal to the employer's contribution and use that amount to purchase coverage through the exchange. Employers with lower paid workers may lose employees to the exchange, especially because employees apparently can keep employer voucher amounts in excess of the cost of exchange coverage. It is unclear at present how employers will issue these vouchers and what form the vouchers will take.

How will an employer know if an employee is eligible for a voucher? Is it based on the prior year's income?

Based on the wording of the new law, it appears the IRS may issue advance determinations, as it does for the individual tax credit. How this process will operate in actual practice remains to be determined.

Will the employer transfer money directly to the exchange, or will the employer write a check to the employee and withhold taxes?

We don't yet know what form the vouchers will take. Our guess is that the exchange will likely bill the employers, rather than require employers pay out monies to employees to purchase the coverage.

If the employee uses the voucher amount to buy coverage through the exchange, is the amount of the voucher taxable?

No, the amount used to buy coverage is not treated as taxable income to the employee. The employer would not have to withhold taxes on the amount it transfers directly to an exchange, provided that entire amount is used to purchase health insurance coverage.

What if the coverage through the exchange is less than the amount of the voucher?

If the coverage purchased through the exchange is less than the amount of the voucher (for example, if an employee under age 30 purchases only catastrophic coverage), the excess amount is not refunded to the employer. The excess instead is paid to the individual, which may encourage some people to purchase the least expensive form of coverage available. That excess amount is to be considered taxable income to the individual. If the employer has sent the money to the exchange and the exchange has refunded the amount to the individual, the individual is solely responsible for tax payments. It does not appear there is any employer withholding obligation in that situation. Additional guidance will shed more light on the details of how taxation and any withholding are to be handled.

Application of Reform to Federal Employees

How does health care reform apply to the federal government and its employees?

There are not many references to the plans that cover federal employees, which we think would have happened if the rules were to apply to the federal employee plans. While those federal employee plans may not be subject to the same penalties, mandates, etc., they probably will offer the same benefits to be competitive. In fact, they may be more generous. We assume the individual mandate and the related penalty would apply to federal employees based on their status as tax payers – regardless of their employer. Some parts of the new law specifically include federal employees in the new rules. For example, the 40% Cadillac plan excise tax does apply to a plan of the federal government, to the extent the plan primarily covers civilian employees. (A “civilian” employee is not defined; it may mean non-military employees.)

A provision in the rules on insurance exchanges says the plan covering members of Congress and their staff must be a plan created by the new law (basically the essential benefits plan) or a plan offered through a state exchange (which will be similar to the essential plan but which may contain more benefits).

Impact of Reform on State Law

How do the provisions on federal health care reform affect, interact with, or preempt state laws?

In general, federal rules will govern (similar to the way ERISA preempts state laws); however, there are some state laws that will be permitted to stand - this will be on a section by section basis.

Home Health Care Provisions

Can you please provide some information on the new Home Health care provision of the bill?

In general, some of the home health care provisions were promoted within Congress as a way for the federal government to determine if it might be less expensive to provide services in the home setting rather than in a hospital, hospice, or similar setting.

The “independence at home demonstration project” in Section 3024 of Health Reform is a program for chronically ill persons (someone with 2 or more conditions, such as diabetes, stroke, congestive heart failure, etc.) in the hope that the expenditures will be less than if these persons were admitted and monitored in a hospital or other setting. The program is not just for physical conditions, or what we might think of as physical conditions. For example, dementia and Alzheimer’s are two listed conditions. One consideration in evaluating this new section of the law is whether persons with the listed conditions should be at home or not. In addition, there is a financial incentive to be paid to the at home provider firm if the costs are lower for at home care than expected. Decreased hospital readmissions are one consideration; hospitals are very dangerous in terms of infections and medical mistakes. On the other hand, one may ask if home health firms will provide the same level of monitoring, care, tests, and other services a person receives in a higher level setting, including the Standard Operating Procedures that apply to care in a hospital setting. Finally, the financial incentive is an issue; please note that the law states nothing in this section should be construed as incentivizing rationed care.

Section 3131 provides for re-consideration of home health prospective payment amounts and the system as a whole to improve payment accuracy.

Finally, section 3143 provides the new law will not result in the reduction of current home health benefits. (It does not mention the other result – expansion.)

A few observations – the home health provisions may be included, in part, to address the high cost of hospitalization, the lack of rural health care, the cost of hospice care, and other similar issues, all discussed in nearby provisions of the reforms to Medicare. Some people are more worried about home health care in terms of whether the federal programs are being redesigned to provide lower cost benefits to older, less healthy persons as an offset to increased costs to provide benefits to other populations.

Enrollment Issues

Has there been any discussion about imposing specific entry dates (likened to Open Enrollment dates) for government imposed or run programs, such as tax credits and vouchers? Are there specific termination dates? May individuals be able to forego insurance, pay the modest fine, and, when they get sick, enroll through government programs to make sure they have coverage for what might otherwise be very expensive care? Is there anything to stop them from dropping the insurance once they are healthy again?

The law does not address government plan entry dates or termination dates. This concern is completely valid - there doesn't seem to be anything to stop adverse selection from occurring. Insured policies in the individual market apparently do not have protections under entry date rules. It seems that someone could actually be in the hospital and sign up for a plan through the exchange.

What protections does an employer plan have against adverse selection?

For employer plans, there is some protection by plan enroll standards that do not conflict with the new law, limited special enrollment rules, cafeteria plan election provisions, and cafeteria plan change in status rules.

Minimum Loss Ratio

Is there a delayed effective date being discussed for the minimum loss ratio rules that apply to carriers?

We are unaware of any discussion of a delay. The requirements for carriers to spend a certain amount of fully-insured premium dollars on claims or rebate amounts to plan participants is scheduled to take effect January 1, 2011.

The information contained herein is intended to provide general information and does not constitute legal advice. You should not act or rely on any information contained herein without seeking the advice of an attorney.