

AFFORDABLE CARE ACT OF 2010—PRACTICAL REALITIES

Key Points:

- This legislation (the Patient Protection and Affordable Care Act/Health Care and Education Reconciliation Act of 2010, or collectively “Health Care Reform”) is about providing health insurance, and not necessarily focused on correcting the flaws of the current health care system.
- The key objective therefore is to provide access to health insurance, and heavily subsidize the cost of such insurance, for 31+ million people who were previously “uninsured”. It does not “fix” the existing issues for the other 160+ million who already have health insurance today.
- The majority of the Reform is phased in over a decade – with many of the larger reforms beginning in 2013 and 2014 and continuing well into the next congressional cycle—rules likely to be modified in the interim.

Immediate Issues of Importance:

- No change for employees of under 50 employees, though employers with less than 25 full-time employees who earn under \$50,000/year may qualify for a 35% tax credit if the employer pays at least 50% of monthly insurance premiums;
- If more than 50 employees, several coverage mandates require changes to existing health plans (“grandfathered plans”) that must be made and be effective for the first plan year beginning on or after September 23, 2010 (most “calendar year” plans must make these changes by December 31, 2010—many fully insured health plans are having some changes made by the insurance carrier before that deadline, and other “new” plans are required to comply immediately), including but not limited to:
 - elimination of lifetime limits on coverage for “essential health benefits” (presently undefined, though generally includes hospitalization, emergency room services, maternity/newborn/ pediatric services, lab services, etc.) until 2014, but then total removal of annual or lifetime limitations on coverage for such “essential health benefits” thereafter;
 - non-cancellable insurance provisions (i.e., no ability for an insurance company to rescind coverage after its effective date unless due to fraud or based on an intentional misrepresentation of a material fact);
 - no pre-existing condition limitations for children under age 19 (all pre-existing conditions limits removed in 2014, regardless of age); and
 - adult children can stay on their parents’ employer group coverage until age 26;
 - o IRS has now clarified that there is no imputed income to the qualifying child for either making contributions through the employer’s plan for the cost of such coverage, or for the benefits provided to the child even if not otherwise deemed to be a “dependent” for general tax purposes.
 - o Until 2014, employers can deny coverage to any such child that is either married or has the ability to receive group health insurance elsewhere; in 2014, all children can participate without restriction (based on current guidance), but spouses and children of the employee’s child can be excluded.

- New plans and “non-grandfathered” plans have additional obligations and restrictions, including but not limited to:
 - First dollar coverage (e.g., no copays, deductibles or other cost-sharing arrangements) for preventive care (including immunizations, breast cancer screening and other recommended services from the US Preventive Services Task Force);
 - Non-discrimination standards apply to self-funded health plans AND fully-insured arrangements;
 - Increased requirements for claim adjudication and administrative appeals.
- Nursing mother provisions: employers with 50 or more employees must provide a private space, other than a bathroom and in an area free from intrusion, for a nursing mother to express breast milk during working hours (though not required to be “paid time”) for 1 year following the birth of a child.
- Effective June 1, 2010, employers may be reimbursed for 80% of the total cost of claims paid for retirees that are covered by the employer-sponsored health plan between the ages of 55 and 64—requires application submission and is available only as long as \$5 Billion in federal funding remains unused; the employer must specify reimbursement amounts are to be used for limited purchases that offset future plan costs (e.g., mitigate future premium increases).

Intermediate Impact:

- 2011 Forms W-2 (due in January of 2012) must report the aggregate cost of employer-sponsored health insurance (COBRA rates deemed to allowable for cost determination);
- Wellness initiatives are enhanced to encourage greater participation in wellness programs (e.g., Employers may provide premium discounts of up to 30% to reward employees for participation in certain health and wellness programs that encourage long-term behavior modification);
- Health savings accounts (“HSA’s) and Section 125 “cafeteria plan” flexible spending accounts (“FSA’s”) will feel some impact, including but not limited to:
 - Beginning January 1, 2011, the penalty tax for distributions other than for qualified medical expenses from HSAs will increase to 20% (from 10%);
 - January 1, 2011, over-the-counter medications will no longer be reimbursed as “qualified medical expenses” (meaning only prescribed drugs will be reimbursable under HSA and FSA plans) ;
 - On January 1, 2012, The maximum contribution to an FSA will be reduced to \$2500 (unlimited today, unless imposed by an employer’s plan);
- Employers with at least 200 full-time employees must automatically enroll eligible employees in the employer’s group sponsored health plan (actual effective date still unknown) unless the employee otherwise opts out from coverage;

Long-Term Impact (Based on Current Law):

- **Beginning in 2013 and beyond:**
 - Payment provisions begin to offset governmental cost to “pay” for the cost of providing coverage to 31+ Million people (primarily through the health care exchanges, discussed below), including but not limited to:
 - Increasing Medicare tax on employees of .9% above certain income thresholds (\$200,000 for individuals/\$250,000 for Joint filers);
 - A new Medicare tax of 3.8% is to be created on “unearned income” (interest, dividends, etc.) for high income individual and couples;
 - The imposition of fees on various stakeholders within the health care industry, including the health insurance industry and pharmaceutical manufacturing;
- **Beginning in 2014:**
 - Employers will be required to offer “minimum essential” health insurance to their employees (though traditional “nondiscrimination” standards appear to remain in effect from a tax perspective), or face per employee penalties;

- o Non-compliance penalty: \$2,000 per full-time employee (less first 30 full-time employees);
- o Free Rider Penalty: If employee's cost of coverage exceeds 9.5% of household income and at least one employee purchases coverage through a Health Care Exchange (see below), penalty is lesser of: a) \$3,000 for each employee who obtains coverage through the Exchange, or \$2,000 per employee;
- o Free Choice Voucher: applies if any employees earn less than 400% of federal poverty level, and the employee's cost of coverage is greater than 8% but less than 9.8% of household income—employer must provide a "voucher" of amounts paid for the most generous employer coverage, which is paid directly to the Exchange on the employer's behalf.
- o Health Care Exchanges will be established to provide coverage options to qualifying individuals and small businesses, and also provide premium and cost-sharing credits to assist qualifying individuals and families with purchasing coverage.
- o Health Care Exchanges are state-based entities that are regulated by Health and Human Services (HHS);
- o Governmental agencies or non-profit entities will administer Health Care Exchanges—no for-profit administration allowed; and
- o Small Employers (those with less than 50 employees) will be allowed to coordinate with Health Care Exchanges to provide coverage for their employee—small employer tax credit increases to 50% if less than 25 full-time employees earning under \$50,000.
- Beginning in 2018, a 40% surtax on premium insurance plans (so called "Cadillac" plans with annual premiums of at least \$10,200 Single/\$27,500 Family) based upon a tiered system for evaluating the "richness" of health care benefits.

Steps to Take Now:

- GET ENGAGED!
- If under 50 employees, determine level of compliance and/or application of small employer tax credits;
- If greater than 50 employees and offer post-employment coverage to pre-Medicare retirees, consider filing an application for retiree reinsurance reimbursement benefits.
- If greater than 50 employees, determine what, if any, changes need to be made to existing health insurance (if in effect on March 23, 2010), including plan documents and/or cafeteria plans;
- Determine what, if any, design changes should be considered in advance of later Reform effective dates, such as:
 - o Coverage Modifications

For more information on health care reform, please contact:

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