PATTON BOGGS LLP
ATTORNEYS AT LAW

2550 M Street, NW
Washington, DC 20037
202-457-6000

Facsimile 202-457-6315

MEMORANDUM

To: Interested Clients
From: Patton Boggs LLP
Date: May 7, 2010
Subject: The Impact of Health Reform on Employers

After months of debate and considerable political maneuvering, President Barack Obama signed the Patient Protection and Affordable Care Act (H.R. 3590/P. L. 111-148) into law on March 23, 2010. On March 30, 2010, the President signed into law the Health Care and Education Reconciliation Act of 2010 (H.R. 4872/P. L. 111-152), which makes select changes to H.R. 3590.

Together, these laws are designed to expand health insurance coverage to 32 million Americans who are currently uninsured, while reining in rapidly-growing health care costs. Health care spending is the fastest growing line item in the Federal budget. Health care premiums have doubled in the last decade and have been an increasing burden to employers and employees, as well as State and local governments. This memorandum details the impact of the newly-enacted health reform laws on employers.

I. Employer Requirements

The new law establishes an employer responsibility requirement for employers with more than 50 full-time employees to offer health insurance coverage to full-time employees and dependants or alternatively be subject to a penalty per full-time employee. A "full-time employee" is defined as an employee who works an average of 30 hours per week, calculated on a monthly basis. The responsibility requirement does not call for employers to provide health insurance coverage to part-time employees.

There is no exception to the employer responsibility requirement for government employers. The law specifically includes State and local governments (and any political subdivisions) with more than 50 full-time employees in the definition of an employer-sponsored group health plan.

The Federal government will assess a fee of $2,000 per full-time employee – *excluding* the first 30 employees – on all employers with more than 50 employees who do not offer coverage and have at least one full-time employee receiving a premium tax credit.[1]

[1] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 1513 (2010).

One of the underlying goals of health care reform is to ensure that health insurance is affordable. If any employees have an income below 400 percent of the Federal Poverty Level (FPL) and pay between 8 percent and 9.8 percent of their income on the employer-sponsored coverage, the employer must offer a free choice voucher to enable the employee(s) to purchase coverage through the health insurance Exchanges to be established by January 1, 2014. The voucher must equal the amount the employer would have contributed toward the employer-sponsored coverage.[2] If an employer offers coverage that is unaffordable, or exceeds 9.5 percent of an employee's household income, and the employee opts out of employer-sponsored coverage, the employer will be required to pay a penalty the lesser of: (1) $3,000 for each full-time employee receiving the subsidy; or (2) the number of total employees minus 30 multiplied by $2,000. Penalties will be assessed on a monthly basis.[3]

Larger employers with more than 200 employees must automatically enroll employees into the company's health coverage. Employees who do not want to be auto-enrolled must actively opt out of the plan.[4] Large employers also are required to report to the Secretary of the Department of Health and Human Services (HHS) certain information about their health coverage, including monthly premiums for the lowest-cost plan the employer offers, the employer's share of the total plan costs, and other information the Secretary will specify in regulations.[5] All of the employer responsibility provisions described above take effect on January 1, 2014.

Beginning in 2011, employers will be required to report the value of employer-sponsored health coverage on each employee's W-2 form.[6] The law requires that employers provide written notice to employees at the time of hire – or by March 1, 2013 for current employees – regarding: (1) the existence of an Exchange; (2) the employee's potential eligibility for a premium assistance tax credit and cost-sharing reduction if the benefits provided under the employer plan's share of total allowed costs is less than 60 percent; and (3) the potential loss of the employer contribution to any employer-sponsored health care plan if the employee purchases health insurance through the Exchange.[7]

Effective 2013, the amount of contributions to health flexible spending accounts (FSAs) will be limited to $2,500 per year indexed to the Consumer Price Index – All Urban Consumers (CPI-U). Beginning in 2011, a prescription will be required for the purchase of over-the-counter medications using FSA funds. However, the law does not change pre-tax contributions for health insurance for current or retired employees.

---

[2] *Id.* at § 10108.
[3] *Id.* at § 1513 as amended by Health Care and Education Reconciliation Act of 2010, H.R. 4872, 111th Cong. § 1003 (2010).
[4] *Id.* at § 1511.
[5] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 1514 (2010).
[6] *Id.* at § 9002.
[7] *Id.* at § 1512.

II. Employment-based Health Plans and Retirees

On May 4, 2010, the Secretary of HHS issued regulations to establish a temporary, $5 billion reinsurance program to reimburse participating employment-based plans for part of the cost of providing health benefits to retirees ages 55 to 64 and their families. The insurance program will be eliminated in 2014, after the health insurance Exchanges have been established.

Participating employment-based plans will submit claims to the Secretary of HHS and will be reimbursed for 80 percent of the cost of benefits provided per enrollee between $15,000 and $90,000, indexed for inflation. A participating employment-based plan is defined as a plan that: (1) submits an application to the Secretary for participation in the program; (2) implements programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions; (3) provides documentation of the actual cost of medical claims involved; and (4) is certified by the Secretary.[8]

Effective in 2013, employers will no longer be able to deduct their subsidies of Medicare Part D prescription drug plans for eligible retirees.[9]

III. Health Insurance Exchanges

A new system of State-based health insurance Exchanges (American Health Benefit Exchanges), and Small Business Health Options Program (SHOP) will become operational in 2014 to facilitate the purchase of insurance coverage in the individual and small group market. States have the option of joining together to form regional Exchanges or allowing more than one Exchange to operate in a State. Individuals and small businesses with less than 100 employees may purchase coverage through these Exchanges.[10] States may elect to allow large employers (defined as an employer that employed an average of at least 101 employees on business days during the preceding calendar year and that employs at least one employee on the first day of the plan year) to make all of their full-time employees eligible to purchase insurance through the Exchanges beginning in 2017.[11] The Office of Personnel Management (OPM) is required to enter into contracts with health insurers to offer at least two multi-State plans through each Exchange in each State.[12]

The health insurance Exchanges will offer plans that fall into one of the specified benefits tiers – Bronze, Silver, Gold, Platinum, and Catastrophic-only. Insurance plans offered through the

---

[8] *Id.* at § 1102.
[9] *Id.* at § 9012 as amended by Health Care and Education Reconciliation Act of 2010, H.R. 4872, 111th Cong. § 1407 (2010).
[10] Id. at § 1311.
[11] Id. at § 1304.
[12] *Id.* at § 1334 as amended by Health Care and Education Reconciliation Act of 2010, H.R. 4872, 111th Cong. § 10104 (2010).

Exchanges will be required to include certain minimum essential benefits. While the legislation specifies general categories of coverage that must be included, the Secretary of HHS will establish the minimum essential benefits through rulemaking.[13]

In an effort to control the rising cost of health insurance, the law also establishes a process for reporting and reviewing premium cost increases and will require insurers to justify such increases. States will have the discretion to recommend whether a plan should be removed from the Exchange due to unjustified premium increases.[14]

In addition, the Consumer Operated and Oriented Plan (CO-OP) program is designed to promote the establishment of non-profit, member-run health insurers that will offer insurance for the individual and small group markets. Congress provided $6 billion to finance this program and award loans and grants, with the intent of making CO-OPs available by July 1, 2013.[15]

The law requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-State health plans through Exchanges.[16]

The public plan option previously debated as part of health reform legislation was *not* included in the new laws.

IV. Small Business Provisions

The law exempts small businesses with fewer than 50 employees from the responsibility requirements to provide health insurance coverage to full time employees.[17] Beginning in 2014, States are required to establish an Exchange that includes a Small Business Health Options Program (SHOP) to assist small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State.[18]

In 2010-2013, eligible small employers can receive a tax credit for up to 35 percent of their contribution to each employee's health insurance premium, and tax-exempt small businesses are eligible for a tax credit of up to 25 percent of their contribution. The law provides a two-year tax credit starting in 2014 for eligible small employers that purchase coverage through the Exchange in an amount up to 50 percent of their contribution (or 35 percent in the case of tax-exempt small businesses). Employers that contribute at least 50 percent of the total premium cost or 50 percent of a benchmark premium and have fewer than 25 employees and average annual wages of less than

---

[13] *Id.* at § 1302.
[14] *Id.* at § 1003.
[15] *Id.* at § 1322.
[16] *Id.* at § 1334.
[17] *Id.* at § 1513.
[18] *Id.* at § 1311.

$50,000 are eligible for the tax credit, which is available on a sliding scale. Employers with ten or fewer employees and average wages of less than $25,000 are eligible for the full credit.[19]

The law establishes simple cafeteria plans with relaxed participation rules to allow small businesses to provide tax-free benefits to their employees effective January 1, 2011. A "simple cafeteria plan" is defined as a plan that the employer establishes and maintains consistent with specified contribution and eligibility requirements. A plan meets the definition if an employer contributes: (1) a uniform percentage that is no less than two percent of the employee's compensation for the plan year; (2) an amount no less than six percent of the employee's compensation for the plan year; ***or*** (3) twice the amount of the salary reduction contributions of each qualified employee. To be eligible, employees must have had at least 1,000 hours of service for the preceding plan year. The law exempts employees who have not reached the age of 21 prior to the close of the plan year, who do not have one year of service, are covered under a collective bargaining agreement, or who are nonresident aliens working outside the United States. Employers are eligible if they employ an average of 100 or fewer workers on business days during either of the two preceding years.

If an employer was not in existence during the previous year, that employer's eligibility will be determined based on the average number of employees that the employer expects to employ on business days during the current year. If an employer meets the eligibility requirements in any year and then grows beyond an average of 100 employees, the employer will continue to be eligible to provide tax-free benefits until it employs an average of 200 or more employees on business days during any preceding and subsequent year.[20]

The law authorizes grants for eligible employers to provide comprehensive workplace wellness programs to their employees. An "eligible employer" is defined as a for-profit or non-profit employer that: (1) employs less than 100 employees who work 25 hours or more per week; and (2) did not provide a workplace wellness program as of March 23, 2010. The Secretary of HHS is responsible for developing criteria for workplace wellness programs, which must include the following components: (1) health awareness initiatives; (2) efforts to maximize employee engagement; (3) initiatives to change unhealthy behaviors and lifestyle choices; and (4) supportive environment efforts. The law authorizes $200 million in grant funding for Fiscal Years 2011-2015.[21]

V. Insurance Market Reforms

The health reform laws establish many new requirements and standards for the health insurance market, which are designed to strengthen consumer protections and curb perceived abuses. Insurers and health plans are prohibited from denying coverage, excluding certain categories of coverage, or charging high premiums due to an individual's pre-existing conditions. These prohibitions generally

[19] *Id.* at § 1421.
[20] *Id.* at § 9022.
[21] *Id.* at § 10408.

become effective in 2014.[22] Effective within six months of enactment, however, health plans are prohibited from excluding coverage for children with pre-existing conditions.[23]

Also within six months of enactment, insurers must cover the full cost of preventive health care services, with no cost sharing or co-payments for consumers.[24] The reform measures also establish yearly caps on what insurers may charge for out-of-pocket expenses such as co-payments or other co-insurance charges.[25]

Existing individual and group plans are "grandfathered" and exempted from some of the new benefit standards, but they are still required to comply with many of the rules. Effective six months after enactment, insurers may no longer cancel their policy-holders' health insurance coverage, unless an individual committed fraud or intentionally misrepresented a material fact.[26] Also effective in six months, insurance plans that offer dependent coverage (including those offered by employers) must cover non-dependent children (unmarried or married) until age 26 if they do not have their own employer-offered coverage.[27] Plans are not required to cover the spouse or dependants of an adult child, however.

Until 2014, grandfathered plans may only impose annual limits on coverage as specified by the Secretary of HHS. Beginning in 2014, plans must eliminate lifetime coverage limitations.[28] Within six months of enactment, plans must eliminate pre-existing condition exclusions for children under age 19. However, the ban on pre-existing condition exclusions for adults does not take effect until 2014.[29]

VI. Tax Provisions

To offset the costs associated with health reform, several new and increased taxes were enacted. The so-called "Cadillac tax" is a 40 percent excise tax on certain high-cost insurance plans. This tax will apply to any plan with an annual premium greater than $10,200 for single coverage and $27,500 for family coverage. The tax, which is nondeductible, does not take effect until 2018, and it applies only to the amount of the premium that exceeds the specified dollar threshold. The value of stand-alone dental and vision plans is not included in the threshold calculation. For retired individuals age 55 and older and individuals in high-risk professions, the threshold is $11,850 for single coverage

[22] *Id.* at § 1201.
[23] *Id.* at § 10103.
[24] *Id.* at § 1001.
[25] *Id.*
[26] *Id.*
[27] *Id.* as amended by Health Care and Education Reconciliation Act of 2010, H.R. 4872, 111th Cong. § 2301 (2010).
[28] *Id.*
[29] *Id.* at § 10103.

and $30,950 for family coverage. Beginning in 2019, the dollar value of the thresholds is indexed for inflation.[30]

The new law also increases the Medicare Hospital Insurance (HI) tax rate by 0.9 percent on individuals with wage and self-employment income greater than $200,000 for individuals or $250,000 for couples filing jointly. In addition, the bill imposes a Medicare tax on unearned income on the same class of high-wage earners by broadening the taxable base for the HI tax to include net investment income (such as interest, dividends, royalties, rents, annuities, gross income from a trade or business involving passive activities, and net gains from disposition of non-business property).[31] Both taxes take effect in 2013.

For additional insights regarding the impact of the new health reform laws, please feel free to contact John Jonas, Chair of the Patton Boggs Health Care Practice, at 202-457-5624 or by email at jjonas@pattonboggs.com.

[30] *Id.* at § 9001 as amended by Health Care and Education Reconciliation Act of 2010, H.R. 4872, 111th Cong. § 1401 (2010).
[31] *Id.* at § 9015 as amended by Health Care and Education Reconciliation Act of 2010, H.R. 4872, 111th Cong. § 1402 (2010).