KEY PROVISIONS OF 2010 HEALTHCARE REFORM LEGISLATION FOR SMALL (UNDER 50) EMPLOYERS

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NOTE: Yesterday, the U.S. Supreme Court upheld the Patient Protection and Affordable Care Act, with the exception that the Federal government's power to terminate Medicaid funding is to be narrowly read. The main focus of the Court was on the individual mandate, which requires most individuals to maintain health coverage or pay a penalty beginning in 2014. The Court found the mandate constitutional as a tax. The individual mandate is not discussed in this memorandum, since it is not an employer responsibility.

NOTHING IN THE COURT'S RULING CHANGED EMPLOYER RESPONSIBILITIES UNDER THE ACT. EMPLOYERS THEREFORE SHOULD CONTINUE TO COMPLY WITH THE PROVISIONS OF THE ACT THAT ARE ALREADY EFFECTIVE AND TO PLAN FOR THOSE THAT ARE TO TAKE EFFECT IN FUTURE YEARS. THE REMAINDER OF THIS MEMORANDUM IS THUS UNCHANGED BY THE RULING.

The sweeping healthcare reform legislation enacted in 2010 is exceedingly complex and raises innumerable issues for employers. To add to the complexity, the new rules have varying effective dates, from 2010 to as late as 2018, and the rules for employers vary depending on the number of employees. The "small employer" threshold may be 25, 50, 100 or 200 employees, depending on the provision, but this memorandum focuses on changes that affect employers with fewer than 50 employees.

Also, grandfather rules apply to existing plans and may alter or delay the requirements for those plans. A "grandfathered plan" is a group health plan or individual health policy that was in effect on the date of enactment (March 23, 2010.) Grandfathered plans are exempt from some of the new rules and have later effective dates for others. The different rules for such plans are noted where applicable. Interim guidance provides that, in order to maintain grandfathered status, a plan must (1) include a statement in plan materials describing plan benefits and stating that the plan is believed to be grandfathered and (2) provide contact information for questions and complaints. Loss of grandfathered status is triggered by certain reductions in benefits or increases in certain employee costs.

The effective dates in this memorandum are based on the original effective dates in the legislation. Many of those effective dates have now been delayed, as noted in the text.

Tax credits for certain small employers.

The new law provides small employers with a tax credit (i.e., a dollar-for-dollar reduction in tax) for employer contributions to purchase health insurance for their employees. The credit can offset an employer's regular tax or its alternative minimum tax (AMT) liability.

Small business employers eligible for the credit. A "small business" for purposes of the credit is a business that has **no more than 25** full-time equivalent employees ("FTEs"), and those employees must have annual full-time equivalent wages that average no more than $50,000. The full amount of the credit is available only to an employer with 10 or fewer FTEs and whose employees have average annual full-time equivalent wages from the employer of less than $25,000, however. The credit is phased out above those levels. To qualify for the credit, a business must offer health insurance to its employees as part of their compensation and pay at least half the total premium cost. The IRS posted a flow chart on its website to assist employers in determining eligibility for the credit. The chart is at: http://www.irs.gov/pub/irs-utl/3_simple_steps.pdf

Years the credit is available. The credit is initially available for any tax year beginning in 2010, 2011, 2012, or 2013. Qualifying health insurance for claiming the credit for this period is coverage purchased from an insurance company licensed under state law. For tax years beginning after 2013, the credit is only available to an eligible small employer that purchases health insurance coverage for its employees through a state exchange. That credit is available for only two years. The maximum two-year coverage period does not take into account any tax years beginning in years before 2014. Thus, an eligible small employer could potentially qualify for this credit for six tax years - four years under the first phase and two years under the second phase.

Calculating the amount of the credit. For tax years beginning in 2010, 2011, 2012, or 2013, the credit is generally 35% (50% for tax years beginning after 2013) of the employer's contributions toward the employees' health insurance premiums. The credit phases out as firm-size and average wages increase. Tax-exempt small businesses meeting these requirements are eligible for payroll tax credits of up to 25% for tax years beginning in 2010, 2011, 2012, or 2013 (35% in tax years beginning after 2013) of the employer's contributions toward the employees' health insurance premiums.

Special rules. The employer will still be entitled to an ordinary and necessary business expense deduction equal to the amount of the employer contribution minus the dollar amount of the credit. For example, if an eligible small employer pays 100% of the cost of its employees' health insurance coverage and the amount of the tax credit is 50% of that cost, the employer can claim a deduction for the other 50% of the premium cost.

Self-employed individuals, including partners and sole proprietors, 2% shareholders of an S corporation, and 5% owners of the employer are not treated as employees for purposes of this credit. Any employee with respect to a self-employed individual is not an employee of the employer for purposes of this credit if the employee is not performing services in the trade or business of the employer. Thus, the credit is not available for a domestic employee of a sole proprietor of a business. There is also a special rule to prevent sole proprietorships from receiving the credit for the owner and their family members. Thus, no credit is available for any contribution to the purchase of health insurance for these individuals and the individual is not taken into account in determining the number of full-time equivalent employees or average full-time equivalent wages.

EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER SEPTEMBER 23, 2010

- Group health plans and insurers that offer dependent coverage must allow uninsured children to remain on parent's health insurance until age 26 *(prior to 2014, this provision applies to grandfathered plans only to extent the "child" is not eligible for another employer-sponsored health plan)*

- Plans and insurers cannot impose lifetime limits on coverage of "essential health benefits"

- For plan years beginning prior to January 1, 2014, a plan may impose a "restricted annual limit" on essential health benefits. The restricted annual limits are as follows:

    - 09/23/10 - $750,000
    - 09/23/11 - $1,250,000
    - 09/23/12 - $2,000,000

- *Essential Health Benefits* will be further defined, but must include the categories listed below. The task of further defining essential health benefits has been delegated to the states.
    - Ambulatory patient services
    - Emergency services
    - Hospitalization
    - Maternity and newborn care
    - Mental health and substance use disorder services, including behavioral health treatment
    - Prescription drugs
    - Rehabilitative and habilitative services and devices
    - Laboratory services
    - Preventive and wellness services and chronic disease management
    - Pediatric services, including oral and vision care

- Plans must provide coverage for preventative services and immunizations with no cost-sharing *(n/a to grandfathered plans)*

- Insurers may not rescind coverage (exception for fraud or misrepresentation)

- Elimination of pre-existing condition limitations for children under age 19

- Appeals process, including a binding external review, required to allow for appeals of coverage and claims determinations *(n/a to grandfathered plans)* ***These requirements have been delayed to 2012.***

- Insured group health plans are subject to the nondiscrimination rules of IRC § 105(h)(2), which previously applied only to self-insured plans. In a nutshell,

this means that benefits must be equally available to all employees. Key employees cannot get special benefits. *(n/a to grandfathered plans)* The penalties for violating the nondiscrimination rules are severe. Discriminatory insured health plans will be subject to excise taxes of $100 per day per participant. ***This requirement has been delayed indefinitely, subject to the issuance of regulations. The comment period closed in March, 2011, but regs have not yet been issued.***

EFFECTIVE 2011

- All employers must reflect the value of health insurance provided to an employee on the employee's W-2 Form. (Note: This does not mean that the benefit is taxable. The reporting is informational only.) ***This requirement has been delayed. Reporting is optional for 2011 and will be mandatory for 2012 for employers issuing 250+ W-2 forms. The delay is indefinite for smaller employers.***

- HSA/FSA/HRA Changes

    - The definition of qualified medical expense for Health Savings Accounts, Flexible Spending Accounts and Health Reimbursement Arrangement is amended to exclude over-the-counter medicine (except for insulin) unless obtained with a prescription

    - The excise tax on distributions from HSAs not used for qualified medical expense is increased to 20%

- Small employers (under 100) may establish a "simple cafeteria plan"

    - Deemed to satisfy nondiscrimination requirements
    - Requires specified minimum contributions by employer on behalf of each qualified employee

EFFECTIVE 2013

- FSA contributions limited to $2,500/year (indexed)

- *The IRS issued guidance on May 30, 2012 providing that the limit will not apply to fiscal-year plans until the plan year beginning in 2013.*

EFFECTIVE 2014

- Most citizens and legal residents will be required to have health coverage to avoid a tax penalty. *Small employers are not required to offer coverage. The "voucher" requirement, which would have applied to employers regardless of size, has been repealed.*

- No pre-existing condition exclusions under group health plans.

- No waiting periods in excess of 90 days for group health plans

- Wellness program rewards subject to the satisfaction of health standards may be as much as 30% of the cost of employee-only coverage *(n/a to grandfathered plans)*

- Group health plans cannot have out-of-pocket limits greater than the limits for high-deductible health plans (which are paired with HSAs) (currently $6,050 for individual coverage and $12,100 for family coverage)

- Employers must report to the IRS and provide a statement to employees regarding whether and when an individual was covered under the employer's group health plan for the minimum "essential health coverage." (Effective for 2014; first reporting deadline is 01/31/15.)

- All qualified health benefit plans must offer at least the essential health benefits package (not yet fully defined). *(n/a to grandfathered plans)*

EFFECTIVE 2018

"Cadillac tax" on high-cost health plans.

The new law places an excise tax on high-cost employer-sponsored health coverage (often referred to as "Cadillac" health plans) effective 2018. This is a 40% excise tax on insurance companies, based on premiums that exceed certain amounts. The tax is not on employers themselves unless they are self-funded, so this provision will generally not have a direct effect on small employers. Insurers are expected to pass on this expense to employers sponsoring high-cost plans, however, so those employers will be indirectly affected.

This is merely a brief summary of some of the key benefit provisions of more than 3,000 pages of legislation. Substantial additional guidance from the IRS and other regulatory agencies will be issued over the coming months and years and additional legislation can also be expected. We will keep you informed regarding new developments. Please contact Alice Helle at 515-242-2407 or helle@brownwinick.com or contact your BrownWinick attorney if you have questions or need assistance.

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