BENEFITS

Tax *and* Employee Benefit CONSEQUENCES *of* Healthcare Reform

Popular media coverage of "healthcare reform" has focused largely on how individual consumers might be affected. Less attention has been given to what the legislation means for businesses — and not just businesses in healthcare-related industries. The 2010 Healthcare Reform Act (Patient Protection and Affordable Care Act[1] or PPACA), in conjunction with the Health Care and Education Reconciliation Act[2] ("Reconciliation Act") contains significant tax and employee benefit changes. Many of these provisions are phased in over several years, so their full impact is yet to be felt. This article examines a few of the key provisions contained in this new legislation.

I. Tax Changes

The tax changes found in the new legislation focus on the universal health insurance coverage mandate and revenue raisers, some health-related and others not. Certain changes are expected to have the greatest impact.

A. Beginning in 2011

Beginning in 2011, a fee will be levied against drug manufacturers and importers based on market share. The total fee assessed for 2011 will be $2.5 billion and will gradually increase until it peaks in 2018 at $4.1 billion. In 2019, the fee will decrease to $2.8 billion and will remain constant thereafter.[3]

B. Beginning in 2013

1. Federal Sales Tax on Sales of "Medical Devices"

Manufacturers and importers of medical devices will be taxed 2.3% of the sales price of any "taxable medical device" intended for humans.[4] This tax will not apply to medical devices the IRS determines are of a type "generally purchased by the general public at retail for individual use" such as eyeglasses, contact lenses, and hearing aids.[5]

2. Loss of Deduction for Retiree Prescription Drug Plans

The Reform Act not only imposes additional fees and taxes but also reduces or eliminates certain deductions. Currently, employers are entitled to an income tax deduction for the cost of providing a prescription drug plan to retirees even though they receive a tax-free Medicare Part D subsidy from the federal government. Under the new legislation, the amount allowed as a deduction for retiree prescription drug expenses will be reduced by the amount of the tax-free subsidy payments received.[6]

3. Surtax on Investment Income of High-Income Taxpayers

As a revenue raiser, a surtax will be imposed on the investment income of high-income taxpayers. This tax will be a 3.8% Medicare contribution tax and will be imposed on the net investment income of certain individuals, estates, and trusts with income above specified thresholds. For individuals, the tax is 3.8% multiplied by the lesser of either net investment income or adjusted gross income in excess of $200,000 for single filers or $250,000 for joint filers. Net investment income includes interest, dividends, royalties, rents, and net gain from the disposition of investment assets. The surtax is subject to individual estimated income tax payment requirements and is not deductible for income tax purposes.[7]

C. Beginning in 2014

1. Industry-wide Fee on Health Insurance Providers

An industry-wide fee will be levied against health insurance providers with net premium income from health insurance of more than $25 million. For purposes of this fee, health

insurance does not include coverage for a specified disease or illness only, hospital indemnity or other fixed indemnity insurance, insurance for long-term care, or Medicare supplemental health insurance. This fee, which will be apportioned based on net premiums received during the preceding year, will be $8 billion in 2014. The fee gradually increases to $14.3 billion in 2018. Thereafter, the fee will be indexed for premium growth.[8]

2. Employer Group Health Insurance Mandate

A "pay-or-play" tax will be imposed on employers that fail to provide affordable coverage to employees. (*See section* II.E.1.) This provision applies to employers with an average of fifty full-time employees during the preceding calendar year and who are not offering "minimum essential coverage." For purposes of determining whether an employer has fifty employees, business entities under common control must aggregate employees. "Minimum essential coverage" is a plan where the employer covers at least 60% of the costs under the plan and employee costs do not exceed 9.5% of household income. The monthly penalty is one-twelfth of $2,000 multiplied by the number of employees in excess of thirty.[9]

D. Beginning in 2018

A 40% excise tax will be imposed on "coverage providers" for the cost of the employer-sponsored health coverage to employees that exceeds $10,200 for single coverage and $27,500 for family coverage. These plans are often referred to as "Cadillac" plans. For purposes of this tax, "coverage providers" include the health insurer for fully-insured plans, employers making the contributions for health savings accounts (HSA) or Archer medical savings accounts (MSA) contributions, and the person administering the plan for self-insured plans or flexible spending accounts (FSA).[10]

II. New Employer-Sponsored Group Health Plan Requirements

Applicability and Grandfathered Plan Exclusion

Employer-sponsored group health plans (GHPs) subject to the Reform Act include both private and governmental GHPs, whether insured or self-insured. Those GHPs in existence on March 23, 2010, are "grandfathered" (the "if-you-like-your-current-coverage-you-can-keep-it" provision) and are thus eligible for the *limited* grandfathered GHP exclusion (GPE).[11] While the scope of the GPE appears extremely broad on its face, the regulations promulgated by the affected federal agencies — Department of Labor/Employee Benefits Security Administration, Internal Revenue Service, and Department of Health and Human Services ("Agencies") — severely limit what can and cannot be done in plan redesign and still maintain eligibility for GPE status.[12]

Employees covered under a GHP qualifying for the GPE still satisfy the employee's individual responsibility requirement, even if the GHP provides less coverage than required under the new legislation.[13] (*See section* I.C.1.) Additionally, new employees hired after March 23, 2010, and their dependents can still be covered under a GHP eligible for the GPE.[14] Furthermore, dependents of an employee covered by an eligible GHP may be added to the employee's coverage after March 23, 2010.[15] Theoretically, those GHPs that can maintain GPE status should be able to achieve a permanent exemption from certain provisions of the Reform Act targeted at GHPs. However, the Administration has indicated that it expects that most GHPs will lose the GPE by 2014 and that the GPE might be temporary anyway.

While the GPE is a significant and pervasive concept in the Reform Act, it is nevertheless not all-inclusive. Since it is only available for certain requirements of the Reform Act and not for others, the significance of a particular requirement to a GHP must be considered in light of its availability. The new GHP requirements are outlined below, by their effective date.[16] Those requirements for which the GPE is available are designated with the parenthetical "(GPE)."

A. Beginning in 2010

1. Automatic Enrollment

The Reform Act requires that employers with more than two hundred employees automatically enroll eligible employees in their GHP unless an employee opts out pursuant to a required opt-out notice.[17] Since this requirement has no stated effective date, the effective date technically was the date of enactment. However, compliance is being delayed by the Agencies until regulations are issued.[18]

The following provisions are effective for GHPs with plan years beginning after September 23, 2010.

2. Annual & Lifetime Limits

No lifetime limits or annual limits on "essential health benefits" are allowed.[19] "Essential health benefits" is to be defined by Department of Health and Human Services regulations.

3. Retroactive Rescissions

Retroactive cancellation of coverage is prohibited except for fraud or intentional misrepresentation of material facts, and then only with prior written notice.[20]

4. Pre-Existing Condition Exclusions

Through 2013, there are to be no pre-existing condition exclusions for employees under age 19 or dependents under age 19.[21] Beginning January 1, 2014, there are to be no pre-existing condition exclusions for any employees or dependents irrespective of age.[22]

5. Coverage of Children to Age 26 (Limited GPE)

GHPs offering dependent coverage must also permit coverage of children until their twenty-sixth birthdays. The child does not have to be a student or a tax-dependent of the employee and can be married. The child can be included on the parent's plan even if coverage is available under that child's own employer's group health plan (if coverage is available under a plan sponsored by an employer other than a parent's employer, a limited GPE is available only until January 1, 2014).[23] A HIPAA special enrollment period is required for any such children who have already ceased to be covered but are now re-eligible.[24] GHPs are not required to cover the child's spouse or children.[25] If the covered child has not reached the age of twenty-seven before the end of the year,

the value of coverage is excluded from the employee's income for the entire year for tax purposes, and benefits are excluded from the child's income for tax purposes.[26]

6. Preventive Care — First-Dollar Coverage (GPE)

GHPs are to provide first-dollar coverage, *i.e.* no cost-sharing, for certain types of preventative care including certain well-child, adolescent, and female care, as well as certain immunizations.[27]

7. Nondiscriminatory Insured Plans (GPE)

There also can be no discrimination in favor of highly-compensated employees by insured GHPs, similar to the previously existing nondiscrimination rules for self-insured GHPs.[28] The IRS, though, has announced delayed enforcement of this requirement until after implementing regulations are issued.[29]

8. Claims Appeals/External Review Procedures (GPE)

New benefit appeals procedures allow claimants to present evidence and oral testimony as part of the appeal and require continued coverage during the appeals process.[30] GHPs will have to provide an external review process as part of the review procedures for denied claims.[31] Written notice of these new rights must be provided.[32]

9. Patient Protections (GPE)

GHPs must now include a number of new patient protection features. For instance, if enrollees are required by their GHP to designate a primary-care provider, certain types of enrollees may designate certain types of providers as their primary-care provider, *i.e.* pediatricians for children and OB/GYNs for women.[33] In addition, there can be no preauthorization or increased cost-sharing required for emergency services, and no preauthorization or referral can be required for OB/GYN care.[34]

B. Beginning 2011

1. Reimbursement of OTC Drugs

Effective January 1, 2011, there can be no reimbursement for over-the-counter medicine (except insulin) by an FSA, health

reimbursement accounts (HRA), HSA, or MSA without a prescription.[35]

2. Form W-2 Requirements

Beginning with 2011 W-2s, employers must report the aggregate value of employer-sponsored GHP coverage (solely for informational purposes) for the benefit of the covered employee. The IRS has announced that compliance will not be required until 2012 W-2s are issued.[36]

C. Beginning March 23, 2012

1. Benefits Summary

A new summary of benefits and coverage of no more than four pages, separate from the summary plan description already required by ERISA must be provided to applicants and enrollees in GHPs both at initial and annual enrollment.[37] The style, content, and even format of this new summary will be specified in regulations.

2. Notice of Material Modifications

A new notice of material modifications, separate from the summary of material modifications already required by ERISA, must be provided at least sixty days *before* the effective date of a material modification in coverage.[38]

3. Quality Report (GPE)

The GHP must annually file a quality report with the Department of Health and Human Services, reporting any plan design changes intended to improve outcomes, reduce hospital readmissions, reduce medical error, implement wellness programs, etc.[39] The effective date for this reporting requirement is to be in accordance with regulations required to be published by March 23, 2012; the actual effective date could be earlier.

D. Beginning in 2013

1. FSA Limitations

Effective January 1, 2013, FSA salary reductions are limited to $2,500 per year. This is to be indexed to the consumer price index beginning in 2014.[40]

2. Exchange Notice (GPE)

Effective March 1, 2013, employers must provide written notice to their employees, at hiring, of the availability of state exchanges and of the employee's right to purchase healthcare coverage through such an exchange. This notice must also inform the employee that he or she may be eligible for a subsidy through the exchange if the employer's share of the GHP benefit cost is less than 60% of the cost of the individual plan and that, if the employee purchases coverage through an exchange without an employer-provided voucher, the employee will lose the employer's contribution for health benefits.[41]

E. Beginning in 2014

The Reform Act requires the states to establish health insurance exchanges by January 1, 2014. These exchanges are generally designed to provide affordable health coverage to people not covered under a GHP sponsored by an employer. Smaller employers, *i.e.* those with one hundred or fewer employees (states have the option to limit this to fifty employees), and individuals may purchase coverage through required state exchanges.[42]

1. Minimum Essential Coverage

While the Reform Act does not mandate that any specific benefits be provided, effective January 1, 2014, employer-sponsored GHPs must nevertheless offer "minimum essential coverage" in conjunction with the establishment of the exchanges.[43] "Minimum essential coverage" is to be defined in regulations.

2. Pay-or-Play Penalty

Employers are not required to offer any health coverage. If they do not offer "minimum essential coverage" or the coverage offered is "unaffordable," though, they will be subject to the "pay-or-play" penalty, effective January 1, 2014.[44] (*See section* I.C.2.)

3. Reporting Coverage

If an employer does not offer "minimum essential coverage" to full-time employees and their dependents, the employer must confirm that such coverage is not offered and file a variety of other information in order to permit the assessment of the "pay-or-play" penalty against the employer.[45]

4. Free Choice Vouchers

Employers that pay part of the GHP coverage cost must issue "free choice" vouchers to "qualified employees."[46] These vouchers permit employees to purchase coverage through an exchange instead of their employer's GHP.[47] If the employee chooses to participate in the exchange, the employer pays the redeemed voucher amount to the exchange, which must be the amount the employer would have contributed to its GHP, to the exchange.[48] (If the employer contributes different amounts for different coverage options, the voucher amount must be the maximum employer contribution available to the employee.) The exchange pays any excess to the employee. These vouchers are excluded from the employee's income to the extent they are used for healthcare and also are deductible by the employer.[49]

A "qualified employee" is an employee (1) whose household income is less than 400% of the Federal poverty level (400% of the federal poverty level was $88,000 in 2010 for a family of 4), (2) whose required contribution under the GHP is between 8% and 9.8%[50] of his or her household income, and (3) who does not participate in the employer's GHP.[51]

5. Expiration of Limited Exclusions

For Plan Years Beginning (PYB) after January 1, 2014, the limited GPE for restricted annual limits and for coverage for children until age 26 who have coverage available under a plan sponsored by an employer other than an employer of their parents will no longer be available. The limitation on the pre-existing condition exclusion for covered individuals age 19 and older expires as well. There may also be no waiting periods in excess of ninety days.[52]

6. HIPAA Wellness Program Incentives (GPE)

Under the HIPAA wellness program regulations, the permissible incentive for satisfaction of a health standard increases from 20% to 30% (or as much as 50% by regulation) effective January 1, 2014.[53] However, existing EEOC issues under the Americans With Disabilities Act continue.

7. Cost-sharing Limits (GPE)

Effective for PYB after January 1, 2014, out-of-pocket expenses cannot exceed HSA coverage amounts (currently $5,950 for individuals and $11,900 for families), and deductibles cannot exceed $2,000 for single coverage and $4,000 for family coverage, as indexed.[54]

8. Clinical Trials Coverage (GPE)

Effective for PYB January 1, 2014, GHPs must cover the routine costs of participation in certain approved clinical trials relating to life-threatening diseases.[55]

Conclusion

The Reform Act creates sweeping changes throughout many sectors of the U.S. economy, targeting both businesses and individuals. While many of these benefit mandates and notice and reporting requirements have already taken or will soon take effect, the country is still awaiting regulations to aid in the implementation not only of certain currently effective provisions but also of many others soon to take effect. The true impact of the Reform Act on the healthcare payor system will not really begin to be felt until sometime in 2013, as GHPs prepare for the January 1, 2014, effective date of the state exchanges and coverage mandates.

[1] Pub. L. No. 111-148 (2010).

[2] Pub. L. No. 111-152 (2010).

[3] PPACA, Pub. L. No. 111-148, § 9008 (2010), as amended by HCERA, Pub. L. No. 111-152, § 1404 (2010).

[4] A taxable medical device is defined in Section 201(h) of the Federal Food, Drug, and Cosmetic Act as "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes."

[5] Code § 4191, as added by HCERA, Pub. L. No. 111-152, § 1405 (2010).

[6] PPACA, Pub. L. No. 111-148, § 9012 (2010), as amended by HCERA, Pub. L. No. 111-152, § 1407 (2010).

[7] Code § 1411, as added by HCERA, Pub. L. No. 111-152, § 1402 (2010).

[8] PPACA, Pub. L. No. 111-148, § 9010 (2010), as amended by PPACA, Pub. L. No. 111-148, § 10905 (2010), as further amended by HCERA, Pub. L. No. 111-152, § 1406 (2010).

[9] Code § 4980H, as added by PPACA, Pub. L. No. 111-148, § 1513 (2010), as amended by PPACA, Pub. L. No. 111-148, § 10106 (2010), as further amended by HCERA, Pub. L. No. 111-152, § 103 (2010).

[10] Code § 4980I, as added by PPACA, Pub. L. No. 111-148, § 9001 (2010), as amended by PPACA, Pub. L. No. 111-148, § 10901 (2010), as further amended by HCERA, Pub. L. No. 111-152, § 1401 (2010).

[11] PPACA, Pub. L. No. 111-148, § 1251(e) (2010).

[12] 75 F.R. 116 (06/17/10).

[13] PPACA, Pub. L. No. 111-148, § 1251(a)(1) (2010).

[14] PPACA, Pub. L. No. 111-148, § 1251(c) (2010); Treas. Reg. § 54.9815-1251T(b)(1); DOL Reg. § 2590.715-1251(b)(1); HHS Reg. § 147.140(b)(1).

[15] PPACA, Pub. L. No. 111-148, § 1251(b) (2010); Treas. Reg. § 54.9815-1251T(a)(4); DOL Reg. § 2590.715-1251(a)(4); HHS Reg. § 147.140(a)(4).

[16] While the Agencies have struggled valiantly to issue timely regulatory and sub-regulatory guidance in advance of the effective dates of the provisions which have already become effective, there are still significant gaps in the regulatory scheme, leaving many questions unanswered. Additional regulations and sub-regulatory guidance should answer many of these questions. Future regulations will also determine the effective dates of certain statutory provisions, since several of such provisions either have effective dates coinciding with the issuance of regulations or are not being enforced by the Agencies until the issuance of regulations. In the meantime, where a statutory provision becomes effective without adequate regulatory guidance, the Agencies have indicated that good faith compliance, based upon a reasonable interpretation of the statute, should be undertaken.

[17] FLSA § 18A, as added by PPACA, Pub. L. No. 111-148, § 1511 (2010).

[18] FLSA § 18A, as added by PPACA, Pub. L. No. 111-148, § 1511 (2010).

[19] PHSA § 2711, as added by PPACA, Pub. L. No. 111-148, §§ 1001(5) and 10101(a) (2010).

[20] PHSA § 2712, as added by PPACA, Pub. L. No. 111-148, § 1001(5) (2010).

[21] PPACA, Pub. L. No. 111-148, § 10103(e)(2) (2010); Treas. Reg. § 54.9815-2704T(b)(2); DOL Reg. § 2590.715-2704(b)(2); HHS Reg. § 147.108(b)(2).

[22] PHSA § 2704, as amended by PPACA, Pub. L. No. 111-148 (2010), as amended by HCERA, Pub. L. No. 111-152 (2010).

[23] PHSA § 2704(a), as amended by the PPACA, Pub. L. No. 111-148, § 1201 (2010).

[24] Interim Final Rules Relating to Dependent Coverage of Children to Age 26 under PPACA, 26 CFR Parts 54 and 602; 29 CFR Part 2590; 45 CFR Parts 144, 146, and 147; 75 Fed. Reg. 27121 (May 13, 2010).

[25] Interim Finals Rules Relating to Dependent Coverage of Children to Age 26 Under PPACA, 26 CFR Parts 54 and 602; 29 CFR Part 2590; 45 CFR Parts 144, 146, and 147, 75 Fed. Reg. 27121 (May 13, 2010).

[26] Code § 105. *See also* IRS Notice 2010-38, 2010-20 I.R.B. 682.

[27] PHSA § 2713, as added by PPACA, Pub. L. No. 111-148 (2010).

[28] PHSA § 2716, as added and amended by PPACA, Pub. L. No. 111-148 (2010).

[29] IRS Notice 2011-1, 2011 I.R.B. (12/22/2010).

[30] PHSA § 2719(a)(1)(C), as added by PPACA, Pub. L. No. 111-148 (2010).

[31] PHSA § 2719(b), as added by PPACA, Pub. L. No. 111-148 (2010).

[32] PHSA § 2719(a)(1)(B), as added by PPACA, Pub. L. No. 111-148 (2010).

[33] PHSA § 2719A(a), as added by PPACA, Pub. L. No. 111-148 (2010); Treas. Reg. § 54.9815-2719AT(a)(1)(i); DOL Reg. § 2590.715-2719A(a)(1)(i); HHS Reg. § 147.138(a)(1)(i).

[34] PHSA § 2719A(d), as added by PPACA; Treas. Reg. § 54.9815-2719AT(d); DOL Reg. § 2590.715-2719A(d); HHS Reg. § 147.138(d).

[35] Code § 106(f), as added by PPACA, Pub. L. No. 111-148 (2010).

[36] PPACA, Pub. L. No. 111-148 § 9002 (2010).

[37] PHSA § 2715(a), as added by PPACA, Pub. L. No. 111-148 (2010).

[38] PHSA § 2715(d)(4), as added by PPACA, Pub. L. No. 111-148 (2010).

[39] PHSA § 2717, as added by PPACA, Pub. L. No. 111-148 (2010).

[40] Code § 125(i), as amended by PPACA, Pub. L. No. 111-148 (2010) and HCERA, Pub. L. No. 111-152 (2010).

[41] FLSA § 18B, as added by PPACA, Pub. L. No. 111-148 (2010).

[42] PPACA, Pub. L. No. 111-148, § 1312(f) (2010).

[43] Code § 4980H(a), as added by PPACA, Pub. L. No. 111-148 (2010) and amended by HCERA, Pub. L. No. 111-148 (2010).

[44] Code § 4980, as added by PPACA, Pub. L. No. 111-148 (2010) and amended by HCERA, Pub. L. No. 111-152 (2010).

[45] Code § 6056, as added by PPACA, Pub. L. No. 111-148 (2010).

[46] PPACA, Pub. L. No. 111-148, § 10108(a) (2010).

[47] PPACA, Pub. L. No. 111-148, § 10108(d)(2) (2010).

[48] PPACA, Pub. L. No. 111-148, § 10108(d)(1)(A) (2010).

[49] Code § 162(a), as amended by PPACA, Pub. L. No. 111-148, § 10108(g)(1) (2010).

[50] This rate is inconsistent with similar exchange limitations of 9.5%, and it is felt that this discrepancy is incorrect and will be corrected.

[51] PPACA, Pub. L. No. 111-148, § 10108(c)(1) (2010).

[52] PHSA § 2708, as added by PPACA, Pub. L. No. 111-148 (2010).

[53] PHSA § 2705(j), as amended by PPACA, Pub. L. No. 111-148 (2010).

[54] PPACA, Pub. L. No. 111-148, § 1302(c)(1).

[55] PHSA § 2709(a)(1), as added by PPACA, Pub. L. No. 111-148 (2010).

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