

Health Reform

Employer Impacts in 2010 and 2011

Know the provisions that impacted employers in 2010 and provisions that will impact employers in 2011.

President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which is transforming the current model for employer-sponsored health coverage. Below is a summary of provisions that impacted employers in 2010 and provisions that will impact employers in 2011.

March 23, 2010

Nursing Mothers

Employers must provide a reasonable break time for employees who are nursing mothers to express breast milk for a period of one year following the birth of the child. The employer must provide a place that is shielded from view and free from intrusion of co-workers and the public for use by the employee. A bathroom is specifically excluded as an appropriate place. Employers are not required to pay employees during the time they are expressing breast milk unless mandated under state law. Also, employers with less than 50 employees may be exempt from this requirement if it causes an "undue hardship" by causing "significant difficulty or expense." These terms have not yet been defined.

March 23, 2010

Small Business Tax Credit

For taxable years beginning March 23, 2010, through Dec. 31, 2013, small employers will receive a tax credit of up to 35 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the total premium cost or 50 percent of a benchmark premium. If the small business is a nonprofit, the tax credit equals 25 percent instead of 35 percent.

A small employer is defined for purposes of the tax credit as an employer with fewer than 25 full-time equivalent (FTE) employees with an average annual wage amount of less than \$50,000. FTE employees include leased employees, but do not include seasonal workers (unless the seasonal workers work more than 120 days per year). There are other types of employees who are not included, including a sole proprietor, a partner in a partnership, a shareholder owning more than 2 percent of an S corporation and any owner of more than 5 percent of other businesses. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. The credit phases out as firm size and average wage increases, resulting in a partial credit for employers exceeding 10 employees and average annual wages exceeding \$25,000.

June 29, 2010

Retiree Reinsurance Program

The Department of Health and Human Services (HHS) established a temporary reinsurance program to provide reimbursement to employment-based plans for a portion of the cost of providing health insurance coverage to early retirees who are age 55 and over, but not eligible for Medicare. An employer must submit an application to HHS for participation in the program. Claims between \$15,000 and \$90,000 will be

reimbursed, with certain conditions. The program will end upon the earlier of Jan. 1, 2014, or when the funding runs out. Five billion dollars has been appropriated for the program, so it is in an employer's interest to submit applications and claims early. The applications for the program were made available on June 29, 2010.

September 23, 2010

Insurance Reforms

Effective for plan years beginning on or after Sept. 23, 2010, the following insurance reforms should be included within the policy.

Lifetime limits — All fully insured, self-insured and grandfathered plans will need to remove the dollar value of lifetime limits for any participant or beneficiary.

Annual limits — All fully insured, self-insured and grandfathered group plans will be restricted as to the limit that can be placed on the dollar value of benefits with respect to benefits that are essential health benefits. The minimum annual limit in 2010-2011 is \$750,000. The amount increases in 2012 and 2013. Annual limits will be completely prohibited in 2014.

Ban on Rescissions of Coverage — All fully insured, self-insured and grandfathered plans are prohibited from rescinding coverage, except in the case of fraud or an intentional misrepresentation of a material fact.

Adult Dependent Coverage to Age 26 — All fully insured, self-insured and grandfathered plans that provide dependent coverage must provide coverage for dependents until the age of 26. The dependent may be married or unmarried, and there is no requirement that the dependent be a student or live with the parents. The coverage requirement does not apply to spouses of adult dependents or their children (i.e., grandchildren of employee). For grandfathered plans only until 2014, the coverage requirement applies to dependents who do not have another source of employer-sponsored coverage.

Pre-existing Condition Coverage for Individuals Under 19 Years of Age — The pre-existing condition coverage requirement applies to all fully insured, self-insured and grandfathered plans and applies to individuals under 19 years of age. This includes employees who may themselves be under 19 years of age and dependents of employees under age 19. The PPACA also eliminated the ability of non-federal government plans to opt out of certain HIPAA requirements including pre-existing condition limitations, but HHS has announced that these will not be enforced for plan years beginning before April 1, 2011.

Emergency Services — Fully insured and self-insured plans (other than grandfathered plans) must cover emergency services at in-network rates regardless of the provider and without prior authorization.

Primary Care Physician — Fully insured and self-insured plans (other than grandfathered plans) must permit enrollees to designate any in-network primary care physician as their primary care physician.

New Coverage Appeal Process — Fully insured and self-insured plans (other than grandfathered plans) must provide an appeal process for appeals of coverage determinations that includes an internal claims appeal process, certain notice requirements, evidentiary requirements and an external review process.

Preventive Services Mandates — Fully insured and self-insured plans (other than grandfathered plans) must provide coverage for, and may not apply cost-sharing requirements for, certain preventive services, including: preventive items or services with an "A" or "B" rating in the current recommendations of the U.S. Preventive Services Task Force; immunizations; infant, children and adolescent screenings; and certain preventive women screenings and care. To view a list of mandated services, visit www.healthcare.gov.

September 23, 2010

Nondiscrimination for Highly-compensated Individuals

For plan years beginning on or after Sept. 23, 2010, non-grandfathered fully insured plans may not establish eligibility rules or provide benefits that are based on the salary level of the employee, or that have the effect of discriminating in favor of higher wage employees for age or years of service. This provision will prohibit fully insured executive-only carve-out plans that exclude lower wage employees from eligibility. A fully insured plan found to be discriminatory under Section 105(h) of the Code will result in an excise tax equal to \$100 per day per individual discriminated against.

2011

Wellness Grant Program

Effective Oct. 1, 2010, employers with less than 100 employees, who work 25 hours or more per week, may be eligible for a federal grant to implement a wellness program. The employer must not have had an existing wellness program in place on the date of enactment, March 23, 2010. The employer must implement a wellness program that includes health awareness initiatives, efforts to maximize employee participation, initiatives to change unhealthy behaviors and lifestyle choices, and supportive environment efforts. The grant program runs through 2015 or until the \$200 million appropriation is exhausted. As of the date of this publication, no wellness grant information has been provided.

January 1, 2011

OTC Ineligibility for Reimbursement

Over-the-counter (OTC) drugs, medicines and biologicals will be ineligible for reimbursement from flexible spending accounts unless prescribed by a doctor. The change to OTC reimbursement applies to tax years (not plan years) beginning after Dec. 31, 2010. The effective date applies to when expenses are incurred.

January 1, 2011

Penalty for HSA Distributions Increases

Distributions from a Health Savings Account (HSA) that are not considered a qualified medical expense will be penalized at 20 percent, up from 10 percent on an individual's income tax return.

January 1, 2011

SIMPLE Cafeteria Plan Safe Harbor

Beginning on Jan. 1, 2011, small employers (generally those with 100 or fewer employees) will be allowed to adopt new "simple cafeteria plans." Plans may choose to exclude employees working less than one year, those younger than age 21, collectively bargained employees or non-resident aliens from participation. In exchange for satisfying minimum participation and contribution requirements, these plans will be treated as meeting the nondiscrimination requirements that would otherwise apply to the cafeteria plan. An employer must contribute a uniform percentage of a qualified employee's compensation (not less than 2 percent) or the lesser of: (a) 6 percent of the employee's compensation or (b) twice the employee's contribution. A qualified employee is one who is not a key or highly compensated employee.

Notice Requirements

In addition to the implementation dates described above, employers have notice obligations to consider. Employers should evaluate their plans to ensure the following notices are provided:

- **Dependent Coverage to Age 26** — Children who become eligible for coverage due to the new extension of coverage to age 26 must be given at least a 30-day enrollment period following written notice of their eligibility. The notice must be sent no later than the first day of the plan year following Sept. 23, 2010, with coverage effective the first day of the plan year. This notice must be distributed with other enrollment materials (e.g., in an enrollment packet) and applies to both grandfathered and non-grandfathered plans.

www.dol.gov/ebsa/dependentsmodelnotice.doc

- **Lifetime Limits** — The Lifetime Limits Model Notice is to be used to provide written notice to participants informing them that a lifetime limit on the dollar value of all benefits no longer applies, and individuals whose coverage ended by reason of reaching a lifetime limit under the plan must be notified that they have 30 days in which to re-enroll. The notices and enrollment opportunities, similar to the Patient Protection Model Notice (see below), must be provided by the first day of the first plan year beginning on or after Sept. 23, 2010. Note, however, that the notice can be included with a plan's enrollment materials (as opposed to in the summary plan description (SPD)), provided the statement is prominent. This applies to both grandfathered and non-grandfathered plans.

www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc

- **Patient Protections** — The Patient Protection Model Notice can be used to satisfy the requirement that non-grandfathered health plans and insurers provide notice to participants of their rights to (a) choose a primary care provider or pediatrician from within the plan's network or (b) obtain obstetrical or gynecological care without prior authorization. This notice must be provided whenever the plan provides a participant with an SPD or other summary of benefits, starting no later than the first day of the first plan year beginning on or after Sept. 23, 2010. This is not required to be sent as a separate communication.

www.dol.gov/ebsa/patientprotectionmodelnotice.doc

- **The Grandfathered Health Plans Model Notice** — This is sufficient for use by non-grandfathered plans to meet the requirement that employers include a statement that describes the benefits provided, the fact that the plan or coverage considers itself grandfathered under PPACA, and includes contact information that a participant can use to ask questions or lodge a complaint. The notice must be included in the SPD or in any other plan materials provided to participants or beneficiaries describing the benefits provided under the plan or health insurance coverage.

www.dol.gov/ebsa/grandfatherregmodelnotice.doc

Internal Appeals and External Review Procedures — This must be included in the SPD. It only applies to non-grandfathered plans. The model notice for non-grandfathered self-funded plans to include in the SPD has not yet been released. The model notice for non-grandfathered fully insured plans has been released. It is on Page 32, Appendix A of the NAIC Model Act:

www.dol.gov/ebsa/pdf/externalreviewmodelact.pdf

- Mini-Med Waiver Notification — This must be provided with any plan materials, including the SPD, and must be in bold, 14-point font. This notice applies to a group health plan that received a waiver from the annual limits requirement. Thus, it could apply to both grandfathered and non-grandfathered plans.

www.healthcare.gov/center/regulations/guidance_limited_benefit_2nd_supp_bulletin_120910.pdf

- The PPACA does not require notification regarding the prohibition on pre-existing condition exclusion periods for individuals under age 19, certain preventive care services with no cost sharing (only applies to non-grandfathered plan) or nondiscrimination rules (only applies to non-grandfathered plans). Thus, there are no model notices for such. However, under ERISA, the SPD should be revised to reflect any plan changes in regards to these items or other items. Additionally, ERISA requires a summary of any plan changes be sent to participants summarizing how the plan's eligibility or benefits have changed. This is called a Summary of Material Modification. There is no model language for such notices. They simply need to explain the changes in plain language so that the average participant can understand.

Distribution Timeline

The Adult Children Model Notice, the Lifetime Limits Model Notice and the Patient Protections Notice (if applicable) must be distributed by the first day of the first plan year beginning on or after Sept.23, 2010. The Internal Appeals and External Review Procedures, Grandfathered Health Plan Notice and Mini-Med Waiver Notification must be distributed with the revised SPD.

For more information about the employer impacts in 2010 and 2011, contact your NFP advisor.

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