



# KEEPING ABREAST OF ONCOMING OBLIGATIONS

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With many of the Patient Protection and Affordable Care Act's (PPACA) requirements now going into effect, Americans are beginning to understand how it will impact their lives. Eventually, PPACA will require most legal U.S. residents to obtain health insurance, either through work or through employer-provided vouchers. Government subsidies are designed to help lower-income individuals obtain health insurance through newly created state health insurance exchanges. But before such major changes are implemented, many smaller – but potentially just as significant – changes will occur. To guide their clients through these changes, it is important for attorneys to understand this expansive law.

*This article discusses some of the duties and obligations that the PPACA imposes and provides tips on compliance. Greater emphasis is placed on those obligations arising sooner, as there is less time to comply.*

## Duties and Obligations Currently in Effect that Apply to All Plans

The following requirements are in effect and all plans must be in compliance:

### ***Reasonable Break Time for Nursing Mothers***

Employers must provide nursing mothers, for up to one year after a child's birth, with a reasonable, unpaid break each time the mother needs to express milk. Employers must provide a place, other than a bathroom, for her to express milk; it must be shielded from view and free from the intrusion of coworkers and the public. An employer with fewer than 50 employees is not required to comply if the requirement would impose significant difficulty or expense.

**Group health plans and insurers are prohibited from imposing pre-existing condition exclusions for children under the age of 19.**

**Protections for Employees**

Employers may not discharge or discriminate against an employee because the employee:

1. Received a federal tax credit or cost-sharing subsidy to purchase health insurance;
2. Provided, or is about to provide, information relating to a violation, or what the employee reasonably believes to be a violation, of Title I of the PPACA;
3. Testified, or is about to testify, in a proceeding about such a violation;
4. Assisted or participated, or is about to assist or participate, in such a proceeding; or
5. Objects to, or refuses to participate in, any activity the employee reasonably believes to be a violation of Title I of the PPACA.

**Extension of Dependent Coverage up to Age 26**

Group health plans and insurers that provide dependent health coverage must extend that coverage to children up to age 26.

**Prohibition on Rescissions**

Group health plans and insurers are prohibited from rescinding, or canceling, health coverage of an enrollee except in the case of fraud or intentional misrepresentation of material fact.

**Prohibition on Pre-existing Condition Exclusions**

Group health plans and insurers are prohibited from imposing pre-existing condition exclusions for children under the age of 19. Beginning in 2014, plans are prohibited from including a

pre-existing condition exclusion for any participant.

**Prohibition on Lifetime Benefit Limits**

Group health plans and insurers are prohibited from imposing a lifetime dollar limit on essential health benefits.

**Restriction on Annual Benefit Limits**

Group health plans may impose annual limits on the dollar value of essential health benefits only as determined by the Secretary of Health and Human Services.

**W-2 Reporting**

Employers must report the value of the health insurance coverage they provide employees on each employee's annual Form W-2.

**Qualified Medical Expenses**

Over-the-counter drugs are no longer eligible for reimbursement from a flexible spending account (FSA), health savings account (HSA), health reimbursement account (HRA), or Archer medical savings accounts (MSAs) unless a prescription is obtained. The new standard applies only to purchases made on or after January 1, 2011. Employers have until June 30, 2011 to make this change to their plan documents.

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## ***Duties and Obligations Currently in Effect that Do Not Apply to Grandfathered Plans***

The following provisions also are in effect, but do not apply to “grandfathered plans.”

Generally, a grandfathered plan is a health plan that existed prior to enactment of the PPACA. To maintain grandfathered plan status, the plan cannot substantially change the benefits it provides, increase deductions or co-pays, decrease employer contributions or impose annual limits on certain treatments.

### **1. Preventive Care:**

Group health plans and insurers must cover certain preventive care services without cost-sharing, including recommended preventive care and screenings for infants, children and adolescents and additional preventive care and screenings for women.

**2. Appeals Process:** A new appeals process that includes both internal and external reviews must be provided to employees for appeals of coverage determinations and claims.

**3. Emergency Services:** Group health plans and insurers must cover emergency services without prior authorization and in-network requirements.

**4. Physician Selection:** Group health plans and insurers that provide for or require the designation of a participating primary care provider must permit each participant to designate any participating primary care provider who is available to accept such individual. Also, a plan must allow women to designate an ob-gyn as primary care provider and pediatricians must be allowed as primary care providers in the case of children.

## **Collective Bargaining Implications in 2011-2012**

For employers facing collective bargaining in 2011 or 2012, it is key to maintain flexibility. Because of the uncertainty concerning certain details effective in 2014, very few employers will be in a position in 2011 or 2012 to predict accurately what to do in 2014. Therefore, it generally will not be in the best interests of an employer to lock into any health care option for 2014 at this time.

## **Duties and Obligations Effective Starting 2014**

The following requirements apply to all health plans starting in 2014:

### ***Automatic Enrollment:***

Employers with more than 200 full-time employees that offer health coverage must automatically enroll new full-time employees in a plan. An employee may opt-out of coverage. (The effective date of this provision is contingent upon the issuance of Department of Labor regulations; experts anticipate issuance in 2014.)

### ***Health Insurance***

***Exchanges:*** State-established health insurance exchanges (Exchanges) must be in operation. The Exchanges will be virtual marketplaces that allow individuals and eligible

employers to purchase health insurance. Initially in 2014, only employers with up to 100 employees will be allowed to purchase insurance for their employees through the Exchanges.

### ***Individual Responsibility – Penalty:***

Individuals generally will be required to obtain “minimum essential coverage” or pay a penalty.

- For 2014, the penalty is the greater of \$95 per individual or 1 percent of the difference between the individual’s income and the individual’s federal income tax filing threshold (the “percentage of income”).
- For 2015, the penalty increases to the greater of \$325 per individual or 2 percent of the percentage of income.
- For 2016 and after, the penalty increases to the greater of \$695 per individual or 2.5 percent of the percentage of income.

### ***Employer Responsibility –***

***Penalty:*** While PPACA does not require employers to offer health coverage, large employers will be subject to a penalty beginning in 2014 if they do not:

1. offer coverage;
2. offer coverage that is affordable; or
3. offer coverage that meets the minimum value standards.

For purposes of the penalty, a “large employer” is an employer who has 50 or more full-time employees and full-time equivalents.

### ***Large Employers that Do Not Offer Health Coverage:***

Large employers that do not offer to full-time employees (and dependents) an opportunity to enroll in minimum essential coverage will pay a penalty if at least one of its full-time

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employees receives federal assistance to purchase insurance through an Exchange.

## **Large Employers that Offer Health Coverage:**

Large employers that offer minimum essential coverage to full-time employees (and dependents) will also be subject to a penalty if the health coverage offered is either:

1. not affordable because the employee's required contribution is more than 9.5 percent of their household income; or
2. the plan pays for less than 60 percent of covered health care expenses.

## **Free Choice Vouchers:**

Employers offering health coverage to their employees may also have to provide "free choice vouchers" for eligible employees who would rather purchase health insurance through the Exchange instead of through the employer. Eligible employees are those with household incomes at or below 400 percent of the federal poverty level and whose premium payment is between 8 percent and 9.8 percent of their household income.

## **Employer Reporting Requirements:**

Employers must annually report to the federal government whether they offer health

coverage to their full-time employees and dependents, the total number and names of full-time employees receiving health coverage, the length of any waiting period and other information about the cost of the plan.

## **Wellness Program Incentives:**

The PPACA codifies the existing HIPAA rules allowing wellness programs to offer an incentive, such as a premium reduction, for achieving a health standard, increases the incentive from 20 percent to 30 percent of the applicable cost of coverage, and permits HHS to increase the incentive level to up to 50 percent by regulation.

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## **Duties and Obligations Effective Starting 2018**

The following requirement applies to all health plans starting in 2018:

## **Excise Tax on High-Cost "Cadillac" Health Plans:**

A 40 percent excise tax will be imposed on health insurance issuers and persons that administer plan benefits that provide coverage where the value of such coverage exceeds \$10,200 for single coverage and \$27,500 for family coverage. The excise tax is imposed on the value of coverage in excess of the threshold, which includes both employer and employee premium payments. The threshold may be adjusted for age and gender demographics that are different from a national pool. It may also be adjusted if actual health



inflation exceeds the government's estimate of health inflation between now and 2018.

### **Advice**

Attorneys can help their clients by taking the following actions:

- Reviewing plan documents and summaries for compliance with near-term insurance;
- Ensuring timely distribution of required notices;
- Evaluating whether any post-PPACA enacted or proposed plan changes would cause a loss of grandfathered status and considering advantages of retaining grandfathered status versus advantages of plan changes;
- Revising health FSA, HSA and HRA open enrollment materials;
- Considering effective use of wellness programs; and
- Evaluating benefit and employment policies in light of the 2014 “play or pay” penalty:
  - How does the cost of coverage compare to penalty?
  - Does your plan provide “minimum value?”
  - Is your plan likely to be “affordable?”
  - Determining whether your plan is a “Cadillac plan” and, if so, considering whether it is cost-effective to remain so.

Employers entering into negotiations have four realistic bargaining strategies:

**Short-term CBA:** The optimal strategy for numerous employers will be to negotiate a shorter contract. Many already are doing so in the current uncertain economic environment, as many companies are unwilling to commit to a long-term agreement and, even if they are, many unions are unwilling to agree to a contract with little or no compensation increases for a multiple-year period.

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## ***“Me-too” Health Care***

**Language:** In terms of health care, a “me-too” provision would provide for the union employees to receive the same health care coverage under the same terms and costs as a defined group of non-union employees.

## ***Limited Waiver of Obligation to Bargain:***

As the PPACA currently stands, employers can anticipate having to make certain changes in response to the 2014 requirements including:

- Addressing the sufficiency and cost of coverage;
- Changing coverage options;
- Ceasing coverage; and/or
- Offering vouchers to employees electing not to be covered by the employer plan.

All of these changes would be considered mandatory subjects of bargaining, meaning that an employer with a contract in effect in 2014 may not be able to make any of these changes unilaterally.

## ***Targeted Health Care Re-opener***

Another strategy available to employers is to negotiate a “re-opener” of the union contract. Essentially, a re-opener is a provision by which the company and the union agree to meet and bargain prior to the expiration of the collective bargaining agreement regarding the issues specified in the re-opener. In this context, a re-opener can be used to provide the parties the flexibility to negotiate over health care prior to 2014 without having to re-negotiate the entire agreement.

## **Conclusion**

Attorneys must to be prepared to counsel their clients on the myriad of new requirements that have and will arise under the PPACA. Compliance with these new requirements begins with an awareness of how this complex legislation will impact employers and a review of current employee benefit plans and practices. As new benefits, penalties and programs become effective, some employers may be driven to reevaluate the cost of providing health care coverage to their employees relative to the penalty for not providing coverage. ■

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