Fox Rothschild LLP
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HEALTH CARE REFORM WORKING GROUP

ALERT

Patient Protection and Affordable Care Act

On March 23, 2010, the Patient Protection and Affordable Care Act (generally referred to as the Health Care Reform Act) was signed into law. We at Fox Rothschild recognize the far-reaching effects of the Act on clients engaged in a variety of industries, which is why we have adopted a multidisciplinary approach to help our clients sort through the myriad of issues and changes stemming from the legislation. This Alert provides a brief summary of the major provisions that impact employers, health care providers and insurers.

How Does Health Care Reform Affect Employers?

The Patient Protection and Affordable Care Act (PPACA or Health Care Reform Act) is intended to provide all individuals with access to health insurance through an employer-provided health plan or an individual insurance policy. Employers will have the choice of offering health coverage to employees or paying significant penalties.

Which Plans Are Affected?

- Both fully-insured and self-insured employer health plans.
- **Grandfathering Provision:** The PPACA distinguishes between "grandfathered" health plans, which are those group health plans in existence as of March 23, 2010, and new group health plans.
  - PPACA exempts "grandfathered plans" from certain requirements (see following section). PPACA provides that family members are permitted to join the grandfathered coverage if the terms of the plan in effect on the date of enactment would allow such enrollment. New employees (and their families) may enroll in a grandfathered group health plan.
  - It is unclear what change to a grandfathered health care plan would cause that plan to lose its grandfathered status.
- Self-insured employer group health plans and multi-employer welfare arrangements (MEWAs) are generally subject to PPACA.

Which Provisions of the Health Care Reform Act Affect Employers in 2010?

- **Reimbursement:** Until January 1, 2014, employers providing coverage to retirees who are over age 55 and not eligible for Medicare coverage may qualify for reimbursement of up to 80 percent of the costs of providing coverage to the extent the costs exceed $15,000 and do not exceed $90,000. The reimbursements must be used to lower costs in the employer's plan.
- **Small Business Tax Credit:** Qualifying small businesses may receive a federal tax credit to offset up to 35 percent of health insurance costs. Small business employers, generally, must have no more than 25 full-time equivalent employees employed during the year, the average annual full-time equivalent employee wages cannot exceed $50,000 and the employer must contribute at least half of the premium. The credit is reduced for each full-time employee in excess of 10 and whose average compensation exceeds $25,000. Beginning in 2014, the employer must participate in an insurance exchange (see below) to claim an enhanced credit of up to 50 percent of the cost.

• **Automatic Enrollment for Employers with 200 or More Full Time Employees:** The effective date is not clear. Interpretations include: date of enactment, upon issuance of regulations, plan years beginning on or after Oct. 1, 2010.

• **Break-Time for Nursing Mothers:** Employers must provide "reasonable break-time" and a private, non-bathroom place for women to express breast milk during the workday, up until the child's first birthday.

Which Provisions Affect Employers in 2011 (Plan Years Beginning on or after 9/23/10)?

• **Requirements and Prohibitions – All Plans:**

• No lifetime benefit limits.

• No revocation (rescission) of coverage (except for fraud and/or intentional misconduct).

• No restrictions on annual limits on the dollar value for "essential health benefits."

• Requirement of plan coverage of dependent children through age 26 if the dependent is not eligible to enroll in another employer-sponsored health plan.

• No pre-existing condition exclusions for enrollees under age 19.

• **Nondiscrimination Rules:** Fully insured group health plans are subject to the same nondiscrimination rules imposed upon self-insured group health plans under Section 105(h) of the Internal Revenue Code.

• **Additional Requirements and Prohibitions – Non-Grandfathered Plans:**

• No discrimination in favor of higher-wage employees (self-insured plans continue to be subject to prior non-discrimination rules). Fully insured group health plans are subject to the same nondiscrimination rules imposed upon self-insured group health plans under Section 105(h) of the Internal Revenue Code.

• Requirement for coverage of certain preventative health services and immunizations without cost to covered individuals.

Which Provisions Affect Employers in 2013?

• Contributions to a flexible spending account for medical expenses are limited to $2,500 per year, increased annually by a cost of living adjustment.

• The employee-side of the Medicare Part A tax rate is increased from 1.45 percent to 2.35 percent on individuals earning more than $200,000 (indexed) and married couples filing jointly and earning more than $250,000 (indexed). There is no corresponding increase in the employer-side payroll taxes. A 3.8 percent tax on unearned income is imposed on higher-income taxpayers, for which the thresholds are not indexed.

• Employers must provide written notice to employees of the existence of an insurance exchange (see below) and how the employee may contact the exchange to request assistance. If the employer pays less than 60 percent of the benefits costs (actuarial value), the employer must inform each employee that he or she may be eligible for a premium tax credit if the employee purchases insurance through the insurance exchange but the employee will lose any employer health care contribution. Employers not providing the notice would not be subject to any fines under PPACA.

Which Provisions Affect Employers in 2014?

• **Insurance Exchanges:** States will begin to operate insurance exchanges for both the individual and the small group markets to facilitate the purchase of health care insurance and certify compliance with new federal standards for "essential health benefits."

• **Employer Penalties:** Employers are fined if any employee purchases health insurance through an insurance exchange and receives a federal subsidy. The idea is to penalize employers without coverage or with expensive coverage that forces the employee to use an insurance exchange.

• An employer with more than 50 employees that **does not** offer health care coverage is fined $2,000 for each **full-time employee** (FTE) (30 or more hours per week) each year if at least one of its FTEs receives a premium tax credit.

• An employer with more than 50 employees that **does** offer health care coverage is fined the lesser of $3,000 for **each employee receiving a premium tax credit** from the federal government or $2,000 for each FTE if at least one of its FTEs receives a premium tax credit.

• In calculating the number of FTEs, the first 30 FTEs (for purposes of calculating the penalty) are subtracted. Commonly owned employers are treated as a single employer.

- **Vouchers for Health Insurance Exchange**: Employers with more than 50 employees that offer health insurance coverage must provide a "free choice voucher" to those employees:
  - Who have an income less than 400 percent of the federal poverty level;
  - Whose share of the premium is between 8 percent and 9.8 percent of income; and
  - Who choose to enroll in the insurance exchange.
  - The voucher amount equals what the employer would have paid if the employee had chosen the employer's plan. Employers will not be subject to fines for such an employee's participation in the insurance exchange.
- **IRS Reporting:** Employers with more than 50 FTEs must certify to the IRS whether they offer employees minimum essential coverage, the length of any waiting period, monthly premiums, the employer's share of the total costs of benefits, number of FTEs per month and identifying employee information, including whether the employee was covered under any benefit plan. Employers must also provide employees with notice of the information provided to the IRS.
- **Pre-Existing Condition Exclusions:** The prohibition of pre-existing condition exclusions applies to all enrollees in all plans.
  - **Employee Notifications:** Employers must provide a non-technical summary of benefits, not exceeding four pages, describing covered benefits, exclusions, cost sharing and continuation coverage.
  - **No Excessive Waiting Periods:** Effective for plan years beginning on or after January 1, 2014, group health plans may not impose waiting periods in excess of 90 days.

Which Provisions Affect Employers in 2018?

An excise tax is imposed on employer-sponsored plans with annual premiums exceeding $10,200 for individuals and $27,500 for families, increased for retirees 55 and older who are not eligible for Medicare. The thresholds are increased for high-risk professions and indexed for inflation beginning in 2020. The tax is 40 percent of the value of the plan that exceeds the threshold amounts. The excise tax is imposed on the insurer (or plan administrator in the case of a self-insured plan).

Which Provisions Affect Health Care Providers?

- **Anti-Kickback Violations Are Deemed to be False Claims Act Violations:** Previously, it was also necessary for a relator (whistleblower plaintiff) to show that a false statement was made (i.e., the certification that the provider was in compliance with applicable laws). Hospitals have been required to make such certifications for years, but physicians generally were not required to do so.
- **Retention of Overpayments:** The PPACA expanded on changes made by the 2009 Fraud Enforcement and Recovery Act (FERA) under which so-called "reverse false claims" are prohibited. The PPACA requires that an overpayment must be reported and returned by the later of 60 days after the date on which the overpayment was identified or the date the cost report is due, if applicable.
- **Physician-Owned Hospitals:** No new physician-owned hospitals will be allowed to participate in Medicare unless they have a provider agreement by December 31, 2010. Those existing physician-owned hospitals grandfathered as of this date will not be permitted to expand their capacity or add more physician owners after this year.
- **Stark Law Changes:** Referring physicians are required to inform patients in writing that they have ownership or compensation relationships with in-office ancillary services, and inform them they may obtain the specified service elsewhere. Health and Human Services (HHS) must consider reduced penalties for Stark violations based on: the nature and extent of the improper or illegal practice; the timeliness of such self-disclosure; the cooperation in providing additional information related to the disclosure; and other relevant factors.
- **"Transparency" Requirements:** Drug, device, biological and medical supply manufacturers will be required to report payments made to physicians, physician medical practice, a physician group practice and/or a teaching hospital.
- **Tax Exemption:** Charitable hospitals' tax-exempt status will be revoked unless they meet all of the following requirements:
  - **Community Health Needs Assessment:** Input from "persons who represent the broad interests

of the community served" must be conducted once every three years and the hospital must adopt an "implementation strategy to meet the community health needs identified" by the assessment. The assessment must be made widely available to the public.

• **Financial Assistance Policy:** Must include: (1) eligibility criteria for financial assistance, and whether it includes free or discounted care; (2) the basis for calculating patient charges; (3) the method for applying for financial assistance; (4) for hospitals without separate billing and collections policies, the actions the hospital may take in the event of non-payment, including collections actions and reporting to credit agencies; and (5) measures to widely publicize the policy within the community to be served by the hospital.

• **Limitations on Charges:** Amounts charged by hospitals for emergency or medically necessary care to patients eligible for assistance may not exceed those charged to patients who have insurance. Hospitals are prohibited from "the use of gross charges." Emergency services must be covered by insurers in a manner that does not discriminate against a patient using an out-of-network hospital.

• **Billing and Collection:** Prohibits "extraordinary" collection actions before the hospital has made "reasonable efforts" to determine whether the patient is eligible for assistance under the financial assistance policy. The hospital must determine whether the patients with high deductibles or co-insurance amounts qualify for financial assistance before billing.

• **Penalty for Non-Compliance:** Is loss of tax-exempt status, compounded by an "excise tax" of $50,000 per year for failure to satisfy the **community health needs assessment** requirements.

Which Provisions Affect Insurance Carriers?

- The health care act is the first federal regulation of insurance since the "McCarran-Ferguson Act of 1945" that granted an antitrust exemption to insurance companies.
- The Health Care Reform Act did not repeal the McCarran-Ferguson Act or address whether the federal government will begin to regulate the insurance industry.
- Currently, no federal apparatus exists for regulation of the insurance industry. Regulation is left to the 50 individual state insurance commissioners.
- The effect of the Health Care Reform Act will depend largely upon the interpretation of each of those 50 individual state commissioners, although many states have similar "model" insurance acts.
- Specific provisions affecting insurers:
    - Effective immediately, HHS is directed to review plans with excessive premiums.
    - Effective January 1, 2013, a $500,000 deduction limit for current and deferred compensation to employees of insurance carriers.
    - Effective January 1, 2018, the so-called Cadillac Tax is imposed upon insurers offering certain high-cost plans. However, insurers are expected to pass this tax on to consumers.

Fox Rothschild looks forward to working with you as a valued business partner in our effort to help guide and explain the impact and effect of the Health Care Reform legislation.

Please visit Fox Rothschild's web site for more information on our multidisciplinary Health Care Reform Working Group as well as the firm's Employee Benefits and Compensation Planning, Labor and Employment, Health Law, Tax & Estates and Insurance Practice Groups.

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