

Comprehensive Guide To Health Care Reform For Human Resources

Legal Workplace, May 11, 2010

Health care reform consists of two laws — the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 11-152), which makes minor changes to the Patient Protection Act. The effective date for provisions in this legislation ranges from immediately to as late as 2018. Although some of the biggest changes to the health care system won't take place until 2014, there are some significant provisions that take effect later this year.

Below you will find a concise summary of everything you need to know to make sure that your organization's health plan complies with the right provision at the right time.

Provisions That Are Immediately Effective

Beginning January 1, 2010, employers with fewer than 25 full-time equivalent employees that offer health care may be eligible for a tax credit toward the cost of health coverage. Full-time equivalent employee's means the number of employees equal to the total number of hours of compensable service divided by 2,080. *Watch this:* Because the credit is based, in part, on the number of full-time equivalent employees, and not the number of employees, many employers will qualify even if they employ more than 25 employees. *Key:* Employee contributions into cafeteria plans can't be taken into account for purposes of the credit. Seasonal employees aren't counted. The credit is part of the general business credit, so it's eligible to be carried back one year and carried forward for 20 years.

The credit is phased out as average employee compensation increases from \$25,000 to \$50,000 and as the number of employee's increases from 10 to 25. Compensation means wages subject to income tax withholding, plus 401(k) pre-tax deferrals. The \$50,000/\$25,000 salary amounts are indexed for inflation, **beginning in 2014**. *No double dipping:* Employers may deduct qualified employee health coverage expenses equal to total health coverage expenses minus the dollar amount of the credit.

The credit is available for two years and equals the lesser of the following two amounts, multiplied by the applicable tax credit percentage:

- the amount of contributions employers made on behalf of employees during the tax year for qualifying health coverage; or
- the amount of contributions that employers would have made during the tax year if each employee had enrolled in coverage, with a small business benchmark premium. The benchmark premium is multiplied by the number of employees enrolled in coverage and then multiplied by the uniform percentage that applies for calculating the level of coverage selected by employers. The uniform percentage can't be lower than 50%.

The credit is divided into two phases. For Phase I — **2010 through 2013** — the maximum credit is 35%. **Beginning in 2014**, under Phase II, employers that purchase benefits through a Small Business Health Options Program are eligible for a 50% credit; the credit lasts for two years. *Watch this:* The maximum two-year coverage period for the credit doesn't take into account tax years beginning before 2014. *Upshot:* A qualified small employer could potentially qualify for the credit for six taxable years — four years under Phase I and two years under Phase II.

Special rule for non-profits: Non-profit employers can't use the general business credit, because they don't have taxable income. Non-profits are limited to taking a 25% credit in Phase I and a 35% credit in Phase II. Non-profits will take the credit against the amount of taxes withheld from employees' pay.

Breast-Feeding Breaks Are Now Required

The Patient Protection Act amends the Fair Labor Standards Act (FLSA) to require that employers provide reasonable break time for up to one year after the birth of a child, and a place, other than a bathroom, for nursing mothers so they can express breast milk. Employees need not be compensated for this time, despite the fact that other rest breaks are considered compensable working time. Employers of fewer than 50 employees don't have to comply if doing so would create an undue hardship by causing the employer significant difficulty or expense. State laws aren't preempted. This provision became effective **March 23, 2010**.

Adoption alert: In addition, the Patient Protection Act tweaks employer-provided adoption assistance for tax years beginning this year. The maximum amount that employers can provide tax-free to employees increases to \$13,170 (the IRS inflation-adjusted maximum was \$12,170 for this year). Furthermore, employer-provided adoption assistance will expire on December 31, 2011, instead of December 31, 2010.

Provisions Effective Later This Year

With certain exceptions listed below, group health plans in existence on March 23, 2010, are grandfathered, and don't have to comply with the insurance market reforms. Group plans can continue to enroll new employees without jeopardizing their grandfathered status. Likewise, self-insured plans are exempt from the insurance market reform provisions. Benefits provided under collective bargaining agreements don't have to comply until the next contract.

Provisions that apply to all plans. Here's the rundown of provisions that are effective **for plan years beginning September 23, 2010**, and that apply to grandfathered plans and non-grandfathered plans alike.

- Coverage must be offered to employees' children until they turn 26 whether or not they qualify as a tax dependent. Grandfathered plans don't have to offer coverage if dependents are eligible to be covered under another plan other than their parent's plans. Plans may increase premiums otherwise required for coverage provided to a qualified child but cannot charge higher premiums for older children based on their age. Notice must be sent to an employee who had a child that previously aged out of the plan of the opportunity to obtain coverage under the employer's plan by the beginning of the first plan year that begins after September 23, 2010. To avoid taxation issues with the extended coverage, **beginning March 23, 2010**, the tax code has been amended to allow employers to provide tax-free health benefits to employees' dependent children who have not reached age 27 by the end of the taxable year.
- Group health plans and health insurers can't impose aggregate lifetime limits on benefits. Group health plans and health insurers may only establish a restricted annual limit, to be set by the Department of Health and Human Services (HHS), on the dollar value of essential health benefits (scroll down to see a list of essential benefits). To the extent authorized by law, annual or lifetime limits may be imposed on specific benefits that aren't minimum essential benefits. As discussed later in this report, all annual limits will disappear **beginning in 2014**.
- Group health plans and health insurers can't impose pre-existing condition exclusions on enrollees who are younger than 19. As discussed later in this report, all pre-existing condition exclusions will disappear **beginning in 2014**.
- Group health plans and health insurers can't rescind coverage.

Provisions that apply to new plans only. These provisions apply to non-grandfathered plans (i.e., new plans), effective for plan years beginning **September 23, 2010**.

- Group health plans and health insurers must provide coverage for certain preventive health services with no cost-sharing for children and women. *Services included:* immunizations, preventive care, and screenings.
- Sponsors of group health plans, other than self-insured plans, will be prohibited from limiting eligibility for coverage to executives and other highly compensated employees. Thus, the non-discrimination rules that now apply to self-insured plans will apply to insured plans. *Heads up:* If self-insured plans (and soon insured plans) discriminate in favor of executives and other highly compensated employees, the excess is fully taxable to those employees for payroll purposes.

Miscellaneous provisions. Group health plans, including self-insured plans and grandfathered plans, will have to simplify the presentation of any written material and provide an accurate summary of benefits and an explanation of coverage. Formats must be uniform and language must be easily understood by the average enrollee. Plans must describe standard insurance and medical terms in a uniform manner. The explanation must describe any cost-sharing, exceptions, reductions, and limitations on coverage, and provide examples to illustrate common benefits scenarios. Enrollees must be provided with a contact number they can call with additional questions and the URL of a website where the group certificate is posted. Notice of any material changes must be provided to enrollees 60 days prior to the effective date of any change. Entities that willfully fail to comply with this provision may be fined \$1,000 per enrollee. This provision is effective **March 23, 2011**. Effective **March 23, 2012**, plans will have to provide summaries to new enrollees.

Early Retirees Get A Break

Early retirees who exhaust their COBRA benefits are in about the worst position to obtain individual coverage. A provision of the Patient Protection Act targets these early retirees.

By June 21, 2010, and ending January 1, 2014, a temporary reinsurance program will assist participating employment-based plans with the cost of providing health benefits to eligible retirees who are 55 and who aren't Medicare-eligible (retirees' dependents are eligible, too). Plans must apply to participate in this program. Participating plans will be reimbursed for 80% of the portion of a claim over \$15,000 and below \$90,000. These amounts will be adjusted for inflation. Plans must use their reimbursements to lower participants' premiums, co-payments, and other out-of-pocket expenses. *Warning:* Reimbursements can't be used to reduce the employer's costs to maintain the plan.

Health Care Reform: The New Frontier

Everything you've heard about health care reform is true, sort of. Almost everyone will have to get health insurance, either through their employers or on the open market. These plans are called qualified health benefit plans (QHBP). QHBPs must offer certain levels of coverage and specified benefits. Employers can stick with their current plans or, for those that are small enough, buy insurance through a new Health Insurance Exchange.

Insurance market reforms — structural and transparency requirements for group health plans. For plan years beginning January 1, 2014, group health plan insurers, including plans in the large group market and the small group market (typically two to 50 employees, but up to 100 employees in some states), must comply with the requirements for QHBPs. Individuals whose coverage doesn't qualify as a QHBP will be penalized. Health insurance exchanges will certify plans as QHBPs.

Beginning March 23, 2010, to ensure transparency and accountability, group health insurers will be required to report the proportion of premium dollars they spend on reimbursements for clinical services, for activities that improve the quality of health care, and on all other non-claims costs, including an explanation of those costs.

Through 2013, for each plan year, group health insurers (*including grandfathered plans*) must provide enrollees a rebate on a pro-rated basis equal to the amount by which premium revenue spent on non-claims costs exceeds 20% in the small group market and 15% in the large group market; states may set different percentages. **Beginning in 2014**, the rebate formula changes.

For plan years beginning January 1, 2014, the Patient Protection Act amends the Health Insurance Portability and Accountability Act (HIPAA) by prohibiting group plans and insurers, *including grandfathered plans*, from imposing any pre-existing condition exclusions. In addition, plans can't establish eligibility rules based on health-status-related factors, including health status, medical conditions (including physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. In addition, health insurers will be required to accept every employer that applies for coverage; renewals will also be guaranteed.

Insurance market reforms — minimum essential benefits. For plan years beginning January 1, 2014, QHBPs must cover at least an essential benefits package, but can offer additional benefits, such as adult vision and dental benefits. QHBPs, *including grandfathered plans*, can't impose waiting periods that exceed 90 days or place lifetime or annual limits on any benefit. Cost-sharing (i.e., deductibles, co-insurance, co-payments, or similar charges) is limited to the health savings account (HSA) amount in effect for the taxable year. **Beginning in 2015**, this amount will be adjusted for inflation. For a point of reference, in 2010, maximum HSA out-of-pocket costs are \$5,950 for individuals and \$11,900 for families.

Deductibles for *small employer plans* are limited to \$2,000 for individuals and \$4,000 for families. Deductibles may be increased by the maximum amount of employer contributions into health flexible spending accounts (FSAs). These amounts are indexed for inflation. *Key:* For purposes of determining the maximum amount of employer contributions into health FSAs, employees' pre-tax contributions don't count.

The essential benefits package includes at least the following:

- preventive services with no deductibles, wellness services, and chronic disease management;
- emergency services without prior authorization or network affiliation;
- ambulatory patient services;
- hospitalization;
- maternity and newborn care;
- rehabilitative and habilitative services;
- pediatric services, including dental and vision;
- prescription drugs;
- laboratory services; and
- mental health and substance abuse services, including behavioral health treatments.

There are only four levels of QHBP coverage:

- **Bronze package** — this is the minimum creditable coverage, and has an actuarial value of 60% of the cost of benefits.
- **Silver package** — has an actuarial value of 70% of the cost of benefits.

- **Gold package** — has an actuarial value of 80% of the cost of benefits.
- **Platinum package** — has an actuarial value of 90% of the cost of benefits.

QHBP not offering a bronze, silver, gold, or platinum plan can offer a **young invincible policy** to young adults who are not yet 30 years old before the beginning of the plan year, or, regardless of age, to individuals who are certified as exempt from the individual mandate because no affordable coverage is available, or because they qualify for a hardship exemption. This is catastrophic-only coverage that provides essential benefits. The catastrophic levels are set at the HSA limits for the current year, but deductibles don't apply to at least three primary care visits. This plan may only be offered in the individual market.

Health exchanges. Beginning January 1, 2014, states will establish separate exchanges for the individual and small group market. States that don't establish exchanges will have exchanges established for them. States that established exchanges before January 1, 2010 (Massachusetts and Utah), which insure a certain percentage of the population, may continue to operate. Exchanges certify plans as QHBPs.

The exchange for the small group market goes by the catchy name of the Small Business Health Options Program (SHOP). States have the option of combining the individual and business exchanges. An exchange is not an insurer, but is similar to Travelocity™ or Expedia™, which provide comparable information on flights and hotel rooms. Plans sold through the exchanges must be QHBPs. QHBPs offered through the SHOP can offer additional benefits. States have the option of requiring QHBPs to offer additional benefits, but they must pick up the additional cost by paying enrollees directly or by contributing to the health plan. Insurers that offer QHBPs at any level may also offer that plan at any level in which the only enrollees are children under the age of 21. **Beginning in 2017**, states may opt out via a waiver process, but waivers will only be granted if state coverage is at least as generous as federal coverage.

Employers that buy coverage through the SHOP must make that coverage available to all full-time employees (i.e., employees working at least 30 hours a week), but employers may obtain health insurance through a plan that doesn't operate within the SHOP. Individuals who can't afford insurance or who suffer hardships will receive a certification through the exchange, which will then forward this information to the IRS. Exchanges will also forward the names of employees who are eligible for premium assistance tax credits to their employers.

What's a small employer: For plan years beginning before January 1, 2016, states have the option of defining small employers as either employers with 100 or fewer employees, or employers with 50 or fewer employees during the preceding calendar year, and that employ at least one employee on the first day of the plan year. Small employers that outgrow the SHOP limit can still use it. Employers treated as a single group for tax purposes are treated as a single group for this purpose. If employers weren't in existence during the preceding year, the average number of employees that an employer is reasonably expected to employ during the current calendar year is used to determine the employer's size. **For plan years beginning January 1, 2017**, states may allow larger employers to use the SHOP.

Employers May Play, But Must Pay

Employers aren't required to provide health benefits to employees. But employers that fail to provide health insurance will pay a penalty. Likewise, employees aren't required to accept employer-provided coverage. But those who turn down employer-provided coverage are still responsible for obtaining individual coverage. Employers with fewer than 50 employees are excluded from these play-or-pay requirements. The Patient Protection Act also imposes new information reporting requirements.

Employers with 50 or more full-time employees (i.e., employees working at least 30 hours a week) during the preceding calendar year that don't offer insurance, or those that provide unaffordable coverage, will be liable for non-deductible penalties, **beginning in 2014**. Employers may appeal either of these determinations. For purposes of determining whether an employer meets the 50-employee threshold, part-time employees must be counted as full-time equivalent employees by dividing the total number of hours part-time employees work for the month by 120. Here's the rundown.

- Employers that choose to not offer health benefits pay an excise tax, if *any* full-time employee obtains coverage through an exchange for a month for which a premium assistance tax credit is paid or a cost-sharing reduction is allowed. The excise tax for any month equals the number of full-time employees over a 30-employee threshold during that month (regardless of how many employees are receiving a premium assistance tax credit or cost-sharing reduction), multiplied by \$166.67. Employees who are in a waiting period of not longer than 90 days count as part of the 30-employee threshold. **Beginning in 2015**, the penalty will be adjusted.
- Employers that offer *unaffordable coverage* or coverage that doesn't qualify as a QHBP will pay a monthly excise tax of \$250 for each full-time employee who receives a premium assistance tax credit (see below) and cost-sharing reduction for insurance purchased through an individual exchange. The penalty for any month is capped at an amount equal to the number of full-time employees during the month (regardless of how many employees are receiving a premium assistance tax credit or cost-sharing reduction) in excess of 30, multiplied by \$166.67. The penalty will be adjusted, **beginning in 2015**. *Exception:* The penalty is not assessable against any employee for whom the employer provides a free-choice voucher.

Counting rules: Employers won't be considered to employ more than 50 full-time employees if their workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year and those additional employees during that 120-day period are seasonal workers. Employers treated as a single group for tax purposes are treated as a single group for this purpose. If employers weren't in existence during the preceding year, the average number of employees that an employer is reasonably expected to employ during the current calendar year is used to determine whether an employer is a large employer.

\$\$\$ Assistance For Low Earners...But Employers May Pay

Premium assistance tax credits are available to employees who don't receive employer-provided coverage and who buy individual coverage on an exchange. Premium assistance tax credits are calculated on a sliding scale starting at 2% of employees' income for those at or above 100% of the federal poverty line, and phasing out at 9.5% of income for those at 400% of the poverty line. The reference premium is the second lowest cost silver plan available in the individual market in the rating area in which employees reside.

Additional amendments to the FLSA prevent employers from discriminating against or discharging employees who receive premium assistance tax credits. Employee whistleblowers are also protected. Employers will be notified if their employees are determined to be eligible for premium assistance tax credits because they don't provide a QHBP or offer only unaffordable coverage. The notice must include information about their potential liability for a free-rider penalty.

These employees may also be eligible for lower cost-sharing maximums. For individuals between 100% and 200% of the federal poverty line, out-of-pocket costs are capped at one-third of the HSA amount; for those between 200% and 300% of the federal poverty line, the cap is 50% of the HSA amount; and for those between 300% and 400% of the federal poverty line, costs are limited to two-thirds of the HSA amount.

Free Choice Vouchers To Qualified Employees

Employees offered employer-based coverage generally aren't eligible for premium assistance tax credits and other assistance to buy individual coverage through an exchange. However, employees who are offered *unaffordable* employer coverage may be eligible for assistance. For employers that choose to offer health insurance, the following rules apply.

- Employers offer full-time employees (i.e., employees working at least 30 hours a week) and their dependents coverage in a grandfathered plan or in a QHBP through the SHOP and pay a portion of the premiums.
- An employer isn't treated as meeting its requirements for an employee if it offers *unaffordable coverage*. Coverage is unaffordable if: 1) employees are eligible for premium assistance tax credits because their required contribution exceeds 9.8% of their household income, or 2) the plan's share of the total allowed costs of benefits provided is less than 60% of the costs (i.e., a bronze plan). *Important:* For purposes of determining whether coverage is affordable, employees' pre-tax contributions into cafeteria plans are treated as employee payments. However, if employers reimburse employees for any portion of the premium for insurance purchased through an exchange, including reimbursement through pre-tax contributions into cafeteria plans, the coverage is employer-provided and employees aren't eligible for premium assistance tax credits or cost-sharing reductions.
- Employers that pay any portion of the premium (i.e., offering employers) must provide *free-choice vouchers* to employees whose household income isn't greater than 400% of the federal poverty line and whose health care contribution is between 8% and 9.5% of household income. Vouchers equal the monthly amount employers would have contributed into the plan for those employees with respect to which employers pay the largest portion of the cost of the plan. Employees then use their vouchers to purchase coverage on the individual exchange. *Key:* Employers providing vouchers don't have to pay any free-rider penalty.

The HHS will establish a program for determining whether individuals are eligible to enroll in an individual exchange and to claim premium assistance tax credits. The HHS will also establish the criteria for determining whether employees' coverage under an employer-sponsored plan is unaffordable. This means that the HHS may need to contact employers for some of this information.

The play requirement. A key provision of the play requirement is an amendment to the FLSA requiring employers with more than 200 employees that offer health insurance to automatically enroll new full-time employees into the plan. Employees must receive adequate notice and an opportunity to opt out of their auto-enrolled coverage.

Which plan? The Patient Protection Act doesn't specify into which plan employees must be auto-enrolled. One possibility is that employers will be required to auto-enroll employees into a self-only coverage plan with the lowest cost.

The FLSA is further amended to provide that, **beginning March 1, 2013**, employers must provide existing employees and each new hire a notice regarding health insurance coverage. The notice must include the following information.

- It must inform employees of the existence of the exchange, and include a description of the services the exchange provides and the manner in which employees may contact the exchange to request assistance.

- If the employer picks up less than 60% of the cost, the notice must inform employees who purchase insurance through the exchange that they may be eligible for premium assistance tax credits and cost-sharing reductions.

Individual Play Or Pay

Unless employees want to be dinged with a no-coverage penalty, for each month **beginning in 2014**, all U.S. citizens and legal residents must purchase coverage that qualifies as a QHBP. Coverage can be purchased through the individual market; through a public program, such as Medicare, Medicaid, the Children's Health Insurance Program, Veteran's Health Care Program, or TRICARE; or through an employer plan. The penalty is phased in as follows: \$95 in 2014 and \$325 in 2015.

Beginning in 2016, the penalty is the greater of 2.5% of income that exceeds that year's threshold amount necessary for filing a tax return (the 2010 amounts are \$9,350 for single taxpayers and \$18,700 for marrieds filing jointly) or \$695 a year per adult in the household; the penalty for dependents under 18 is half. The maximum penalty per household is \$2,085. After 2016, the penalty will be adjusted for inflation. Penalties are payable with employees' 1040s. *Exemptions:* Taxpayers who lack coverage for less than three continuous months (only one three-month lapse is allowed per calendar year) and taxpayers for whom the full premium of the lowest cost option exceeds 8% of their income are exempt. Taxpayers with income below 100% of the federal poverty line are exempt, as well as taxpayers who are undergoing hardships and individuals with health arrangements provided by established religious organizations comprising individuals with sincerely held beliefs (e.g., participants in Health Sharing Ministries).

New Payroll Headaches: Tons Of Information Reporting Requirements

Three new information reporting requirements accompany health care reform. W-2 reporting begins much sooner than you think. In addition, Form 1099-MISC reporting has been tweaked; those changes are discussed later in this report.

W-2 reporting. To accompany the individual mandate to be insured, **for tax years beginning January 1, 2011**, all employers, regardless of size or whether they offer health insurance, must report on employees' W-2s the aggregate value of health insurance they receive, not including employees' pre-tax contributions into health FSAs or HSAs. For example, if employees receive major medical benefits and dental benefits under two different policies, Payroll would only be required to report the aggregate amount. You must use the same value for all similarly situated employees who receive the same category of coverage (i.e., single or family coverage). So employees with the same coverage would have the same amount reported.

How coverage is determined: For W-2 purposes, the method of determining the value of employer-provided coverage is the same as the method used to calculate the employer-provided portion of the applicable premium under COBRA. However, if the plan charges the same COBRA premium for self-only and family coverage, the plan would have to calculate separate self-only and family premiums.

More annual reporting. In coordination with the individual and employer mandates, **beginning with tax year 2014**, large employers (i.e., employers with 50 or more full-time employees) and every offering employer (i.e., employers required to provide free-choice vouchers) must make an annual report to the IRS and to employees. To the extent practicable, reports will be on employees' W-2s. The following information must be reported.

- The employer's name, date, and Employer Identification Number (EIN).
- A certification regarding whether the employer offers its full-time employees and dependents the opportunity to enroll in the group health plan.

- If a large employer certifies that it gave employees and their dependents an opportunity to enroll in a health plan, the length of any waiting period, the months during the calendar year for which coverage was available, the monthly premium for the lowest cost option in each of the enrollment categories, and the employer's share of the total costs of benefits provided under the plan.

Offering employers must report the option for which they pay the largest portion of the cost in each enrollment category, plus the following information.

- The number of full-time employees for each month of the calendar year.
- Employees' names, addresses, and Social Security numbers, and the months during the calendar year during which they and their dependents were covered under the health plan.

Employees' statements must also include the name, address, and phone number of the person required to make the return. Employees must receive their statements by January 31. Large employers offering health benefits through health insurers may agree with their insurers to coordinate this information reporting requirement with the insurer information reporting requirement.

Insurer information reporting. For tax years beginning January 1, 2014, group health insurers, including employers that sponsor self-insured plans, must file annual information returns with the IRS and employees. Employees must receive their copies by January 31. The following information must be shown on a return.

- The name, address, and Taxpayer Identification Number (TIN) of the primary insured and every other individual obtaining coverage under the policy.
- The dates during which the individual was covered under minimum essential coverage during the calendar year.
- Whether the coverage is a QHBP.
- The amount of any premium tax credit or cost-sharing subsidy received by the individual with respect to such coverage.

To the extent the coverage is provided through the group health plan, the insurer must also report the employer's name, address, and EIN; the portion of the premium, if any, required to be paid by the employer; if the health insurance is a QHBP in the small group market offered through a SHOP; and any other information needed to administer the tax credit for qualified small employers. Employees' statements must also include the name, address, and phone number of the person required to make the return.

Congress enacts, IRS implements: It's likely that, to the extent possible, these reporting provisions will be coordinated and simplified, since they're somewhat overlapping.

Health Care Miscellany

The Patient Protection Act makes some quirky amendments to the tax code.

Definition of medical expenses. Several years ago, the IRS loosened up the definition of medical expenses that are eligible to be reimbursed by health FSAs, HSAs, and health reimbursement accounts (HRAs) to include over-the-counter medicines. Prior to that, health FSAs, etc., could only reimburse for medical expenses that were deductible under tax code Section 213. Congress has overridden the IRS and has reimposed the original definition of reimbursable medical expenses to include only those expenses that are deductible. *Catch:* Reimbursements may still be made for OTC items for which employees have prescriptions. *Impact:* Employees will forfeit contributions under the FSA use-it-or-lose-it rule if they can't buy non-prescription OTC items. **This provision is effective for**

expenses incurred for tax years beginning January 1, 2011. *Tip:* Employees should be informed of this provision before they designate pre-tax FSA contributions for 2011.

Itemized deductions. In addition, taxpayers who itemize deductions can deduct medical expenses that aren't reimbursed by insurance when those expenses exceed 7.5% of their adjusted gross income. However, **for tax years beginning January 1, 2013**, unreimbursed medical expenses will be deductible if they exceed 10% of adjusted gross income. *Age matters:* **Through 2016**, the increased deduction threshold applies only to taxpayers who are under 65 years old; taxpayers who are 65 years old and older may continue to deduct unreimbursed medical expenses that exceed 7.5% of their adjusted gross income.

Check Please — Paying For Health Care Reform

It's true that paying for all of these reforms will cost bundles of money. So here's the itemized bill.

Employees' portion of Medicare increases. High earners — single employees earning more than \$200,000 and joint filers earning more than \$250,000 — will pay an additional 0.9% in Medicare taxes, for a total tax rate of 2.35%. The dollar thresholds are not indexed for inflation. *Impact:* Some joint filers may be underwithheld; they may pay estimated taxes. *Key:* For withholding purposes, regardless of employees' marital status, employers treat high earners as single. *Reason:* Although joint filers are responsible for the additional tax on a combined basis, employers must withhold only on wages exceeding the \$200,000 threshold. Couples whose combined wages exceed \$250,000 are responsible for paying the additional tax with their 1040s. *Key:* The additional tax is only to be collected from the employee; no employer match is required. **This provision is effective for tax years beginning January 1, 2013.**

Medicare tax on unearned income: Beginning in 2013, high earners will also pay Medicare taxes on their investment income — income from interest, dividends, capital gains, annuities, royalties, and rents, other than income derived in the ordinary course of business. The tax rate is 3.8% of the lesser of their net investment income or the amount of modified adjusted gross income that exceeds \$200,000 for single taxpayers and \$250,000 for married couple's filing jointly. This tax is subject to the estimated tax rules. *Note:* This tax applies independently from the additional 0.9% Medicare tax on high earners.

Everyone kicks in, a little. Revenue raisers that are targeted to health-related provisions of the tax code include the following.

- **For distributions made beginning January 1, 2011**, the penalty for distributions from HSAs that aren't used for qualified medical expenses increases to 20%, from 10%. **For distributions made beginning January 1, 2011**, qualified medical expenses include expenses for prescription drugs or insulin.
- **Beginning January 1, 2013**, the amount that employees can defer into a health FSA is capped at \$2,500. This amount is adjusted for inflation, **beginning in 2014**. **For distributions made beginning January 1, 2011**, qualified medical expenses include expenses for prescription drugs or insulin.
- Employers can't deduct the amount of the free-rider penalty on their business returns.

Expanded 1099-MISC reporting. Currently, payers are only required to file Forms 1099-MISC when they pay at least \$600 for services provided by non-corporate service providers. **Beginning with payments made in 2012**, payers will be required to provide Forms 1099-MISC to corporations that receive at least \$600, and when payees receive at least \$600 in goods, as well as services. *Exception:* Payers won't need to report payments made to payees who are tax-exempt. *Tip:* To avoid the backup withholding rules, be sure you have a process in place that captures payees' TINs prior to payment.

Excise tax. Beginning in 2018, insured and self-insured health plans that offer "Cadillac" coverage will be subject to a 40% excise tax. Cadillac plans have an aggregate cost exceeding \$10,200 for single-only coverage and \$27,500 for family coverage. These amounts increase to \$11,850 and \$39,500 for retirees over the age of 55 who receive employer-sponsored health care, and for employees in high-risk professions or employees who repair or install electrical or telecommunications lines.

Employer Pay Or Play: Special Cafeteria Plan Rules For Small Employers

Most employees contribute toward their health benefits by making pre-tax contributions into Section 125 cafeteria plans. Cafeteria plans, like all employee benefits plans, require non-discrimination testing, which can be quite onerous for small employers. Unfortunately, the consequence for failing a non-discrimination test is severe — the entire cafeteria plan is disqualified and employees will have taxable income, even for benefits that would otherwise not be taxable (e.g., health reimbursements). The Patient Protection Act creates so-called SIMPLE cafeteria plans, which provide a safe harbor from non-discrimination testing for certain small employers. **This provision is effective for tax years beginning January 1, 2011.**

Eligible employers. Employers that employ an average of 100 or fewer employees during either of the two preceding years can adopt SIMPLE cafeteria plans. Employers that grow out of the 100-employee maximum may continue to maintain their SIMPLE cafeteria plans until they hit 200 employees, at which point full non-discrimination testing kicks in.

Eligibility requirements. The safe harbor requires that SIMPLE cafeteria plans satisfy minimum eligibility and participation requirements, and minimum flex-credit contribution requirements. *Flex credits* are non-elective employer contributions that are made available to employees who are eligible to participate in the SIMPLE cafeteria plan; employees use flex credits to buy qualified benefits (but not cash or taxable benefits).

The minimum eligibility requirement is met if all employees are eligible to participate and are able to elect any benefit available under the plan. Leased employees must be counted. The following employees, however, may be excluded from participating in the plan.

- Employees who haven't yet turned 21 years old (or a younger age as specified in the plan) before the end of the plan year.
- Employees who worked fewer than 1,000 hours in the preceding plan year.
- Employees who have less than one year of service as of any day during the plan year.
- Employees who are covered under a collective bargaining agreement.
- Employees who are non-resident aliens working outside the U.S.

The minimum contribution requirement is met if, without regard to whether employees have pre-tax deductions made from their pay, employers provide flex credits equal to at least 2% of each eligible employee's compensation (i.e., *non-elective* contributions).

Alternatively, the minimum *matching* contribution is the lesser of 100% of employees' pre-tax contributions or 6% of employees' compensation. Eligible employees are those who aren't highly compensated employees or key employees. Employers can provide flex credits in addition to the flex credits provided to meet the minimum requirements. *Caveat:* The minimum requirements aren't met if matching contributions for highly compensated or key employees are at a greater rate than matching contributions for rank-and-file employees.

Special rules for some employers: For employers that weren't in existence throughout a preceding year, the determination of whether 100 employees are employed is based on the average number of employees that they reasonably expect to employ during the current year. Employers that continue, without interruption, to offer employees a SIMPLE cafeteria plan may do so until they employ an average of 200 employees.

CLASS Act Requires Payroll Withholding

The Community Living Assistance Services and Supports Act, or CLASS Act, allows individuals with functional limitations to stay in their homes by purchasing non-medical community assistance services and support. This is an optional benefit, for which employees pay through voluntary withholding. **This program becomes effective with tax years beginning January 1, 2011.**

Participation requirements. The CLASS Act allows participants to purchase community living assistance services. Employees pay premiums, which may be adjusted based on age, but all employees who are the same age must pay the same amount. Premiums will be inflation-adjusted and may be adjusted for program solvency purposes. Premium adjustments don't apply to individuals who are 65, have paid into the program for at least 20 years, and aren't actively employed. For individuals whose income doesn't exceed the poverty line, and individuals who are full-time students and younger than 22 and actively employed, the maximum monthly premium is \$5, adjusted for inflation. Employees whose earnings exceed the poverty level and who turn 22 are charged the regular premium for employees their age.

Employees must pay premiums for at least 60 months, must earn in the first three calendar years of those 60 months enough to be credited with a quarter of coverage for Social Security benefits, and must have paid premiums for at least 24 consecutive months if a lapse in premium payments of at least four months has occurred. Employees who re-enroll after a 90-day lapse will be treated as age-adjusted new enrollees. However, employees who re-enroll after a 90-day lapse, but before the end of the five-year period of initial enrollment, will be credited with their prior payments. Employees who re-enroll after a five-year lapse are treated as new enrollees on an age-adjusted basis, increased by the greater of a payment of a penalty for the lapse months or 1% of the applicable age-adjusted premium.

Benefits. There is a five-year vesting period for eligibility for benefits. Individuals become eligible for benefits if they have a medical condition that's expected to last longer than 90 days, and they can't perform at least two or three activities of daily living without substantial assistance from someone else, or they require substantial supervision to protect themselves from threats to health or safety due to a substantial cognitive impairment.

The minimum daily benefit is \$50; this amount can vary based on a scale of functional ability. There is no lifetime or aggregate limit. Benefits also include advocacy services and advice and assistance counseling.

Auto-enrollment. Employees must be auto-enrolled into the CLASS program in the same manner that employees are auto-enrolled into 401(k) plans. Employees who qualify to make the minimal payment must be allowed to self-certify that they are eligible for paying the minimum as part of the auto-enrollment process. They must make similar certifications annually. The government will provide enrollment and disenrollment forms. Premiums will be withheld by employers.

Since auto-enrollment into 401(k) plans isn't mandatory, it's not mandatory for the CLASS program, either. An alternative enrollment procedure will be developed for employees who have more than one employer, for employees whose employers elect out of auto-enrollment, and for spouses. An opt-out procedure will also be provided.

Wellness Programs Get A Shot In The Arm

To stanch the rising tide of health care costs, employers have been encouraged to institute wellness programs, since healthy employees are presumably more productive and use fewer health care resources. The main drawbacks to wellness programs are their initial costs and outcome measurements, which can be elusive. The parameters of wellness programs are set by HIPAA. The Patient Protection Act encourages employers to institute wellness programs and builds on HIPAA's requirements.

Wellness grants. Beginning July 1, 2010, employers with fewer than 100 employees who work at least 25 hours a week will be eligible for grants to offset some of the costs paid or incurred for qualified wellness programs. *Key:* Costs associated with the wellness program and general health plan costs must be segregated, since the grant applies only to wellness programs. Grants will be available for up to five years.

Qualified wellness programs must be available to all employees, but employees' participation must be voluntary. *Heads up:* HIPAA's constraints on wellness programs remain intact. However, financial rewards may be provided to employees who choose to participate, provided rewards aren't tied to premiums or cost-sharing amounts. Qualified wellness programs must include the following components.

- A health awareness component, which may consist of health education, including preventive screenings and health risk assessments.
- An employee engagement component, which provides for the active engagement of employees through worksite assessments and program planning, on-site delivery, evaluation, and improvement efforts.
- A behavioral change component, which encourages employees to adopt healthy lifestyles through counseling, seminars, online programs, and self-help materials. These programs can be aimed at tobacco use, obesity, stress management, physical fitness, nutrition, substance abuse, depression, and mental health promotion.
- A supportive environment component, which includes having company policies that promote healthy lifestyles by banning tobacco use, making nutritious food available in cafeterias and vending machines, minimizing stress and promoting positive mental health, and encouraging employees to be physically active during and after work hours.

CDC to the rescue. Employers with wellness programs, or employers that are thinking about starting wellness programs, can seek assistance from the Centers for Disease Control and Prevention (CDC). The CDC will work with health-promotion organizations to make employers aware of the benefits of wellness programs, and will provide employers of all sizes with technical assistance, consultation, tools, and other resources they can use to evaluate their wellness programs. This assistance, for which employers normally pay a pretty penny, includes:

- measuring participation and ways to increase employees' participation;
- developing measures to assess policy, environmental, and systems changes necessary to have a positive impact on employees' healthy behaviors, health outcomes, and health care expenditures; and
- evaluating programs as they relate to changes in employees' health status, absenteeism rates, productivity, and the rate of workplace injuries.

Allowable discounts. Under current law, there are two types of HIPAA-approved wellness programs — those that reward employees just for participating (e.g., taking age-appropriate tests) and those that reward employees for attaining a certain health result (e.g., losing weight, lowering blood pressure). For wellness programs that reward employees for attaining a result, the total reward given to employees under all wellness programs must be limited to 20% of the total cost of coverage (i.e., employer and employee contributions). In addition to limiting rewards to

20% of the total cost of coverage, HIPAA currently mandates that wellness plans that require employees to attain a health result meet these requirements, which the Patient Protection Act codifies.

- The program must be *reasonably* designed to promote health and prevent disease. The reasonably designed standard must be flexible. Smokers, for example, don't necessarily have to quit to earn their reward; it's the trying that's important, not the quitting. Also, the program should offer participants a reasonable chance of improving their health, but doesn't need to be overly burdensome.
- Participants must be allowed to qualify for the reward at least once a year.
- Reasonable alternative standards for obtaining the reward must be provided if it's unreasonable for certain participants to attempt to satisfy the original standard because of a medical condition or because it's medically inadvisable for them to try. A simple alternative is lowering the original standard. Plans can seek verification of a participant's medical condition from a doctor.
- Plan materials describing the wellness program and the rewards must disclose the availability of the reasonable alternative standard.

For **plan years beginning January 1, 2014**, the Patient Protection Act raises the maximum reward to 30% of employee-only coverage or 30% of employee-plus-dependent coverage. The Patient Protection Act also allows the discount to rise to 50% via regulations, if the Secretaries of Labor, Treasury, and Health and Human Services deem the increase appropriate.