On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("Act"), which provides for significant changes in the delivery of health care. The Health Care and Education Reconciliation Act of 2010 ("Reconciliation Bill"), which reconciles and amends certain provisions of the Act, was signed into law by President Obama on March 30, 2010. The following is a high-level summary that identifies some of the key provisions of the Act, as amended by the Reconciliation Bill.

**Highlights of Health Care Reform for Employers**

Many provisions of the Act will have a significant impact on employers, employees and their group health plans, whether insured or self-insured (with certain exceptions for small employers). Although state-based American Health Benefit Exchanges ("Exchange(s)") are established under the Act, there is generally no requirement for employers to offer the same health coverage that insurers offering coverage in an Exchange must offer. In fact, there is generally no requirement for employers to offer any health coverage. However, failure to offer “minimum essential coverage” and to meet other requirements will result in various direct and indirect monetary penalties on employers.

Employers (with, on average, at least 50 employees) that do not offer, as well as employers that do offer, minimum essential coverage to full-time employees and that have at least one employee receiving premium assistance tax credit to obtain health coverage will be subject to penalties. In addition, the Act imposes a nondeductible 40-percent excise tax on the issuer of the coverage on the “excess benefit” provided under any employer-sponsored health plan that exceeds certain thresholds. Plans currently in existence will be subject to certain grandfathering rules.

The Act also includes a number of design and administrative changes that will have a significant impact on group health plans. These include certain mandated levels of benefit coverage for dependents until age 26, eliminating lifetime and annual limits, caps on waiting periods and eliminating pre-existing conditions and exclusions. Additional design changes include automatic enrollment for large employers (with 200 or
more employees), a cap on the annual health flexible spending account (“FSA”) contributions of $2,500 and certain retiree health subsidies under a temporary reinsurance program. Administration will change under the Act as it includes, for example, new requirements for enrollment materials and communications, electronic and security requirements, claims and appeals procedures as well as reporting and disclosure obligations. All of these various changes have different grandfathering rules and effective dates that require close attention and monitoring of group health plans, health insurers and employers.

Additional details regarding some of these key provisions and their effective dates are as follows:

**Effective June 21, 2010, through January 1, 2014**

The Secretary of Health and Human Services (“Secretary”) must create a temporary reinsurance program to provide reimbursement to participating “employment-based plans” for a portion of the cost of providing health insurance coverage to “early retirees” (and to their eligible spouses, surviving spouses and dependents). “Early retirees” are generally retirees (age 55-64) covered by an employer plan but not eligible for Medicare. The reinsurance program provides employers participating in the program reimbursement up to 80 percent of eligible expenses incurred between $15,000 and $90,000.

**Effective Date Subject to Future Regulation**

Effective upon future promulgation of regulations by the Department of Labor, employers with 200 or more full-time employees that sponsor a health plan must automatically enroll all new full-time employees in the employer-sponsored plan. Employees may opt-out of the employer plan if they demonstrate that they have coverage from another source.

**Effective for Plan Years Beginning After September 23, 2010**

Group health plans (including grandfathered plans) must eliminate lifetime limits and annual limits on the dollar value of benefits provided under such group health plans. There is no grandfathering exception for existing group health plans. However, for plan years prior to 2014, an annual restriction on “essential health benefits” will be allowed under standards to be determined by the Secretary. Also, beneficiary limits (annual or lifetime) may be placed on particular benefits that are not essential benefits.

Group health plans (including grandfathered plans) that provide dependent coverage of children must continue to make that coverage available until they turn age 26. "Dependent" will be defined in future regulations and includes married adult children. However, before January 1, 2014, grandfathered plans may exclude an adult child if he or she is eligible for coverage under his or her own employer's group health plan. Favorable income tax treatment will be available for dependent coverage to adult children who have not turned age 27 as of the end of the tax year.

Insured group health plans may not discriminate in favor of highly compensated employees by using the rules and definitions under Section 105(h) of the Internal Revenue Code. Self-insured plans are not subject to this requirement. However, if the self-insured plans do offer
more favorable benefits to highly compensated individuals, the premiums and the benefits will be taxable as provided under Section 105(h) of the Internal Revenue Code.

Group health plans and insurers will not be permitted to impose pre-existing conditions or exclusions on children under age 19.

Effective 2011 Tax Year

Unless prescribed by a doctor, over-the-counter drugs other than insulin will no longer qualify for reimbursement under a health reimbursement account or FSA or under a health savings account (“HSA”) or an Archer medical savings account (“MSA”).

The additional tax on HSAs and MSAs for distributions not used for qualifying medical expenses is increased to 20 percent.

An employer will be required to report on its employees’ Forms W-2 the aggregate cost of health coverage (determined on a basis similar to that under COBRA) received by employees under the employer’s health care plan.

Small Businesses

Employers with 25 or fewer employees and average annual wages of less than $50,000 per employee will be eligible for a tax credit starting with the 2010 income tax return filed in 2011. There are special rules in determining eligibility and the amount of the tax credit as well as separate rules for small tax-exempt employers.

Small employers with 100 or fewer employees may adopt a simple cafeteria plan. The simple cafeteria plan may not discriminate in favor of highly compensated employees and requires the employer to make uniform contributions (generally, no less than 2 percent of an employee’s compensation).

Effective No Later than March 23, 2012

The Act requires the plan sponsor/plan administrator, if self-insured, or the insurer to prepare and distribute a uniform explanation of benefits and coverage for group health plans (including grandfathered plans) no later than March 23, 2012. There are certain content and language requirements for the summary, and the Secretary must establish and publish standards for the summary by March 23, 2011. This is in addition to any summary plan description requirements under the Employee Retirement Income Security Act.

- The uniform explanation of benefits and coverage summary must be provided to applicants at the time of application, enrollees prior to the time of enrollment or reenrollment and policyholders or certificate holders at the time of issuance of the policy or delivery of the certificate. Any entity that willfully fails to provide the information required will be subject to a fine or not more than $1,000 for each failure.
No later than March 23, 2012, the Secretary will develop reporting requirements for group health plans and issuers with respect to improving the quality of care, including, among other things, reporting on wellness programs.

**Effective 2013 Tax Year**

The current tax deduction for employers that receive Medicare Part D drug subsidy payments is eliminated.

The Medicare Part A (hospital insurance) tax will be increased by 0.9 percent for individual taxpayers with income over $200,000 and for married couples filing joint returns with income over $250,000. The increase will apply only to wages or self-employment income above those limits, resulting in a hospital insurance tax rate of 2.35 percent on those amounts. This change does not affect the employer’s portion of the payroll tax.

Certain taxpayers will be subject to a 3.8 percent Medicare Part A (hospital insurance) tax on unearned investment income. Unearned investment income typically means income from interest, dividends, annuities, royalties, rents and capital gains, less appropriate deductions and amounts subject to self-employment tax. The increase will generally apply only to the extent the net investment income exceeds any of the taxpayer’s adjusted gross income that is in excess of $200,000 for individual taxpayers and $250,000 for married couples filing joint returns. Again, this change does not affect the employer’s portion of the payroll tax.

The amount of salary that an employee can defer to a FSA is limited to $2,500 per year.

Employers must notify each employee at the time of hire (and for current employees, no later than March 1, 2013) of the existence of the Exchange, that the employee may be eligible for a premium tax credit if the employer’s share of the total cost of benefits is less than 60 percent of such costs and that, if the employee purchases a policy through the Exchange, the employee may lose the employer contribution to any health benefits offered by the employer (except as otherwise required by a “free choice voucher”).

**Effective 2014 Tax Year**

Group health plans and insurers will not be permitted to impose pre-existing conditions or exclusions on either adults or children.

Employers with more than 50 “full-time employees” (i.e., those who work an average of 30 hours per week regardless of how the employer defines full-time employee) that do not offer minimum essential coverage through an eligible employer-sponsored plan for a month and have at least one full-time employee who receives a premium tax credit or cost share reduction in connection with their enrollment in a qualified health plan will be assessed a monthly penalty of 1/12 of $2,000 multiplied by the number of full-time employees (the first 30 full-time employees are not counted in the calculation).

Employers with more than 50 full-time employees that do offer minimum essential coverage through an eligible employer-sponsored plan for a month and that have at least one full-time
employee who receives a premium tax credit or cost share reduction in connection with their enrollment in a qualified health plan will be assessed a monthly penalty equal to the lesser of:

- 1/12 of $3,000 multiplied by the number of employees receiving a premium tax credit or cost share reduction; or
- 1/12 of $2,000 multiplied by the number of full-time employees (the first 30 full-time employees are not counted in the calculation).

“Applicable individuals” and their dependents must maintain “minimum essential coverage.” Failure to do so will result in tax penalties imposed on the individual.

Employers that offer minimum essential coverage to employees must provide a “free choice voucher” to employees with incomes of less than 400 percent of the federal poverty level if that employee’s share of the premium exceeds 8.0 percent, but does not exceed 9.5 percent, of the employee’s income and the employee enrolls in a health plan through the newly created Exchange. The amount of the free choice voucher is the amount the employer would have paid for the employee under the employer-sponsored plan.

A group health plan may not establish rules of eligibility for any individual to enroll under the terms of the plan or coverage based on health status-related factors in relation to the individual or dependent of the individual (with limited exceptions for wellness programs).

Group health plans and insurers may not impose waiting periods in excess of 90 days.

**Small Businesses**

States will be required to establish a small business health options program (or “SHOP exchange”) for eligible small employers.

**Effective 2018 Tax Year**

The Act imposes a 40-percent nondeductible excise tax (the so-called “Cadillac Tax”) on insurance companies and plan administrators of self-insured plans for any health-related coverage if the combined employer/employee premiums exceed the threshold of $10,200 for single coverage and $27,500 in family coverage (as adjusted). The excise tax applies to the amount of the premium in excess of this threshold. The thresholds will be subject to cost adjustment increases based on a comparison against the cost for providing coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan. Higher thresholds will be applied to workers in high risk jobs and retirees age 55 and older if certain requirements are met.

We are continuing to review and analyze the provisions of the Act and their implications and expect to provide in-depth analysis in the coming weeks.
For more information about this issue of IMPLEMENTING HEALTH AND INSURANCE REFORM, please contact one of the authors below or the member of the firm who normally handles your legal matters.

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