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The New Healthcare Law

What Every Business Must Know – and Do Now

A SPECIAL REPORT FOR EXECUTIVES

The New Healthcare Law: What Every Business Must Know – and Do Now

PBP Executive Reports are straightforward, fast-read reports designed for time-pressed executives and managers. PBP Executive Reports excel at cutting the fluff, eliminating jargon and providing just the information today's executives need to improve organizational performance.

This PBP Executive Report was researched and produced by the veteran Editorial team at Progressive Business Publications, a leading provider of information for business people. It outlines the impact of the Patient Protection and Affordable Care Act, and gives clear insight on how businesses can best prepare and adjust to these sweeping changes in health care.

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EXECUTIVE SUMMARY

Executive Summary

It's not often an event comes along of such sweeping significance that it warrants its own section in a history textbook.

The wave of federal legislation known as the Patient Protection and Affordable Care Act is one such event.

What's been proposed and passed into law so far is all subject to change. It could all be repealed, or it could be replaced.

But for now, as the law stands, American businesses are facing some of the most dramatic changes ever to healthcare delivery and healthcare insurance.

Naturally, employers and employees alike have lots of questions.

The most immediate changes for this year, what the White House refers to as the "early deliverables," mostly affect health insurers and the coverage they must offer.

But every organization that provides health benefits needs to be familiar with and prepare for both the short-term changes – and the long-term ones, too.

Ultimately, employers will do best if they work with their insurance carriers to find out how they plan to roll out these federal mandates.

Notable first-year changes include increasing the age dependents can remain on a parent's health plan, moving uninsurable people with health problems into a federal program, banning lifetime limits on plan payouts, and adding more oversight of premium increases and tax credits for some small businesses.

The big changes in the law – the ones that will have the broadest affects – don't kick in until 2014 and after.

Those include expanding Medicaid, requiring insurers to accept all applicants and creating new insurance marketplaces called "exchanges" where businesses and individuals can go, in theory, to buy good coverage at lower prices.

Included in this Executive Report:

- **New help for some uninsured**
- **Discounts and free care in Medicare**
- **Dependent coverage**
- **Tax credits for small businesses**

EXECUTIVE SUMMARY

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The Executive Report

The New Healthcare Law: What Every Business Must Know – and Do Now

Healthcare reform will cause tumultuous changes in the way America deals with medical issues.

And employers will be in the forefront of those changes.

Case in point: In 2014, companies with more than 50 employees will have to pay penalties if they don't provide health coverage for their workers.

It's worth remembering that a number of the changes called for in the Patient Protection and Affordable Care Act will phase in over a period of years.

Given the nature of the political process, it's entirely possible that a good percentage of what's in the law today may be amended – or even repealed.

What follows is an overview of the changes, and how they will affect employers today.

What's happening immediately

Several key provisions of the new law go into effect this year.

They include:

New help for some uninsured

People with medical conditions that have left them uninsurable may be able to enroll in a new federally subsidized insurance program to be established within 90 days of the bill's passage.

Discounts and free care in Medicare

The approximately 4 million Medicare beneficiaries who hit the so-called "doughnut hole" in the program's drug plan will get a $250 rebate this year and see the coverage gap drop 50% next year.

Dependent coverage

Dependents may remain on their parent's health insurance plan up to age 26, even if the dependent is employed elsewhere and not a student.

Tax credits for small businesses

Businesses with fewer than 25 employees and average wages of less than $50,000 could qualify for a tax credit of up to 35% of the cost of their premiums.

Elimination of lifetime caps

All existing insurance plans will be barred from imposing lifetime caps on coverage. Restrictions will also be placed on annual limits on coverage. Insurers can no longer cancel insurance retroactively for things other than outright fraud.

Oversight

Insurers must report how much they spend on medical care versus administrative costs, a step that later will be followed by tighter government review of premium increases.

'Will my health plan change?'

Employers are bound to field a lot of questions from employees. They'll be wondering if the new law is going to force changes to their current health plans.

The short answer is no. The law grandfathers existing plans.

Although employer plans will have to conform to the new coverage requirements – which could affect overall premium costs down the road – the law mostly lets businesses keep on doing what they've been doing.

It's certainly possible further legislative changes could affect your health benefits. But for the moment, there is little impact on existing company provided insurance.

Key coverage changes

The new law does contain several key plan coverage changes you'll want to communicate to employees.

As already noted, **plans that offer dependent coverage must extend that coverage to children up to their 27th birthday** – even if they're married, not a student or employed elsewhere.

Currently, most health plans drop young adults at 19 and dependent students at 25 years of age.

Insurers will be prohibited from denying children (defined as dependents under 19) because of pre-existing conditions. A similar prohibition will cover adults when the final reform measures wind up in 2014.

Insurers are now prohibited from dropping covered employees who become ill. Up until now, insurers had that option – and frequently exercised it as a cost-cutting measure.

Also already noted, **health plans can't impose lifetime limits on the dollar value of coverage.** On Jan. 1, 2014, insurers will be prohibited from imposing annual limits on coverage.

Changes in retiree coverage

Many companies offer health benefits to retirees between the ages of 55 and 64 (to cover the gap between retirement and Medicare eligibility).

Starting this year, the feds will reimburse these employers for 80% of the cost of these benefits above $15,000 annually.

The subsidy would apply to amounts up to $90,000.

Small employer incentives

Small employers (fewer than 25 employees) will get tax credits for purchasing group health insurance. The average wage of company workers must be less than $50,000.

From this year through 2013, the tax credit is 35% of the employer's contribution – but the company must pay at least 50% of the total health plan premium.

In 2014 and 2015, the employer would be entitled to a tax credit of 50% of its health premium.

What's down the road

The bulk of the reform measures kick in over the next four years.

Here's an overview.

Health exchanges

Central to the reform process is the establishment of multi-state health exchanges. This is an attempt to inject low-cost competition into the health insurance marketplace.

The exchanges are slated to be up and running by 2014.

Health exchanges will allow individuals and small businesses to band together and to negotiate prices and more health insurance options – the kinds of breaks that big corporations can negotiate for their employees today.

The federal Office of Personnel Management (OPM) – which manages healthcare plans for federal workers – will form the exchanges by contracting with insurance carriers to offer at least two multi-state health plans. One of those must be managed by a non-profit organization.

In the initial years, the exchanges will be open only to those who work for firms with 100 or fewer employees, and to individuals looking to buy insurance for themselves.

Beginning in 2017, states could opt to open the exchanges to larger employers.

The exchanges would also serve as industry watchdogs – checking policies to make sure they meet minimum standards, and making sure the plans are, in the words of the reform legislation, "in the interest" of buyers.

Hand-in-hand with the exchange concept are coverage subsidies the government provides for low-income workers.

'Non-mandate' could cost plenty

Even though reform supporters were careful to stress employers wouldn't be required to provide health coverage for workers, there will be consequences for those who don't – or for those whose coverage doesn't measure up to certain standards.

Beginning Jan. 1, 2014, employers with more than 50 employees will be required to offer healthcare coverage to full-time workers or pay a penalty. Under the statute, a full-time employee is one who works at least 30 hours per week, on average.

Here's where the health-exchange concept and employer health plans collide.

The penalty for failure to provide coverage – applicable if at least one full-time employee receives government-subsidized exchange coverage – is $2,000 per full-time employee in excess of 30 employees.

An example of how it works: If a company with 100 employees chooses not to offer health coverage – and just one full-timer gets subsidized health

coverage through a state exchange – the employer would be on the hook for a yearly penalty of $2,000 apiece for 70 workers – $140,000.

And it gets more complicated.

Even if the employer does offer coverage, the employer still must pay an annual penalty if at least one full-time employee receives the government-subsidized coverage.

The question of whether an employee can opt out of his or her employer's plan in favor of getting coverage through the exchange depends on the extent and cost of the employer's plan.

If employer coverage with an actuarial value of at least 60% (more on that next) is unavailable, or if an employee's cost for employer coverage exceeds 9.5% of household income, a full-time employee would be eligible for the government-subsidized coverage.

Actuarial value is a measure of a health insurance plan's benefit generosity, and it's not based on premium costs. It is expressed as the percentage of medical expenses estimated to be paid by the plan under its schedule of allowed charges.

Just who's going to figure out the actuarial value of an employer's health plan, and how often those calculations will be reviewed, isn't clear under the current legislation.

Employer penalty in this case: either $3,000 per full-time employee who receives the premium tax credit, or $750 multiplied by the number of the employer's full-time employees – whichever is less.

Free choice vouchers

Employers will be required to provide a "free choice voucher" – equal to the value of the employer's insurance plan – to some low-income workers.

To qualify, an employee would have to have income below 400% of the federal poverty level, would be paying more than 8% of his or her income for employer coverage, and must enroll in a plan in the health exchange.

As of 2013 – a year before the penalties for not offering coverage kick

in, companies with more than 200 employees must automatically enroll workers in its employer's group health plan.

Employees may opt out of the plan, but then they'll have to obtain other coverage or pay an individual penalty.

The individual penalty for not having insurance will be phased in over three years.

By 2016, it will top off at $695 per individual per year, up to a maximum of $2,085 per family per year, or 2.5% of household income – whichever is greater.

Changes in FSAs, HSAs, HRAs

A key change for employees that'll take effect in 2013: Flexible spending accounts (FSAs), health savings accounts (HSAs) or health reimbursement accounts (HRAs) will no longer reimburse employees for over-the-counter medicines unless their physician writes a prescription.

The new law also caps annual pre-tax contributions to FSAs at $2,500. That number will be adjusted annually according to inflation rates.

New waiting period requirement

Effective Jan. 1, 2014, employers can't impose waiting periods longer than 90 days for employees to be eligible for health plan enrollment.

New tax on high-cost plans

Starting in 2018, a 40% excise tax will be levied on so-called "Cadillac plans" – the costliest level of health insurance. The tax applies for premiums higher than $10,200 (single coverage), and family coverage that costs more than $27,500. The tax is actually levied on insurers, but it's expected the cost will be passed directly to customers.

What effect will reform have on wellness?

One trend that seems to be emerging after the passage of healthcare reform: Companies saying they'll be cranking up their wellness programs as part of their cost-cutting initiatives.

The new law does offer opportunities to boost the number of companies that offer wellness programs, as well as the number of employees who participate in those programs.

The bill also aims to make it easier for companies to track the effects of a wellness program and improve the program's long-term results.

Programs that do not depend on 'health status' factors

Employers that wish to implement a wellness program that doesn't depend on specific "health status" factors of employees – (i.e., overall wellness, fitness and any underlying diseases or injuries) must make the program available to all "similarly situated" individuals.

Here's a breakdown of what employers can and cannot offer in terms of wellness programs under the law as it now stands:

- Can reimburse all – or part of – a fitness center's membership cost
- Can provide a diagnostic testing program that offers rewards for participation in the program – but not for results
- Can encourage preventive care of a specific health condition
- Can reimburse employees for the costs of a smoking-cessation program – regardless of the results of the program, and
- Can reward employees for attendance at periodic health-education seminars.

Programs that depend on 'health status' factors

Employers that start wellness programs that *depend* on specific health factors must meet the following requirements:

- Reward for wellness programs *cannot* exceed 30% of the

premium cost of employee-only coverage if the employee is the only individual who is eligible to participate in the program (20% under current HIPAA regs)

- When wellness programs are available to dependents, rewards *cannot* exceed 30% of the premium cost of the dependent's coverage [20% under the current Health Insurance Portability and Accountability Act (HIPAA) regulations]
- Administrative agencies *can* reward wellness program participants up to 50% of the premium cost of coverage if they determine the increase is appropriate
- All wellness programs must have a reasonable chance of improving participating individuals health or preventing disease (Wellness programs cannot be "overly burdensome," used as a way to discriminate against employees based on health status factors or be "highly suspect" in terms of the method chosen to promote health and prevent disease)
- Must give participants the chance to qualify for the reward *at least* once per year, and
- Must offer a reasonable alternative standard to the wellness program if the program is "unreasonably difficult" because of an employee's medical condition or because the program is "medically inadvisable."

Note: Employers that have wellness programs already in place under the existing HIPAA regs are able to follow those regulations *as long as* they remain in effect.

Grants, assistance and other resources for employers

Other provisions in the healthcare act are geared toward providing employers with a series of grants and other resources to improve the performance of employer-sponsored wellness programs.

Here are some of the programs the bill is designed to encourage:

- Create a grant program to aid in the delivery of evidence-based and community-based wellness programs are geared toward increasing prevention activities, decreasing chronic disease rates and addressing health disparities – particularly in rural areas.
- Give grants of up to five years to small businesses that set-up wellness programs with funds appropriated for the five years starting in FY 2011
- Provide technical assistance and additional resources to analyze employer-based wellness programs, and
- Conduct a national worksite health policies and programs survey to employer health policies and wellness programs (study is currently set to be conducted within the next two years).

HR/Benefits timetable

Here is a look at the HR/Benefits timetable, in a nutshell:

2010

Keep your healthcare plan if you like it.

The healthcare reform bill "grandfathered" existing employer plans, so while some changes to premiums may show up down the line, employers can keep their healthcare plan now if they like it.

Review new rules for establishing wellness plans.

The new law offers a lot of opportunities for employers to provide wellness plans, but companies must ensure their wellness initiatives follow the government's new requirements.

For example, employers can provide a diagnostic testing program that offers rewards for employees to participate, but they cannot give a reward for positive results.

Alert Medicare prescription users about potential $250 rebate.

Companies that have senior employees who are on the Medicare prescription drug program should inform them they may be eligible for a $250 rebate. Seniors who spend more than $2,700 on prescription drugs in 2010 are eligible.

Anticipate government relief for providing health benefits to retirees.

Companies that offer health benefits to retirees who are not yet eligible for Medicare (ages 55 to 64) will be reimbursed for 80% of those costs between $15,000 and $90,000.

2013

Inform employees about changes to over-the-counter medications.

Come 2013, employees' flexible spending accounts, health savings accounts and health reimbursement accounts will no longer cover over-the-counter medications unless prescribed by a doctor.

2014

Limit health plan probationary periods to 90 days.

Employers will no longer be able to impose waiting periods longer than 90 days for employees to join company health plans.

Offer a free choice voucher to qualifying low-income workers.

Some low-income staff will be eligible to receive a free choice voucher equal to the value of the employer's insurance plan. Employees must satisfy three provisions to qualify:

1. Have an income below 400% of the federal poverty line
2. Be paying 8% or more of income for employer coverage, and
3. Must enroll in a plan in the multi-state health exchanges.

Payroll timetable

2010

Continue certain payroll deductions longer.

Employees will be able to keep dependent children on their health plans through the age of 26.

Health plans can no longer impose:

- pre-existing condition exclusions on children, or
- lifetime limits on the value of coverage.

Greater income exclusion for qualified adoption assistance.

The maximum adoption tax credit and income exclusion for employer-provided adoption assistance increases to $13,170 (indexed for inflation). The Economic Growth Tax Relief Reconciliation Act (EGTRRA) sunset date for adoption assistance is extended to 12/31/11.

Provide data needed to qualify for employer subsidies – specifically, the number of employees on the payroll. There's a tax credit for company-provided coverage for firms with:

- no more than 25 employees, and
- less than $50,000 in average wages.

The credit equals 35% of an employer's contribution if it pays at least 50% of the premium up through 2013.

After that, the credit equals up to 50% of an eligible small employer's contribution for coverage bought through state exchanges, the new program designed to help individuals and some smaller firms to buy subsidized insurance.

2011

New W-2 reporting duties.

Payroll will report the value of each employee's employer-provided health coverage, along with other info, on Forms W-2.

Adjust payroll deductions.

Employees may decide to set less money aside through their employers' healthcare spending plans. Beginning in 2011, employees won't be able to buy over-the-counter drugs tax-free through a:

- flexible spending account
- health reimbursement account, or
- health savings account.

2012

Deduct more taxes from some.

The Medicare portion of the FICO tax increases to 2.35% (up from 1.45%) for those earning more than $200,000 ($250,000 for couples).

2013

Set deductions to reflect limits on contributions to health accounts.

Employees will be able to set aside through payroll deduction up to $2,500 (subject to inflation) for health flexible spending accounts.

2014

Provide higher-ups info on head count.

In 2014, employers must begin offering a minimum level of health coverage. If an employer offers basic coverage that's "unaffordable," the

company pays the lesser of:

- $250/month ($3,000/year) for all full-time workers receiving a government subsidy, or
- $166.67/month ($2,000/year) for all full-time workers.

Employers that offer no coverage will pay a $2,000 penalty per full-time worker – even if just one employee receives a tax credit to buy insurance.

Note that employees are eligible for the government subsidy if:

- employer-provided coverage that has "an actuarial value of at least 60%" is unavailable, or
- an employee's cost exceeds 9.5% of household income.

Start new payroll deductions for some in larger health plans.

Soon, many workers will be required to get health coverage. In 2014 (possibly earlier, the language in the bill isn't entirely clear) employers with more than 200 employees will automatically enroll anyone without insurance in the company health plan.

As with many other auto-enrollment plans (think retirement), workers may opt out of the plan and either:

- get coverage on their own (and show proof of doing so), or
- pay a penalty.

Employees who can't prove a minimum level of coverage will have to pay the government a penalty.

The amounts will increase over three years, ranging from:

- 2014 – $95 per year or 1% of income, and
- 2016 – $695/year or 2.5% of income.

Families won't pay more than $2,085.

There are always exceptions (naturally):

- American Indians are exempt from buying insurance
- People willing to pay more than 8% of their income for the cheapest plan won't pay the penalty, and

- Those exempt or under age 30 can buy a catastrophic medical cost policy only.

Effects on accounts payable

It turns out the healthcare bill will change how your company handles 1099s. Congress tucked a series of changes to 1099 reporting directly into the healthcare bill.

Here's a run down of the 1099 changes, and how A/P can best prepare.

More 1099-able vendors

The biggest change requires additional reporting responsibilities for a once-exempt vendor classification: corporations.

Previously, firms were required to report certain payments of $600 or more to corporations on a 1099, like attorney's fees or substitute payments in lieu of dividends.

But the latest law eliminates that exemption, meaning there will be a whole new set of vendors to track reportable payments to.

There's one exception to the new law: Companies will not have to report payments – even if they cross the $600 threshold – to nonprofit corporations that are exempt from tax under section 501(a).

New 1099-able payments

Another shake-up is now there is a new type of payment to track.

In addition to typical payments for rents, services, etc., a company's purchases of goods, merchandise or other property must be reported on a 1099.

Because the same $600 threshold per year is in effect, most companies will end up crossing the limit, and handling hundreds of additional 1099s in the process.

When to get ready

Even though changes are coming on a massive scale to an already arduous task like handling 1099s, there is time to prepare.

The 1099 changes enacted under the healthcare law take effect after Dec. 31, 2011, meaning they will apply to payments made in 2012 that are reported in 2013.

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