The Patient Protection and Affordable Health Care Act and the Health Care and Education Reconciliation Act of 2010

Important Provisions for IAAPA Members
May 24, 2010

The health care reform bill which President Obama signed into law on March 23, 2010 is exceptionally complicated and comprehensive. It contains hundreds of provisions which will impact virtually every business, person, and health care entity in the nation. Some of the sections of the law require action by federal and state agencies to put into effect, others are subject to widely varying interpretations and must be clarified by administrative action. Accordingly, implementation of this massive statute will require the issuance of hundreds of regulations, guidances, policy statements, rulings, and other regulatory and sub-regulatory pronouncements by numerous federal agencies including the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, the Department of Labor, the Treasury Department, and the Internal Revenue Service. In addition, state governments will be required to promulgate far-ranging rules to implement portions of the law for which they are responsible.

In an effort to assist its members in understanding the new health care reform law, IAAPA has formed a task force composed of a cross section of the IAAPA membership to examine the Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act of 2010 ("HCERA") and identify provisions that may impact the attractions industry. In addition, the task force will monitor federal and state regulatory activities to implement the legislation and, where necessary, engage to protect the interests of IAAPA members.

Set out below is a brief summary of the major provisions which may affect the attractions industry; more comprehensive summaries are available from IAAPA's Government Relations Department. (Note that the section numbers for the provisions refer to the section numbers of the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act of 2010*, not the sections of the laws the Acts create or amend.

Two caveats: (1) With two noted exceptions, the descriptions below are based exclusively on the statutory language and in many cases the statutory provisions are imprecise or incomplete and in need of further explication through regulatory action; and (2) Nothing in this documents should be construed as legal advice or a legal opinion. IAAPA members are strongly encouraged to consult their attorneys and human resources professionals when interpreting relevant provisions of law or determining compliance strategies.

Small Business Tax Credits (Section 1421 of PPACA) – Effective January 1, 2010

Regulating authority: Internal Revenue Service, Department of the Treasury

Section 1421 of the PPACA added Section 45R to the Internal Revenue Code which creates a tax credit for qualifying small businesses to off-set the cost of providing health insurance to employees. The tax credit is effective as of January 1, 2010 and the IRS has established transition rules for 2010 since the law was not passed until March 23, 2010. The credit is available for 2010 through 2013 and for any two years after that. The credit is worth up to 35 percent of a small business' premium costs in 2010 and this percentage increases to 50 percent in 2014. The credit phases out gradually for firms with average wages between $25,000 and $50,000 and for firms with the equivalent of between 10 and 25 full-time workers. The tax credit is available not only for traditional health insurance coverage but also for add-on dental, vision, and other limited-scope coverage. In order to be an eligible small employer , (1) the employer must have 25 or fewer full-time equivalent employees for the taxable year; (2) the average annual wages of its employees for the year must be less than $50,000 per FTE; and (3) the employer must maintain a "qualifying arrangement" pursuant to which the employer pays premiums for each employee enrolled in health insurance coverage offered by the employer in an amount which is not less than 50 percent of the premium cost of the coverage.

For the purposes of determining eligibility for the tax credit, seasonal workers are disregarded in determining FTEs and average wages unless the seasonal employee works for the employer more than 120 days during the taxable year. In calculating the total number of hours of service which must be taken into account for the year (the tax credit's matching rate is highest for employers with 10 or fewer FTEs), the employer may use one of three methods: (1) actual hours of service from records of hours worked and hours for which payment is made or due; (2) a days-worked equivalency whereby the employee is credited with 8 hours of service for each day for which the employee would be required to be credited at least one hour of service; or (3) a weeks-worked equivalency whereby the employee is credited with 40 hours of service for each week for which the employee would be required to be credited with at least one hour of service.

On May 17, 2010, the Internal Revenue Service released a notice which provides detailed information about the small business tax credit. It is available at http://www.irs.gov/pub/irs-drop/n-10-44.pdf.

Dependent Coverage (Section 1001 of PPACA) – Effective for Plan Years after Sept. 23, 2010

Regulating authorities: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Office of Consumer Information and Insurance Oversight, Department of Health and Human Services

The PPACA requires that a health insurance plan or issuer that makes available dependent coverage of children must make such coverage available for children until attainment of 26 years of age. For purposes of this mandate, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of the relationship between the child and the plan participant. Accordingly the following factors cannot be taken into account for dependent eligibility: financial dependency on the plan participant or primary subscriber, residency with the participant

or primary subscriber, student status, employment, eligibility for coverage, or any combination of these factors. In addition, plans and issuers may not limit dependent coverage based on whether a child is married although a plan or issuer is not required to cover the spouse of an eligible child. The terms of a policy cannot vary based on the age of the child—e.g. the plan cannot levy surcharges for coverage of children under age 26 nor can the benefits provided vary based on age. This provision is effective as policies renew on or after September 23, 2010, although many insurance companies are voluntarily implementing it earlier.

The three responsible agencies have published an interim final rule governing dependent coverage and it is available at http://frwebgate4.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=793528269185+30+2+0&WAISaction=retrieve

Nutritional Labeling (Section 4205 of PPACA) – Effective as soon as 2011
Regulating authority: Food and Drug Administration, Department of Health and Human Services

Section 4205 of the PPACA amends the Federal Food, Drug, and Cosmetic Act to impose new nutritional labeling requirements for foods that are a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name and offering for sale substantially the same menu items. Information which must be disclosed in "a clear and conspicuous manner" include, among other things, a nutrient content disclosure statement for each menu item and a statement concerning suggested daily caloric intake designed to help the public understand the significance of the caloric information for the menu item. The Secretary of Health and Human Services may require the disclosure of additional information. The requirements also apply to drive-throughs, self-service, and foods on display. This provision is to be implemented through a regulation promulgated by the Secretary of Health and Human Services not later than March 23, 2011. It is unclear how long the regulatory process will take, but this provision could be effective as soon as 2011.

Employer Responsibility (Section 1511-1513 of PPACA, modified by the Section 1003 of HCERA) – Effective January. 1, 2014
Regulating authorities: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Office of Consumer Information and Insurance Oversight, Department of Health and Human Services

Under the employer responsibility provisions, employers of 50 or more full-time employees and/or full time equivalent employee will be subject to penalties for not offering qualifying coverage to full-time employees. Employers with more than 200 full-time employees and which offer employees enrollment in 1 or more health benefit plans must automatically enroll all new employees in one of the insurance plans and must continue the enrollment of current employees in a health benefits plan offered through the employer. Any automatic enrollment program must include adequate notice to each employee and an opportunity for an employee to opt out of any coverage in which the individual employee was automatically enrolled. Full time employees are defined as employees who work on average 30 or more hours a week during a one-month period.

Section 1513 of PPACA provides that any "applicable large employer" that fails to offer its full-time employees (and their dependents) the opportunity to enroll in

"minimum essential coverage" under an "eligible" employer-sponsored plan for any month and at least one full-time employee qualifies for a premium tax credit or cost-sharing for a plan purchased through a health insurance exchange, shall be subject to an annual penalty equal to $2000 per full-time employee which is pro-rated on a monthly basis. The first 30 employees do not count towards calculation of the penalty.

For purposes of determining employer responsibility, an "applicable large employer" is an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year. An employer is not considered to employ more than 50 full-time employees if (1) the employer's workforce exceeds 50 full-time employees for 120 days or less during the calendar year and (2) the employees in excess of 50 employed during the 120-day period were seasonal workers. For this purpose, a seasonal worker means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor and retail workers employed exclusively during holiday seasons.

Solely for the purpose of determining whether an employer is an "applicable large employer", the employer shall, in addition to the number of full-time employees for any month, also include full-time equivalents as determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120. If the number is greater than or equal to 50, a business is considered to be an "applicable large employer." For example, if a business employs 20 full-time employees (more than 30 hours per week) and 200 part-time employees who work 25 hours a week (or 100 hours a month), it will be considered a "large employer" (with 187 full-time equivalents). The Secretary of the Treasury in consultation with the Secretary of Labor is directed to issue any necessary regulations or guidances that may be necessary to determine hours of service.

Large employers that offer its full time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan but have at least one full time employee that receives a premium tax credit must pay a penalty of $3,000 per full time employee receiving a premium credit up to an overall limitation of $2,000 per full-time employee pro-rated for each month employed during that year. To calculate the overall limitation on the penalty, the law subtracts 30 employees from the number of full time employees.

Employers may not have a waiting period for employee enrollment that exceeds 90 days effective in 2014.

Employer and Business Reporting Requirements (Section 9002 and Section 1514 of PPACA)

Regulating authority: Internal Revenue Service, Department of the Treasury.

The PPACA requires all employers, beginning with taxable years beginning after December 31, 2010, to report on W-2 statements issued to employees the aggregate cost of employer-sponsored health benefits. The amount to be reported will be determined pursuant to rules similar to the rules governing continuation coverage under COBRA. If the employee receives health benefits under multiple plans the employer must disclose the aggregate cost of all such coverage.

Section 1514 of PPACA requires every large employer to file a return (in a form specified by the Secretary) which contains specific information concerning health insurance benefits provided to full time employees. The information required includes a certification as to whether the employer provides an opportunity for employees to enroll in minimum essential coverage under an eligible employer-sponsored plan, and if such an opportunity is provided, the employer must report, among other things, the length of any applicable waiting period, the months for which coverage was available, the employer's share of total allowed costs of benefits, the number of full-time employees for each month during the calendar year, and the name and other identifying information for every employee (and dependent) covered under the plan. The employer must also provide certain information to each full-time employee. these provisions are effective for calendar years beginning after 2013.

Grandfathered Plans (Section 1514 of PPACA as amended by HCERA)
Regulating authorities: Employee Benefits Security Administration, Department of Labor; Office of Consumer Information and Insurance Oversight, Department of Health and Human Services

The PPACA grandfathers existing individual and group health plans with respect to certain new benefit standards and other requirements imposed by the health reform statute. A grandfathered plan is a group health plan, individual health insurance program, or self-insured plan in which an individual was enrolled as of the date of enactment, March 23, 2010. A grandfathered plan, for example, does not have to comply with several of the health reform provisions until January 1, 2014 including the elimination of waiting periods in excess of 90 days, complete elimination of pre-existing condition exclusions, elimination of annual limits on benefits, and certain preventative care requirements. For these reasons, maintaining grandfathered status may be critical to some employers. However, it is far from clear what, if any, changes may be made in a plan before it loses its grandfather status—i.e. was a plan in effect on the date of enactment. Virtually no guidance has been forthcoming from any of the regulating entities on this key issue.