Employee Benefits Report

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Healthcare Tax Credit Makes Group Health More Affordable

The Patient Protection and Affordable Care Act signed into law in March included a tax credit designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have. In October, the IRS released a draft version of the form small employers and tax-exempt organizations will use to claim the credit.

The form, Form 8941, was in draft form only as this issue went to press; however, the IRS expects to release a final version and instructions by year-end. Eligible small businesses and tax-exempt organizations will use the form to calculate their credit. A small business will then include the amount of the credit as part of the general business credit on its income tax return. Tax-exempt organizations will instead claim the small business health care tax credit on a revised Form 990-T. The Form 990-T is currently used by tax-exempt organizations to report and pay the tax on unrelated business income. Form 990-T will be revised for the 2011 filing season to enable eligible tax-exempt organizations — even those that owe no tax on unrelated business income — also to claim the small business health care tax credit.

Amount of Credit

- **Tax years 2010 to 2013.** Small businesses can receive a credit worth up to 35 percent of their

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This Just In…

Employers have gotten a reprieve from mandatory reporting of the cost of group health insurance on 2011 W-2s.

As we reported in our October issue, the Patient Protection and Affordable Care Act requires all employers that provide health coverage to calculate and report the cost of that coverage on employees' W-2 forms. This amount will not be included in employees' taxable income, but will help the IRS track the value of "Cadillac" health plans.

The law requires tracking to start for tax years beginning after December 31, 2010. However, in mid-October, the Treasury Department and IRS released Notice 2010-69,

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premium costs; small tax-exempt employers get a maximum of 25 percent.

- **Tax year 2014.** Beginning on January 1, 2014, the maximum tax credit increases to 50 percent of premiums paid by eligible small businesses and 35 percent for tax-exempt employers.
- **Phase out.** The credit phases out according to the employer's size. The maximum credit goes to smaller employers — those with 10 or fewer full-time equivalent (FTE) employees — paying annual average wages of $25,000 or less. The credit is completely phased out for employers that have 25 FTEs or more or that pay average wages of $50,000 per year or more. Because the eligibility rules are based in part on the number of FTEs, and not simply the number of employees, businesses that use part-time help may qualify even if they employ more than 25 individuals.

Eligibility Rules

Does your organization qualify for the credit? It must meet the following criteria:

- **Health care coverage.** A qualifying employer must cover at least 50 percent of the cost of health care coverage for some of its workers based on the single rate.
- **Firm size.** A qualifying employer must have less than the equivalent of 25 full-time workers (for example, an employer with fewer than 50 half-time workers may be eligible).
- **Average annual wage.** A qualifying employer must pay average annual wages below $50,000.
- **Both taxable (for profit) and tax-exempt firms qualify.**

If your organization is not currently providing employee health benefits but would like to, the healthcare tax credit makes it easier. To discuss qualifying plan options that fit your workers' needs and your budget, please contact us.

which provides "interim relief" from this requirement. Employers that do not report their group health care costs for 2011 will not be penalized; however, they can report this information if they choose.

The Treasury Department and the IRS determined employers needed additional time to make necessary changes to their payroll systems or procedures to comply with the reporting requirement. The Treasury Department and the IRS anticipate issuing additional guidance on this topic before the end of this year.

Healthcare Reform Checklist

New group health insurance plans created after September 22, 2010 and all existing calendar-year plans must meet the following requirements of the Patient Protection and Affordable Care Act (PPACA). Here are the changes you should know about.

Fully insured health plans cannot discriminate in favor of highly compensated individuals in terms of eligibility to participate or in terms of benefits provided.

What this means for you: Take a look at any executive healthcare benefits you offer—a discriminatory plan can lead to serious penalties. According to the IRS, "…if an insured group health plan fails to comply with Code section 105(h), the plan is subject to a civil action to compel it to provide nondiscriminatory benefits and the plan or plan sponsor is subject to an excise tax or civil money penalty of $100 per day per individual discriminated against."

To be considered nondiscriminatory, a health plan must benefit:

(**a**) 70 percent or more of all employees, or 80 percent or more of all the employees who are eligible to benefit under the plan if 70 percent or more of all employees are eligible to benefit under the plan; or

(**b**) such employees as qualify under a classification set up by the employer and found by the Secretary of Labor not to be discriminatory in favor of highly compensated individuals.

For purposes of benefit nondiscrimination, "highly compensated individual" generally means one who is:

(**a**) one of the five highest paid officers,

(**b**) a shareholder who owns more than 10 percent in value of the stock of the employer, or

(**c**) among the highest paid 25 percent of all employees.

Young adults can stay on their parents' plan until they reach age 26. (In the case of existing group health plans, this right does not apply if the young adult is offered insurance at work).

What this means for you: If your plan provides dependent coverage and eligibility that formerly ended before age 26, your plan must provide "transitional relief for a child whose coverage ended…" In plain English, the plan must allow a child who aged out of coverage an opportunity to re-enroll. Under a fully insured plan, your insurer will provide a one-time notice to eligible adult children and allow them to re-enroll for a period of at least 30 days, regardless of any open enrollment period.

Health plans cannot deny coverage to children under age 19 due to a pre-existing condition.

HIPAA, the Health Insurance Portability and Affordability Act, generally defines a preexisting condition exclusion as a limitation or exclusion of benefits relating to a condition that was present before the date of enrollment, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Based on this definition, the Affordable Care Act prohibits not just an exclusion of coverage of specific benefits associated with a preexisting condition, but a complete exclusion from such plan or coverage based on a preexisting condition.

What this means for you: Under a fully insured plan, your insurer must provide an enrollment opportunity for those previously denied coverage for a pre-existing condition but otherwise eligible.

Health plans cannot impose lifetime limits on coverage. Insurers

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can no longer impose lifetime limits on "essential benefits," such as hospital stays.

What this means to you: Plans must provide a notice that the lifetime limit no longer applies to individuals who reached a lifetime limit before of these regulations came into effect and who are otherwise still eligible under the plan. If such individuals are no longer enrolled in the plan, the plan must provide an opportunity for re-enrollment. Under a fully insured plan, your insurer will handle this. Experts expect this provision to have little effect on group health insurance costs.

The law also restricts annual limits on "essential benefits" under group health plans. Restrictions may apply differently to certain account-based plans. The interim final regulations state that annual limit rules do not apply to salary reduction health FSAs (flexible spending accounts). When health reimbursement arrangements (HRAs) are integrated with a group health insurance plan that complies with this requirement, an HRA with limited benefits would not be in violation. A stand-alone HRA limited to retirees would also not be subject to annual limits.

What this means to you: The status of stand-alone health reimbursement arrangements for active employees is unclear. As this issue went to press, the Treasury Department was seeking comments regarding the application of this restriction to stand-alone HRAs.

Plans, including grandfathered plans, cannot rescind coverage except in the case of fraud or intentional misrepresentation.

What this means to you: You may not retroactively cancel a participant's coverage except in the case of fraud, even if he/she made misstatements in the policy application. The plan must also provide 30 days' notice of its intention to cancel coverage and limits reasons for cancellation to termination of plan, fraud, nonpayment of premiums, violation of participation or contribution rules or participant's relocation outside service area.

For a review of your health insurance plan and enrollment/administration procedures and whether they comply with existing laws, please contact us.

Breastfeeding Breaks: It's Now the Law

In the concern over healthcare costs, employers might easily overlook one provision of the Patient Protection and Affordable Care Act (PPACA), which took effect on March 23, 2010. The law requires employers to provide "reasonable break time for an employee to express breast milk for her nursing child for 1 year…" Failure to comply can lead to fines. Here's what you need to know.

General Requirements

Under the PPACA, employers must provide "a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk."

Law Applies to Non-Exempt Employees Only

Only employees who are not exempt from the Fair Labor Standards Act's (FLSA) overtime pay requirements are entitled to breaks to express milk. Employers with fewer than 50 employees are not subject to the FLSA break time requirement if compliance with the provision would impose an undue hardship. Whether compliance would be an undue hardship is determined by looking at the difficulty or expense of compliance for a specific employer in comparison to the size, financial resources, nature, and structure of the employer's business. All employees who work for the covered employer, regardless of work site, are counted when determining whether this exemption may apply.

Time and Location of Breaks

Under the federal law, employers must provide a "reasonable

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amount" of break time to express milk as frequently as needed by the nursing mother. The frequency of breaks needed to express milk as well as the duration of each break will likely vary.

A bathroom, even if private, is not a permissible location under the Act. The location provided must be functional as a space for expressing breast milk. If the space is not dedicated to the nursing mother's use, it must be available when needed in order to meet the statutory requirement. A space temporarily created or converted into a space for expressing milk or made available when needed by the nursing mother is sufficient provided that the space is shielded from view, and free from any intrusion from co-workers and the public.

Employers are not required under the FLSA to compensate nursing mothers for breaks taken for the purpose of expressing milk. However, where employers already provide compensated breaks, an employee who uses that break time to express milk must be compensated in the same way that other employees are compensated for break time. In addition, the FLSA's general requirement that the employee must be completely relieved from duty or else the time must be compensated as work time applies.

State Law May Differ

The FLSA requirement of break time for nursing mothers does not preempt state laws that provide greater protections to employees: for example, providing compensated break time, providing break time for exempt employees or providing break time beyond one year after the child's birth. While the FLSA does not require employers to provide breaks to nursing mothers who are exempt from the overtime pay requirements of Section 7, state laws may obligate employers to provide such breaks to all nursing mothers.

Eighteen states require employers to provide breaks to nursing mothers without regard to whether she is an exempt or non-exempt employee. Most of these states also require the employer to make a "reasonable effort" to provide a private location that is not a bathroom to express milk. These states are Arkansas, California, Colorado, Connecticut, Georgia, Illinois, Indiana, Maine, Minnesota, Montana, New Mexico, New York, Oklahoma, Oregon, Rhode

Island, Tennessee and Vermont.) Most states either require nonpaid breaks or "paid or nonpaid breaks," leaving it to the employer's discretion. Indiana is the only one specifically requiring nursing mothers' breaks for this purpose to be paid.

Hawaii and Mississippi do not require employers to provide breaks to nursing mothers; however, they prohibit employers from discriminating against employees who use breaks to which they are legally entitled for expressing milk.

Many studies have proven breastfeeding has health benefits for both the nursing mother and her baby. Even if the new law does not apply to your employees, you might want to consider the benefits of encouraging working mothers in your employ to continue breastfeeding. It can help increase health, productivity and morale…while reducing healthcare costs.

For more information on this and other compliance topics, please contact us.

Sources: U.S. Department of Labor, www.dol.gov, National Conference of State Legislatures, www.ncsl.org

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Breastfeeding: A Low-Cost, High-Return Wellness Program

A workplace lactation program can encourage working mothers to return to their jobs sooner, without sacrificing their babies' health. Employers also benefit by retaining employees who otherwise might extend their leave or not return to work. Second, breastfed babies are healthier, which can reduce absenteeism due to a child's illness and reduce your dependent healthcare costs.

As just one example of breastfeeding's benefits, consider childhood ear infections, the most common reason for doctor visits among children. Approximately 70 percent of all children will have one or more bouts of acute otitis media, or infection of the middle ear, before age 2. However, breast-fed children have 60 percent fewer ear infections than formula-fed children.

Treating each ear infection costs approximately $90-$200 in doctor's visits and medications. Add the cost of 1-2 days off for your employee. Further, children with chronic ear infections may require surgery to prevent hearing damage. Two common procedures—myringotomy or typmanostomy with tubes—cost approximately $2,000. Medical costs vary by location and other factors, but you can see how the savings add up! Breast-fed babies are also healthier overall, being less likely to develop severe allergies, less likely to develop diabetes and less susceptible to respiratory infections, urinary tract infections and diarrhea.

Breastfeeding also benefits mothers. A study by the University of Pittsburgh showed that women who breastfed their children reduced their likelihood of developing Type 2 diabetes by 50 percent. Other studies have found that women who breastfeed are less likely to develop ovarian and breast cancer.

Convinced that it's time to make your workplace mother- and baby-friendly? Corporate Voices for Working Families, a nonprofit, business membership organization, offers valuable information and links to other resources for employers that want to set up a lactation program. See www.cvworkingfamilies.org/lactation. ■

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