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Health Care Reform: What Employers Need to Know

Congress has enacted the Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Affordability Reconciliation Act (HCEARA). These two pieces of legislation constitute a massive overhaul of the United States health care system. For employers, the new laws represent the most significant changes to their health benefit plans since the passage of ERISA. This document summarizes the key changes.

1. Insurance Market Reforms

There are several new requirements for both fully-insured and self-funded employer group health plans. The changes generally begin to apply as of the first day of the first plan year beginning at least six months after health care reform was enacted in March 2010. For example, if an employer's health plan operates on a calendar year basis, these changes must be made by no later than January 1, 2011. The changes include the following:

- Lifetime Limits Lifetime limits on essential health benefits will be prohibited. For this purpose, essential health benefits include emergency services, hospitalization, ambulatory services, maternity and newborn care, mental health and substance abuse treatment, prescription drugs, rehabilitative services, laboratory services, preventive services and pediatric services.

- Annual Limits Similar restrictions apply with respect to annual limits. However, for plan years beginning before January 1, 2014, the IRS may allow annual limits as long as they still ensure access to needed services with a minimum impact on premiums.

- Eligibility of Dependent Children Plans must allow unmarried **and married** dependent children to be eligible until age 26. However, certain "grandfathered" plans are not required to offer coverage to an older dependent child for plan years beginning before January 1, 2014 unless the child is not eligible for any other employer group health coverage.

    - A "grandfathered" plan is an employer group health plan in effect on the date health care reform was enacted and includes existing participants as well as subsequently enrolling individuals. Guidance is expected to be issued explaining whether subsequent changes in a plan's coverage or benefits might cause a plan to lose its grandfathered status or whether there may be a limit on the duration of the grandfathered status.

- Pre-Existing Condition Exclusions Pre-existing condition exclusions will be prohibited, but not until plan years beginning on or after January 1, 2014. Notwithstanding this general rule, there is an acceleration of this prohibition to the first day of the first plan year beginning at least six months after health care reform was enacted with respect to children under age 19.

The net effect of these changes is that more individuals will be eligible for an employer's group health plan and the plan will provide more expansive coverage. As a result, these changes will likely increase the employer's health insurance costs.

2. Assistance for Employers

While the insurance market reforms may impose greater financial burdens on employers, there are some changes in the legislation designed to assist employers. They include the following:

- Early Retiree Reinsurance Program No later than 90 days after the enactment of PPACA, the IRS will establish a temporary reinsurance program for employer retiree health plans. The program will provide reimbursement for early retirees age 55 and older who are not yet eligible for Medicare and their dependents with respect to 80% of claims in excess of $15,000 but less than $90,000 per year. The program sunsets at the end of 2013.

- Small Employer Tax Credit Starting in 2010, certain small employers who provide health coverage to their workers will be eligible for a tax credit. To qualify, an employer must have no more than 25 full-time employees with average annual wages of less than $50,000. For tax years through 2013, the tax credit is up to 35% of the employer's contribution toward health coverage provided the employer is contributing at least half the cost. The full credit is available to employers with 10 or fewer employees with average annual wages of less than $25,000. The credit phases out as the size of the employer's workforce and average annual wages increase. For tax years 2014 and later, the maximum tax credit increases to 50%.

3. Changes Affecting FSAs, HSAs and HRAs

Some of the provisions in the health care reform legislation are designed to raise tax revenue to pay for other provisions. Several of the revenue raisers affect employers' medical FSAs, HSAs and HRAs. Here is a summary:

- Discontinuation of Pre-Tax Reimbursement of Over-the-Counter Drugs Medical FSAs, HSAs and HRAs may no longer reimburse drugs which are not prescribed. It is not required that the drug be a prescription drug, but rather, be prescribed. As a result, it appears that an over-the-counter drug prescribed by a physician could still qualify. This change takes effect in 2011.

- Cap on Medical FSA Contributions Effective for 2013 and later tax years, annual medical FSA contributions will be capped at $2,500 per participant. It appears this is a calendar year maximum similar to the $5,000 dependent care FSA maximum (rather than a plan year maximum for those employers operating their Section 125 plans on a non-calendar year basis). The cap will be adjusted for inflation after 2013.

- Excise Tax for HSA Distributions The excise tax on early distributions from an HSA for nonmedical expenses is being increased from 10% to 20% effective in 2011.

These changes, particularly regarding over-the-counter drugs and the medical FSA cap, will make medical FSAs, HSAs and HRAs benefits less attractive to employees.

4. Other Revenue Raisers

Other revenue raising provisions in the legislation include the following:

- Payroll Tax Increase Currently, the Medicare hospital insurance payroll tax for employees is 2.9% (1.45% paid by the employee and 1.45% paid by the employer, with self-employed individuals paying 2.9%). Beginning in 2013, single taxpayers with wages in excess of $200,000 and married taxpayers filing jointly with annual wages in excess of $250,000 will be subject to an additional 0.9% Medicare hospital insurance payroll tax on wages in excess of these thresholds. In addition, these higher income individuals will be subject to a 3.8% tax on their net investment income which includes interest, dividends, royalties, rents, etc. However, net investment income for this purpose does not include distributions from a 401(k) plan or other qualified retirement plan.

- Premium Taxes Beginning with plan years ending after September 30, 2012 (e.g., January 1 through December 31, 2012 for a calendar year plan), a premium tax will be assessed against fully-insured and self-funded plans to finance a research program evaluating and comparing health outcomes and clinical effectiveness. The premium tax is $1 per covered life for the first year and increases to $2 per covered life for subsequent years.

- Excise Tax on Cadillac Health Plans Beginning in 2018, there will be a 40% excise tax on the value of "cadillac" health plans. For this purpose, a cadillac health plan has an aggregate value of more than $10,200 for single coverage and $27,500 for family coverage. The total value of medical and prescription drug coverage is included in the calculation but dental and vision coverages are excluded. The value of FSA, HSA and HRA coverages are also included in the calculation. The thresholds are increased to $11,850/single and $30,950/family for employees engaged in certain high risk professions and for early retirees (individuals age 55 or older). If the dollar thresholds are exceeded, the excise tax is imposed on the insurer in the case of fully-insured plans, on the "person that

administers the plan benefits" (appears to be the TPA) in the case of self-funded plans, and on the employer with respect to HSAs.

5. Pay or Play System

Beginning in 2014, one of the centerpieces of the health care reform legislation will begin to apply. First, each state will establish an exchange. The exchange will be similar to a gateway or clearing house to help individuals and groups shop for health coverage in a more efficient and comprehensive manner. At the same time, individuals will be required to either enroll in their employer's group health plan or alternatively, enroll in coverage through the exchange or a government program. Individuals who fail to enroll will pay a penalty. Certain larger employers will also be required to offer health insurance to their full-time employees or pay a penalty. Here are the details:

- Exchange Health plans offered on the exchange will be required to offer "minimum essential coverage" at one of four levels of "actuarial value" (the percentage of covered expenses paid by the plan):

  - Bronze (60% actuarial value)
  - Silver (70% actuarial value)
  - Gold (80% actuarial value)
  - Platinum (90% actuarial value)

  The out-of-pocket limits for these health plans cannot exceed the maximum out-of-pocket limits for HSAs (which are currently $5,950/single and $11,900/family for 2010). Low-income individuals with income no greater than 400% of the federal poverty level will be subject to lower out-of-pocket limits. There will also be a "young invincibles" option available to individuals age 30 and younger.

  The state exchanges will initially offer coverage to individuals and certain small employer groups. Before 2017, exchanges may only cover small employer groups with 100 or fewer employees. Beginning in 2017, states can open up their exchanges to larger employers. If an employer offers coverage to its employees through the exchange, it can allow employees to purchase the coverage on a pre-tax basis under the employer's Section 125 plan.

- Individual Mandate Individuals will be required to enroll in health insurance with minimum essential coverage or pay a penalty. For this purpose, minimum essential coverage is available through public programs such as Medicaid or Medicare, individual coverage on the exchange or employer-provided coverage. Minimum essential coverage provides a comprehensive set of services that has an actuarial value of at least 60% and has maximum out-of-pocket limits no greater than the HSA limits. (The maximum out-of-pocket limits do not apply to grandfathered plans.)

The penalty is the greater of a flat dollar amount and a percentage of household income. The flat dollar amount is $95 for 2014, $325 for 2015 and $695 for 2016. For later years, the flat dollar amount will increase for changes in the cost-of-living. The percentage of household income is .5% for 2014, 2% for 2015 and 2.5% for 2016 and later years. However, no penalty applies for a year if the taxpayer's household income is below the threshold for filing a federal income tax return. The penalty will also not apply to individuals who cannot afford coverage because the lowest cost option would exceed 8% of their household income, individuals who do not maintain coverage for qualifying religious reasons, U.S. citizens residing outside the country, illegal aliens, incarcerated individuals, individuals allowed to be a dependent for tax filing purposes, American Indians, and individuals with no minimum essential coverage for a period of less than three continuous months.

Low income individuals will be provided with assistance to obtain health care coverage on the exchange:

- Premium Credit Individuals with incomes no greater than 400% of the federal poverty level will be eligible for an advanceable, refundable premium credit when they purchase health coverage on the exchange. The premium credit will be set on a sliding scale depending on the individual's income. These low income individuals will also be eligible for cost-sharing subsidies to help pay their out-of-pocket costs.

- Vouchers Where the individual is eligible for employer-provided health coverage, the employer must make its employer contribution for coverage available to the individual as a voucher to purchase coverage on the exchange. However, this option is only required for employees with income no greater than 400% of the federal poverty level where the employee's premium share would be between 8% and 9.8% of the employee's income. The vouchers are excludable from the individual's taxable income and must be equal to the contribution that the employer would have made to its own plan. The voucher can only be used to purchase coverage through the exchange, but any excess funds are payable to the individual on a taxable basis. The voucher program is for individuals who do not qualify for the premium credit but who are exempt from the individual penalty tax due to affordability reasons.

- Employer Mandate The employer must offer health coverage to its employees or pay a "free rider" penalty. The penalty only applies to employers with more than 50 full-time employees. For this purpose, a full-time employee is an employee who works, on average, 30 or more hours per week. A part-time employee is counted as a full-time employee equivalent for purposes of the 50 full-time employee threshold. If the threshold is exceeded, however, any part-time employee is disregarded in determining the amount of the employer's penalty. Seasonal employees are also disregarded for purposes of the 50 full-time employee threshold. All employers in the same IRS controlled group are

aggregated for purposes of the 50 full-time employee threshold. If the penalty applies, the employer's first 30 full-time employees are disregarded when calculating the penalty.

If the employer **does not** offer a health plan and has at least one full-time employee who enrolls in health coverage through the exchange and becomes eligible for the premium credit, the employer must pay a penalty of $2,000 per full-time employee per year. The penalty is determined and assessed on a monthly pro rata basis (i.e., $^1/_{12}$ of $2,000).

If the employer **does** offer a health plan but has at least one full-time employee who enrolls in health coverage through the exchange and receives the premium credit, the employer is subject to a penalty of $3,000 per individual receiving the premium credit. However, the employer's total penalty is capped at $2,000 per full-time employee as described above. Again, the penalty is determined and assessed on a monthly pro rata basis.

- Automatic Enrollment If an employer offers at least one health benefit option and has 200 or more full-time employees, it must automatically enroll all new employees in a health benefit option and continue enrollment of current employees. The employer must provide notice to allow employees to opt out of the automatic enrollment option and select any other available option or opt out altogether.

6. Increased Reporting

Employers will be responsible to provide more information to the federal government and to employees in order to implement health care reform. For example:

- W-2 Reporting Effective for 2011 and later tax years, employers must include on the W-2 statements issued to employees, the aggregate cost of employer-sponsored health benefits. The amount to be reported is similar to the COBRA cost. The value of all health plans must be included except for contributions to an HSA and employee contributions to an FSA.

- Reporting to IRS Beginning in 2014, large employees with 50 or more full-time employees must report to the IRS certain prescribed information such as whether full-time employees are eligible for minimum essential coverage, the length of any waiting period, the number of months during the calendar year for which coverage under the plan is available, the monthly premium for the lowest cost option in each of the enrollment categories under the plan, the employer's contribution share, the number of the employer's full-time employees on a monthly basis, and the name, address and Social Security number of each full-time employee enrolled in the plan and the months during the year they were covered.

- Notice of Availability of Exchange and Premium Tax Credit Beginning in 2014, at the time an individual is hired, the employer must notify the employee of the existence of the exchange, that the employee may be eligible for a premium credit/cost-sharing subsidy under the exchange and that if the employee purchases health coverage through the exchange, he or she will lose the employer contribution toward health benefits offered by the employer except as otherwise provided under the voucher program.

Conclusion

The health care reform legislation is complex and contains many provisions. In many cases, it will be necessary for federal regulators to issue guidance explaining how the laws will be interpreted and establishing the various procedures and programs contemplated by the legislation. We will continue to keep you informed as developments unfold. In the meantime, if you have any questions, please contact any member of the Miller Johnson employee benefits practice group.

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