

EMPLOYEE BENEFITS BULLETIN

March 31, 2010

Health Care Reform – What It Will Mean For You

The President signed the Senate health care reform measure, the Patient Protection and Affordable Care Act (H.R. 3590), into law on March 23, 2010. Companion legislation, the Health Care and Education Affordability Reconciliation Act of 2010 (H.R. 4872), was just approved in the Senate by a vote of 56 to 43. Before the companion bill can be enacted, the House must take a final vote on the legislation, as certain features related to student loans were struck by the Senate Parliamentarian. The House is expected to move quickly to pass the revised legislation. It will then go to the President for signature.

Employers and individuals are now seeking to understand what these measures provide and how they will affect their plans and coverage, both in the short term and on an ongoing basis. For many, especially mid-size and larger employers and their employees, it is likely that little will change, at least for the foreseeable future, and that increased costs will continue to exert significant pressure on plan design and cost-sharing.

This summary is based on the framework contained in the Senate bill and the House's companion legislation, even though the companion bill has not been enacted.

HOW HEALTH CARE REFORM WILL WORK

The combined House and Senate bills undertake a comprehensive overhaul of health care delivery, with a key goal of providing access to affordable health care for the vast majority of Americans. This objective is structured around several key components, most of which go into effect in 2014:

- The establishment of State Exchanges where individuals and small businesses will be able to purchase coverage from participating insurers;
- A mandate for all Americans to obtain health care coverage;
- Financial disincentives for larger employers that do not provide basic levels of coverage;
- Subsidies in the form of tax credits to help small businesses and individuals under 400% of the Federal Poverty Level ("FPL") buy coverage under the Exchanges;
- Expansion of Medicaid at the State level for the least affluent Americans (under 133% of FPL), with significant funding support from the Federal government;
- The imposition of underwriting requirements on insurers in the individual and group markets that are aimed at making the coverage cost effective;
- Encouragement of wellness initiatives. The bill increases the HIPAA wellness program rules to permit a health plan to provide for a reward based on a health factor of up to 30% of the cost of coverage. Further, it provides for an additional increase of up to 50% at the government's discretion. Wellness program credits are made available to eligible small groups;
- A group of insurance reforms, some of which go into effect fairly quickly and impose restrictions on or ban several well publicized practices, including pre-existing condition exclusions, rescissions of coverage and annual and lifetime maximums; and
- A phased-in closing of the Medicare Part D "donut hole," including an immediate \$250 rebate.

To pay for these initiatives, the bills implement a variety of taxes, penalties, and cost savings, including:

- A 10% tax on indoor tanning facilities (July 1, 2010);
- Changes to health FSAs, HSAs and HRAs to reduce some of the tax protections afforded to these arrangements (2011 and 2013);
- Beginning in 2013, increases in the Medicare payroll tax for high-income individuals (\$200,000 of adjusted gross income for a single filer and \$250,000/joint) including an increase in the Hospital Insurance Tax part of FICA from 1.45% to 2.35% and the imposition of a 3.8% tax on passive investment income;
- A 2.3% excise tax on medical device manufacturers (2013);
- Limits on the deductibility of compensation of insurance industry executives in excess of
- \$500,000;
- The imposition of significant fees on pharmaceutical companies and insurers (2014);
- A 40% tax on the value of excess coverage under certain generous health care plans (the so called “Cadillac Plan Tax”), which sparked much controversy due to its impact on some collectively bargained plans and was scaled back by the Sidecar bill and delayed in its implementation until 2018;
- Significant reductions in payments to Medicare Advantage; and
- Other cost savings under Medicare.

GUIDING PRINCIPLES

The key concept behind this legislation is that health care coverage can only be affordable for everyone if the risk that is being insured is spread over the entire population. If not, those with larger populations, such as larger employers and unions, will be able to spread the cost of their claims experience over their own populations, and smaller groups and individuals will be charged with higher premiums because they lack the ability to spread risk and the leverage to negotiate with insurers. This issue is addressed by the key components of the new law:

- The mandate on individuals to have coverage, beginning in 2014, and the financial penalties for failure to comply;
- Insurance reforms aimed at preventing individuals from being denied coverage;
- The establishment by 2014 of State-based Exchanges where individuals and small businesses can purchase coverage;
- The financial penalties imposed on mid-size and larger employers that do not provide basic levels of coverage to their employees, also beginning in 2014; and
- Financial help for less affluent individuals and small businesses in purchasing coverage under the Exchanges.

Here are some key details:

Individual Mandate

Effective January 1, 2014, all U.S. citizens and legal residents must have health insurance coverage or pay a penalty. The penalty will be phased in according to the following schedule:

- In 2014, the greater of \$95 or 1% of taxable income;
- In 2015, the greater of \$325 or 2% of taxable income; and
- In 2016, the greater of \$695 or 2.5% of taxable income. After 2016, the penalty amount will be indexed for inflation.

Certain exemptions apply, including, but not limited to:

- Financial hardship;
- Individuals with income below the tax filing threshold;
- Individuals without coverage for less than 3 months; and
- Religious objection.

Employer Responsibility

Penalties

Effective January 1, 2014, employers with 50 or more employees (*1) who do not provide health insurance coverage to full-time employees (FTE) (*2) will face a \$2,000 per FTE penalty should one or more FTEs receive government assistance to purchase health insurance coverage through an Exchange. In calculating this assessment, the first 30 FTEs are excluded.

Employers with 50 or more employees who do provide health insurance coverage to FTEs will face a penalty if one FTE receives government assistance to purchase coverage through an Exchange. The penalty is the lesser of \$3,000 per FTE receiving government assistance or \$750 multiplied by the number of FTEs. Employers will avoid these penalties if they provide "Free Choice Vouchers" to subsidy-eligible employees, as described below.

(*1) There is inconsistency in the statute as to who is a large employer for purposes of the penalty. As defined, the term applicable large employer means, with respect to a calendar year, an employer who employed on average at least 50 full-time employees on business days during the preceding calendar year. Sec. 1513. Elsewhere, language indicates the penalties apply to employers with more than 50 employees. For purposes of this summary, it is assumed that the penalty applies to employers with 50 or more employees.

Clarification is needed. (*2) The statute defines a full-time employee as an employee who is employed on average at least 30 hours per week.

These penalties do not apply to small employers (fewer than 50 employees).

Free Choice Voucher

Effective January 1, 2014, certain qualified employees of an employer may, in lieu of participating in the employer-sponsored coverage, receive the employer contribution toward health plan coverage in the form of a voucher that may be used to purchase coverage through the Exchange.

A *qualified employee* is an employee who:

- Has income not greater than 400% of FPL;
- Must pay toward the cost of the employer coverage a contribution that exceeds 8% but is not more than 9.8% of their household income; and
- Does not participate in the employer plan.

Automatic Enrollment

Also beginning in 2014, employers with more than 200 employees must automatically enroll new fulltime employees in coverage and provide notice and an opportunity for the employee to opt-out.

Other Requirements

- Group health plan sponsors will be required to provide notice to employees of the existence of the Exchange (2014);
- Certain plan information will need to be reported by the employer to the IRS and participants regarding the coverage provided by the group health plan (2014);
- A new summary of benefits will need to be provided to participants, effective one year from date of enactment (2011).

Small Employers

Premium subsidies are available to small employers. A small employer for purposes of government assistance has no more than 25 full-time equivalent employees and an average full-time annual wage of less than \$50,000.

Initially (2010-2013), the government will provide for a tax credit of up to 35% of the employer's contribution toward health insurance coverage if the employer contributes at least 50% toward the cost. For tax-exempt entities, the tax credit is 25%.

Once the Exchanges are operational in 2014, a small employer who purchases health insurance coverage for employees through the Exchange may receive up to a 50% tax credit of the employer's contribution (assuming the employer contributes at least 50%). For tax-exempt entities the tax-credit is 35%. This credit is available for two years.

Exchanges

Individuals and small employers will be able to purchase insurance coverage through state-based Exchanges beginning in 2014. Initially, these Exchanges will be open to individuals and employer groups of 1-100 employees (however, some states may restrict access to the Exchange to employer groups with 1-50 employees through 2016).

Private carriers and Co-Ops will be allowed to sell coverage through these Exchanges.

Coverage will be required to meet certain requirements prescribed by the statute (discussed below) and by Health and Human Services.

The specific levels of coverage have been established and include:

- Bronze – Covers 60% of actuarial value of covered benefits;
- Silver – Covers 70% of actuarial value of covered benefits;
- Gold – Covers 80% of actuarial value of covered benefits;
- Platinum – Covers 90% of actuarial value of covered benefits; and
- Catastrophic – available to young adults (up to age 30) or those exempt from the individual mandate.

In 2017, Exchanges may open to employer groups over 100 employees.

Details as to what benefits will need to be provided by the policies issued under the Exchanges will likely be the subject of extensive regulations.

Coverage/Design Requirements

Reform Rules

Requirements that apply to all group health plans for the first plan year following 6 months from the date of enactment include:

- No lifetime limitations on essential benefits (*3);
- Restrictions on annual limitations; and
- Coverage for adult children until age 26, unless the adult child is eligible to enroll in other employer-sponsored health plan coverage. There appears to be some confusion under the bills over this extension of coverage – specifically, as to whether the extension is up until the attainment of age 26, or through age 26, which would effectively take the coverage to the 27th birthday. We expect further clarification on this issue.

Requirements that apply to all group health plans for the first plan year on or after January 1, 2014:

- No pre-existing condition exclusions;
- No annual limitations on essential benefits;
- Waiting periods cannot exceed 90 days; and
- Coverage must be provided to all adult children up to age 26, regardless of other employer sponsored coverage.

The definition of a tax dependent under 105(b) is expanded to include adult children to age 27 – thus apparently alleviating some of the burden on an employer to determine tax status and imputed income for eligible adult children.

(*3) Defined under Section 1302 of the Patient Protection and Affordable Care Act and in regulations from HHS that have yet to be issued.

Benefit Requirements

Effective January 1, 2014, the following requirements generally apply to non-grandfathered group health plans:

- Out-of-pocket limitations cannot exceed the limitations imposed on HSA qualified high-deductible health plans (\$5,950/single, \$11,900/family for 2010);
- In the small group market, deductibles cannot exceed \$2,000/individual, \$4,000/family;
- No cost-sharing for preventive care services; and
- No discrimination in favor of highly compensated individuals as to eligibility under the group health plan.

Grandfathered Plans

Plans that are in existence as of the date of enactment are considered “grandfathered” under the health reform bill. Such plans will not be required to comply with the benefit requirements listed above. However, grandfathered plans are required to comply with the reform rules, described above. Plans will lose their “grandfathered status” when any change is made to the plan (e.g. deductibles, co-pays, benefit design, carrier change). Mere enrollment changes (e.g. new hires, adding a spouse or dependent) will not remove a plan from “grandfathered status.”

OTHER CHANGES

High Cost Plans

Beginning in 2018, a 40% excise tax will be assessed on the value of health coverage that exceeds certain prescribed thresholds (the “Cadillac Plan” tax).

These thresholds are:

- \$10,200 for single coverage (adjusted for inflation);
- \$27,500 for family coverage (adjusted for inflation);
- Increased for group health plans that cover retirees and high-risk professions;
- Increased for seventeen high-cost states to be determined by the Secretary of Health and Human Services; and
- Increased if the cost of health care rises unexpectedly between now and 2018.

Health insurance, health FSA, HRA and HSA contributions, EAPs, and wellness programs must all be counted in determining whether the total value of health coverage exceeds the prescribed thresholds. Dental coverage, vision benefits, life and disability insurance are not included.

It appears that the carrier in an insured arrangement and the administrator (who may be the TPA or employer) in a self-insured plan will be responsible for paying the excise tax. The employer will need to appropriately apportion the correct amounts to the relevant vendors and may face penalties for improper reporting.

We expect carriers to pass on the cost of any such tax in the form of rate increases.

W-2 Reporting

Effective January 1, 2011, employers will be required to disclose the value of health coverage provided to the employee on the employee's W-2. This dollar amount does not include dental and vision benefits or health FSA contributions.

Health FSA Limitation

The annual health FSA contribution limit will be capped at \$2,500 (adjusted for inflation) beginning in 2013.

Over-the-Counter Expenses and Tax-Favored Accounts

Beginning in 2011, over-the-counter products may not be reimbursed through a tax-favored account (e.g. health FSA, HRA, HSA), unless prescribed by a doctor.

HSA Distributions for Nonqualified Expenses

Distributions from an HSA for expenses other than qualified medical expenses will be assessed a 20% penalty beginning in 2011.

This is a preliminary review of key provisions affecting employer-sponsored coverage that are included in the combined legislation. We are continuing to monitor developments and will be providing seminars and webinars to assist you in understanding the new requirements. A schedule of events will be announced soon.

The *Employee Benefits Bulletin* is designed to highlight various employee benefit matters of general interest to our readers. It is not intended to interpret laws, regulations or to address specific client situations.