NEWSSTAND

Federal Health Care Reform: Impact of Employers and Employer-Sponsored Health Plans[1] *For Schools and Colleges*

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President Obama signed into law the Patient Protection and Affordable Care Act on March 23, 2010 and the Health Care and Education Affordability Reconciliation Act on March 30, 2010 (collectively, the "Act"). The Act will result in extensive changes to the U.S. healthcare system. This Advisory will focus on the Act's impact on employers and employer-sponsored health plans.

Individual Mandate

Individual Mandate. Beginning in 2014, individuals who are not covered under "minimum essential coverage" will be subject to a penalty. "Minimum essential coverage" includes, among other things, being covered by an employer-sponsored health plan, an individual health plan (including a health plan offered by a state established Exchange), Medicare Part A, Medicaid and other coverage as the Secretary of Health and Human Services designates. The penalty phases in gradually, beginning in 2014 at $95 for each individual, up to a maximum of $285 per family or 1% of household income, increasing in 2015 to $325 for each individual, up to a maximum of $975 per family or 2% of household income and becoming fully phased-in starting in 2016 at $695 for each family member, up to a maximum of $2,085 per family or 2.5% of household income and then adjusted for changes in the cost of living for 2017 and thereafter. The penalty does not apply to incarcerated individuals, individuals eligible for a religious exemption, American Indians, individuals without coverage for less than three months, individuals whose required contributions toward health coverage exceeds 8% of household income, and individuals with income under 100% of the poverty level.

Cost-Sharing Assistance/Premium Assistance Tax Credits. Cost-sharing assistance and premium assistance tax credits will be available for certain low-income individuals receiving health coverage by a qualified health plan offered through a state-established American Health Benefit Exchange. In general, individuals whose total household income is between 100% and 400% of the federal poverty level are eligible for premium assistance tax credits or cost-sharing premium assistance to offset the costs of health insurance premiums.

Employer Mandate

The Act does not require an employer to provide health insurance to its employees but an employer who employs on average at least 50 full-time employees may face significant penalties

for not providing any health coverage to its employees or for providing health coverage that is deemed too costly to employees. The Act defines a full-time employee to mean an individual who works at least an average of 30 hours per week.

Penalty for Failing to Provide Health Coverage. Effective January 1, 2014, an employer with 50 or more full-time employees that does not offer minimum essential coverage and has at least one employee receiving a premium assistance tax credit or cost-sharing premium assistance will be required to pay an annual penalty of $2,000 per full-time employee, exempting the first 30 full-time employees.

Penalty for Offering "Unaffordable" Health Coverage. Effective January 1, 2014, an employer that employs 50 or more full-time employees, offers minimum essential coverage and has at least one employee receiving a premium assistance tax credit or cost-sharing premium assistance will be required to pay an annual penalty equal to the lesser of: 1) $3,000 for each employee who receives a credit or cost-sharing assistance because a) the employer pays less than 60% of the full actuarial value of the coverage provided or b) the employee's premium is greater than 9.5% of his or her household income; or 2) $2,000 per full-time employee.

Free Choice Vouchers. Effective January 1, 2014, an employer that pays a portion of the premiums for health coverage will be required to provide "free choice vouchers" to certain low-income employees who elect not to participate in the employer's health plan. To be eligible for the free choice voucher, the employee must have a household income not exceeding 400% of the poverty level and is required to contribute between 8% and 9.5% of his household income toward the cost of the employer-provided health coverage. The "free choice voucher" is equal to the monthly portion of the cost of coverage that the employer would otherwise have paid if the employee was covered under the employer's plan and is used by the employee to purchase healthcare coverage through an Exchange. If the amount of the voucher exceeds the cost of the premiums for the Exchange health coverage, the employee may retain the excess amount. The amount of the free choice voucher is deductible by the employer.

Notice of Coverage Options. Not later than March 1, 2013, employers must provide a written notice to newly-hired and current employees informing employees: 1) that healthcare exchanges are available, the services provided by the exchange, and how to contact the exchange; 2) if the employer pays less than 60% of the costs of benefits, that the employee may be eligible for a premium tax credit and a cost-sharing reduction if the employee purchases health insurance from an exchange; and 3) if the employee purchases health insurance through an exchange, the employee loses the employer's contribution to the employer's healthcare plan and that amount is excludable from the employee's federal income tax liability.

Automatic Enrollment. Employers with more than 200 full-time employees who offer health plans must automatically enroll new full-time employees in their healthcare plan, subject to any waiting period authorized by law. Employers must provide an opportunity for employees to opt out of employer-sponsored health insurance in which they have been automatically enrolled.

Credit for Small Business Insurance Expenses. Companies with 25 or fewer full-time employees whose workers have an average wage of $50,000 or less are entitled to a tax credit of

up to 35% of the employer's premium costs (25% for tax exempt small employers) of providing health coverage to their employees as long as the employer contribution is at least 50% of the total premium costs. Effective January 1, 2014, the tax credit increases to 50% (35% for tax-exempt small employers) of the employer's premium costs.

"Cadillac Plan" Tax. Effective January 1, 2018, a nondeductible 40% excise tax will be imposed on insurers of fully insured plans and plan administrators of self-insured plans on the amount by which the aggregate value of employer-sponsored health coverage exceeds the statutory threshold. The initial threshold will be $10,200 for individual coverage and $27,500 for family coverage, adjusted annually using a cost of living index.

Employer Reporting Requirements

Reporting Cost of Employer-Sponsored Health Coverage on W-2. Effective January 1, 2011, an employer will be required to report the aggregate value of medical benefits, dental, vision, and supplemental insurance coverage on the Form W-2 that is provided to each employee annually.

Uniform Explanation of Coverage. By March 23, 2012, group health plans and sponsors of self-insured health plans must provide participants a uniform summary of benefits and coverage. The uniform summary cannot be longer than four pages and must describe in a "culturally and linguistically appropriate manner" the health benefits offered under the plan, limitations on coverage, cost-sharing provisions, and any restrictions on continuation of coverage. Failure to provide this summary will result in a $1,000 fine per failure. The Secretary of Health and Human Services is required to issue regulations setting forth the uniform standards by March 23. 2011.

Annual Reports. Effective for 2014, employers with 50 or more full-time employees must file an information return in a form to be established by the Secretary of the Treasury containing 1) the employer's name and employer identification number, 2) a certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, 3) the number of full-time employees for each month during the calendar year, 4) the name, address and TIN of each full-time employee during the calendar year and the months during which such employee was covered under a health plan. In addition, the employer must provide a written report to each employee listed in that report that includes the name and contact information for the person filing the return and the information required to be shown on the return for such employee. The report to employees is due by January 31 of the year following the year for which the return is required to be submitted to the Secretary.

Health Plan Design Changes

Extension of Dependent Coverage. Group health insurance plans and self-insured plans that offer dependent coverage must allow dependent coverage to continue for an adult child up to age 26 (or the end of the plan year in which the child turns age 26). For plan years beginning before 2014, this mandate is limited to adult children who are not eligible for other employer-group health plan coverage. The extension of coverage applies to any child under age 26 without regard to the typical criteria for determining dependent status, such as whether the child is married,

resides with the employee or is a full-time student. The value of the coverage provided to the adult child will not be imputed to the employee.

No Lifetime or Annual Limits. Effective for plan years beginning on or after September 23, 2010, a group health plan or self-insured plan may not impose a lifetime dollar limit on "essential health benefits", and must phase out annual limits on "essential health benefits" coverage[2] through 2014, when annual limits will be prohibited.

No Pre-existing Exclusions. Effective for plan years beginning on or after September 23, 2010, no group health plan or self-insured health plan may impose pre-existing condition exclusions for children under 19 and must completely eliminate pre-existing condition exclusions for participants of any age by January 1, 2014.

Prohibition on Rescissions. Effective for plan years beginning on or after September 23, 2010, a group health plan or self-insured plan will be prohibited from rescinding or cancelling health coverage once the individual has become a covered participant, except in cases of fraud or intentional misrepresentation of material fact.

Waiting Periods Limited. Effective January 1, 2014, waiting periods under a group health plan or self-insured plan cannot exceed 90 days.

No Reimbursement for Over-the-Counter Medications. Effective January 1, 2011, reimbursement for over-the-counter medications will no longer be permitted from health flexible spending accounts, health savings accounts or health reimbursement accounts.

Limits on Health FSAs under Cafeteria Plans. Effective January 1, 2013, annual salary reduction contributions to health flexible spending accounts will be limited to $2,500, indexed for inflation.

College and University-Based Student Health Insurance Plans. The law allows such plans to continue, and permits colleges to offer such plans to students. The law's provision that permits a child to be covered by a parent's health insurance until age 26 is expected to reduce the pressure for students to purchase health insurance offered by colleges.

Although forthcoming regulations will provide much needed guidance on the implementation of many of the Act's provisions, employers should now begin reviewing their health plans, assess whether any plan design changes are necessary and create administrative and operational strategies to ensure compliance with the Act. We continue to closely monitor the relevant federal agencies as they begin work on implementation of the complex healthcare law and will provide timely updates as notable developments occur.

If you have any questions, please contact the Edwards Angell Palmer & Dodge LLP lawyer responsible for your affairs or:

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[1] The healthcare legislation also includes changes to the federal student aid programs, with particular emphasis on federal student loans. These provisions are beyond the scope of this Client Advisory.

[2] Essential benefits include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, rehabilitative and habilitative services, prescription drugs, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.