ROPES & GRAY

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Health Care Reform's Impact on Employers and Group Health Plans

With health care reform a reality, our collective attention now turns to the impact that the Patient Protection and Affordable Care Act (the "Health Reform Act") will have on all of us. In an alert issued last week, we summarized key provisions in the Health Reform Act that affected a cross-section of stakeholders in the health care marketplace. This alert will focus on how the Health Reform Act will affect employers and their plans.

Broadly speaking, health care reform requires most individuals to maintain health insurance coverage and, building on the existing system of employer-based coverage, establishes strict requirements on employers. To establish a framework to better understand these requirements, we will first address the basic building blocks of reform and then discuss employer obligations, health plan reforms, and certain tax changes.

The Building Blocks of Reform

- **Individual Mandate.** Beginning January 1, 2014, most U.S. citizens and legal residents must either maintain "minimum essential coverage" (which can be satisfied by, among other things, participating in an employer sponsored plan or purchasing individual coverage) or pay a monthly "shared responsibility" penalty. When fully in effect, this penalty will, on an annual basis, equal the lesser of the national average premium for coverage provided through a health care Exchange established under the Health Reform Act (discussed below), or the lower of $695 per adult individual and $347.50 per child under 18 (to a maximum of $2,085 per family) or 2.5% of household income in excess of the federal income tax return filing threshold. These penalties phase in gradually starting in 2014 at $95 per adult or $47.50 per child with a family maximum of $285, or 1% of household income in excess of the federal income tax return filing threshold, and increasing in 2015 to $325 per adult or $162.50 per child, with a family maximum of $975, or 2% of household income in excess of the federal income tax return filing threshold, before reaching the full amount on January 1, 2016. Starting January 1, 2017, the penalties will be indexed to cost-of-living increases. These penalties do not apply to certain individuals, including those for whom the cost of coverage is deemed unaffordable under the Health Reform Act as well as to individuals who would be eligible for a religious exemption, as described under the Health Reform Act.
- **Premium Tax Credit.** Low income individuals may qualify for a premium tax credit or cost-sharing assistance. In general, employees whose total household income for the taxable year does not exceed 400% of the federal poverty level may be eligible for a tax credit to offset some or all of the cost of their health care premiums. An employee will not be eligible for the premium tax credit for any month in which he or she is eligible for employer-sponsored minimum essential coverage that pays for at least 60% of the full value of benefits provided by such coverage, the required employee contribution toward which does not exceed 9.5% of the employee's household income.
- **Prohibition on Terminations.** An employer may not terminate an employee based on eligibility for a premium tax credit or cost-sharing assistance.
- **Minimum Essential Coverage.** As applied to an eligible employer-sponsored plan, the term "minimum essential coverage" means a group health plan or group health insurance coverage offered by an employer to an employee that is either a governmental plan or any other plan or coverage offered in a large or small group market within a state, including a grandfathered health plan (described below). Minimum essential coverage does not include coverage comprised solely of excepted benefits like dental or vision coverage.

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Obligations of the Employer

Although the Health Reform Act does not obligate an employer to provide health insurance coverage to its employees, in certain circumstances an employer who employed an average of at least 50 full-time employees during the preceding calendar year may be required to pay penalties if it either does not offer such coverage to its employees or if the coverage offered is too costly for certain employees. That said, the Health Reform Act contains rules for grandfathered health plans, which are defined as group health plans and health insurance coverage in which individuals were enrolled as of March 23, 2010. Plans governed by collective bargaining agreements that were ratified prior to March 23, 2010 are also grandfathered until the expiration of the current CBA. Grandfathered health plans are generally not required to conform to the Health Reform Act. These plans must, however, comply with provisions governing; (1) adult dependents, (2) lifetime or annual limits, (3) pre-existing conditions, (4) excessive waiting periods, and (5) rescission of coverage. Changes made to a grandfathered health plan may forfeit these plans' grandfathered status, although renewing these plans and allowing family members to enroll is permitted. The circumstances under which other plan changes may cause a forfeiture will need to be further defined through additional guidance.

- **Penalties for Employers** *That Do Not Offer Health Insurance*. Effective January 1, 2014, if any employer with 50 or more full-time employees does not offer minimum essential coverage, and one or more of the employer's full-time employees qualifies for the premium tax credit or for the benefits of a cost-sharing reduction, then the employer will be required to pay a fee of $2,000 per year ($166.67 per month) per each full-time employee, excluding the first 30 full time employees. Note that this penalty is calculated based on the total number of full-time employees and not the number of employees qualifying for the credit.
- **Penalties for Employers That Offer Health Insurance**. Effective January 1, 2014, if any employer with 50 or more full-time employees does offer minimum essential coverage, and one or more of the employer's full-time employees qualifies for the premium tax credit or for the benefits of a cost-sharing reduction, then the employer will be required to pay a fee of $3,000 on an annualized basis (assessed at $250 per month) per each full-time employee who receives a credit or reduction. The penalty under this section is capped for any month at an amount equal to $166.67 per month times the number of full-time employees, excluding the first 30 full-time employees. As explained under the premium tax credit above, the penalty will not apply if the actuarial value of the employer's cost of the plan is at least 60% of the full value of the benefits provided by the plan unless an employee cannot afford the employee share and he or she enrolls in coverage offered through an Exchange and receives the premium tax credit.
- **Full-time Employees.** A "full-time employee" is defined as "an employee who is employed on average [for] at least 30 hours of service per week." For the purpose of applying the penalty to employers, the number of full-time equivalent employees is taken into account and is determined through a formula that translates the number of hours worked by non-full-time employees into an FTE equivalent.
- **Exemption for Seasonal Employees.** Workers employed on a seasonal basis appear to be exempt from the full-time employee calculation. While the Secretary of Labor is given the authority to define who is a seasonal worker, the Health Reform Act states that seasonal workers who provide services to an employer for 120 days or less during the tax year are not to be counted for Health Reform Act purposes.
- **Free Choice Vouchers.** Employers who offer minimum essential coverage and who pay a portion of the premiums are required to offer free choice vouchers in the amount of the employer contribution to any employee who does not participate in the employer's plan if the employee has household income for the taxable year not exceeding 400% of the federal poverty level, and the required contribution under the plan is between 8 and 9.8% (both percentages indexed for the rate of premium growth) of the employee's household income. If the amount of the voucher exceeds the cost of the premiums for the Exchange plan selected by the employee, then the employee may retain this excess amount. Employees are only taxed on the value of the vouchers to the extent that the value exceeds the amount paid for a qualified health plan. Employers may treat the amount of a free choice voucher as a deductible expense.
- **Notice of Coverage Options.** Before March 1, 2013, employers must provide written notice to all new hires and current employees describing the Exchange, explaining the premium tax credit and cost-sharing subsidies (if the employer's plan pays less than 60% of costs of benefits) and, if the employer does not offer a free choice voucher, that the employee may lose the employer contribution toward employer-sponsored coverage if he or she elects coverage through the Exchange.

- **Requirements for a Uniform "Summary of Benefits."** Effective March 23, 2012, health insurance issuers, group health plans, and sponsors and administrators of self-insured plans must provide a summary of benefits coverage of no longer than four pages and with print no smaller than 12-point type to applicants, enrollees, and policyholders that meets standards set by the Secretary of Health and Human Services. The summaries must also be presented in a culturally and linguistically appropriate manner. Willful failure to provide a summary that complies with regulations promulgated by the Secretary will result in a $1,000 fine per failure. A failure can occur with regard to an applicant at the time of application, an enrollee prior to enrollment or reenrollment, and a policyholder at the time a policy is issued. Once written, a plan benefits summary must be maintained and reflect material modifications to the plan. The goal of developing a short, easy to understand summary of benefits may be analogous to efforts to develop summary prospectuses for mutual funds, and may generate significant compliance issues. The Secretary of HHS must issue regulations providing more details and guidance by March 23, 2011.
- **Automatic Enrollment for Employees of Large Employers.** In accordance with regulations to be issued by the Secretary of Labor, employers (1) with more than 200 full-time employees and (2) that offer one or more health benefits plans, must automatically enroll new full-time employees in one of the plans offered. Employees have the right to decline such enrollment.
- **Exchange Plans and Cafeteria Plans.** Only "qualified employers" (described below) may offer Exchange-based coverage on a pre-tax basis through a cafeteria plan.
- **Prohibition of Discrimination Based on Salary.** Employers may not establish criteria for health insurance eligibility that are based on total hourly or annual salary, or that otherwise discriminate in favor of higher-wage employees, which for these purposes are not defined. Employers are not prohibited from establishing lower contribution limits for employees receiving lower total compensation.
- **Reasonable Break Time and Separate Place for Nursing Mothers.** Employers are required to provide reasonable break time and a separate place for a nursing mother to express breast milk for her nursing child for one year after the child's birth, but will not be required to compensate the nursing mother for any work time spent for such purposes. An employer with less than 50 employees will not be subject to these requirements if they would impose an undue hardship by causing significant difficulty or expense to the employer. These requirements will not preempt a state law that provides greater protections to employees.
- **Limitations on Health FSAs under Cafeteria Plans.** For taxable years beginning after December 31, 2012, annual salary contributions to health FSAs will be limited to $2,500 a year and will be indexed by the Consumer Price Index for taxable years beginning after December 31, 2013. Beginning January 1, 2011, reimbursement for over-the-counter drugs will no longer be permitted from health FSAs, health savings accounts, and Archer medical savings accounts.

Resources Available to the Employer

- **Exchange.** By January 1, 2014, each state is required to establish an American Health Benefit Exchange that will be a governmental agency or nonprofit entity. An Exchange will (1) facilitate the purchase of qualified health plans to qualified individuals; (2) provide for the establishment of a Small Business Health Options Program to assist qualified employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the state; and (3) make available qualified health plans or stand-alone dental plans to qualified individuals and qualified employers. A state may require that a qualified health plan offer additional benefits but the state must assume the cost. Beginning in 2017, states may allow (but not require) health insurance issuers in the large group market to offer qualified health plans through an Exchange. Large employers that elect to make all full-time employees eligible for one or more qualified health plans offered in the large group market through the Exchange will be considered a "qualified employer." An Exchange may certify a "qualified" plan that would fall into one of the following four categories, based on the covered percentage of the value of benefits provided under the plan: Bronze – 60%; Silver – 70%; Gold – 80%; Platinum – 90%.
- **Qualified Employer.** The term "qualified employer" means a small employer that elects to make all full-time employees eligible for one or more qualified health plans offered in the small group market through an Exchange that

offers qualified health plans. A qualified employer may select any level of coverage to be made available to its employees through an Exchange, and employees of a qualified employer may choose to enroll in such a plan.

- **Employer Size Defined.** For purposes of Exchange qualification, a "large employer" is an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. The term "small employer" means with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. For plan years beginning before January 1, 2016, a state may elect to treat an employer with not more than 50 employees as a small employer and with at least 51 employees as a large employer.
- **Credit for Small Business Insurance Expenses.** For tax years beginning in 2010, 2011, 2012, and 2013, small employers who have 25 or fewer "full-time equivalent" employees and average annual wages of no more than $50,000 (indexed for changes in cost of living increases beginning in 2014), may be eligible for a tax credit of 35% (25% for tax-exempt small employers) of the employer's contribution to the cost of providing health insurance to their employees so long as the employer contribution meets or exceeds 50% of the total cost of coverage. Effective January 1, 2014, this credit will be increased to 50% (35% for tax-exempt small employers) of the lesser of the aggregate amount of nonelective contributions the employer made on behalf of its employees (at least 50% of the premium cost of the qualified health plan) for premiums for qualified health plans offered by the employer to its employees through an Exchange, or the aggregate amount of nonelective contributions that the employer would have made if each employee had enrolled in a qualified health plan with a premium equal to the average premium determined by the Secretary of HHS for the small group market. The amount of the credit will phase out based on the number of employees and average wages. For purposes of this credit, the number of full-time equivalent employees is calculated by dividing the number of hours for which employees (other than seasonal employees) were paid by 2080. If an employee worked in excess of 2080 hours, the hours above that amount are not taken into account for this calculation.
- **Temporary Reinsurance for Early Retirees.** By June 23, 2010, the Secretary of HHS must establish a temporary reinsurance program that will pay for a portion of health benefits provided by employment-based plans (including multiemployer plans) to pre-Medicare eligible retirees and their eligible dependents. For a plan to be eligible for this reinsurance, it must apply to and be approved by the Secretary of HHS. The reimbursement is equal to 80% of the amount of valid retiree claims that exceed $15,000 and are no greater than $90,000, indexed for changes in the medical CPI. This program will end no later than January 1, 2014.
- **National Voluntary Insurance Program for Purchasing Community Living Assistance Services and Support (CLASS program).** Effective January 1, 2011, the Secretary of HHS will establish the CLASS program to provide assistance and support to certain individuals with functional limitations to enable them to live in the community. Under procedures established by the Secretary of HHS and the Secretary of Treasury, employers who choose to participate may automatically enroll qualified individuals in the CLASS program in the same manner as the employer may elect to automatically enroll employees in a 401(k), 403(b) or 457 plan. Qualified individuals must have attained age 18, be actively employed, and receive taxable wages. Individuals may opt out of the program.

Reporting Obligations

- **Reporting of Health Insurance Coverage.** For calendar years beginning after 2013, each employer providing minimum essential coverage to an employee must file an information return with the IRS describing the coverage, stating the employer's name, address, and employer identification number, the portion of the premium paid by the employer, and for coverage in the small group market offered though an Exchange, any information required by the Secretary of Treasury to administer credit for employee health insurance expenses of small employers. In addition, on or before the January 31 following the calendar year of this return, the employer is required to furnish to each listed employee a written statement showing the name, address, and the contact information of the employer and employee-specific information reported on the return.
- **Reporting of Employer Health Insurance Coverage.** Beginning after December 31, 2013, employers with 50 or

more full-time employees must file an information return in a form to be established by the Secretary of Treasury (1) stating the employer's name, employer identification number, and the date, (2) certifying whether the employer offers to its full-time employees (and their dependents) minimum essential coverage under an eligible employer-sponsored plan, and describing certain terms of the plan, if any, (3) the number of full-time employees for each month during the calendar year (not the plan year), (4) the name, address, TIN, and monthly coverage status of each full-time employee during the calendar year and the months, and (5) any other information required by the Secretary. In addition, on or before the January 31 following the calendar year of this report, the employer must provide each listed full-time employee with a statement containing the name and contact information of the person filing the return and the employee-specific information reported.

- **Inclusion of Cost of Employer-Sponsored Health Coverage on W-2.** For taxable years beginning after December 31, 2010, an employer will be required to include the aggregate cost of applicable employer-sponsored health insurance coverage, except for the amount of any salary reduction contributions to Flexible Spending Arrangements (FSAs), on its employees' annual form W-2s.

Key Health Plan Reforms

- **Adult Dependents.** Effective for plan years beginning on or after September 23, 2010, group health plans and health insurance issuers who offer dependent coverage are required to continue coverage for dependent children who have not attained age 26. Neither the dependent nor the participant will be required to include the value of the coverage in income. For plan years beginning before January 1, 2014, a grandfathered group health plan is also required to extend coverage to the adult dependent, but only if the dependent is not eligible to enroll in an eligible employer-sponsored health plan other than the grandfathered health plan.
- **No Lifetime or Annual Limits.** Effective for plan years beginning on or after September 23, 2010, group health plans and insurance issuers may not impose lifetime or annual limits on benefits, however, prior to January 1, 2014, annual limits may be imposed on certain essential health benefits, as defined under the Health Reform Act. Lifetime and annual limits may be imposed on specific, non-essential health benefits without restriction.
- **Preexisting Conditions.** Effective for plan years beginning on or after January 1, 2014, group health plans may not impose preexisting condition exclusions. This prohibition goes into effect earlier (plan years beginning on or after September 23, 2010), however, for coverage provided to children who are under age 19, Secretary Sebelius announced this week that HHS will be issuing regulations that clarify that this provision is intended not only to prohibit insurers from applying preexisting condition limits to already enrolled children but also to prohibit them from refusing to enroll children with preexisting conditions in the first place.
- **Preventive Services.** Effective for plan years beginning on or after September 23, 2010, group health plans must provide coverage for certain preventive services.
- **Nondiscrimination.** Fully insured group health plans must comply with the non-discrimination rules under Section 105(h) of the tax code, effective for plan years beginning on or after September 23, 2010. Questions remain as to the consequences of failing to comply with the non-discrimination rules under a fully-insured plan, but the change will most likely impact an employer's ability to offer certain benefits to only highly paid executives through fully-insured plans.
- **No Excessive Waiting Periods.** Effective January 1, 2014, waiting periods under a group health plan may not exceed 90 days.
- **Appeals.** Group health plans and insurers must each maintain internal appeals procedures for denied claims, and comply with any applicable state-established external review procedures. Group health plans and insurers must provide "culturally and linguistically appropriate" notification of the availability of the appeals processes.
- **Patient Protections.** Group health plans and insurers must comply with certain rules governing choice of primary care providers and access to emergency services, pediatric care, and obstetrical and gynecological care.
- **Rate Variations.** Effective January 1, 2014, rates may only vary for insurance offered in the small group market (or if

permitted in a given state, the large group market) based on age, individual versus family coverage, geographic area, and tobacco use. Rates may not vary based on health status, but they may be reduced by up to 30% based on participation in a wellness program (see below)

- **Wellness Programs.** Incentives employers may now offer under a wellness program increase from 20% to 30% of the cost of group health plan coverage.
- **Prohibition on Rescission.** Effective for plan years beginning on or after September 23, 2010, a group health plan and a health insurance issuer offering group or individual health insurance coverage are prohibited from rescinding coverage for a covered enrollee except in cases where an enrollee commits fraud or makes an intentional misrepresentation of a material fact. Presumably this prohibition on rescission will not affect an employer's ability to rescind coverage if the enrollee experiences a qualifying life event or is enrolled through administrative error.

New or Modified Taxes

In addition to the tax consequences of the Health Reform Act discussed in our alert dated March 26, 2010, the new law includes other tax measures that should be of interest to employers and their employees.

- **Elimination of Incentives for Employer Contributions to Medicare Part D Prescription Drug Plans.** Under prior law, an employer could choose to subsidize prescription drug plans for Medicare Part D eligible retirees and receive a valuable deduction for the value of the subsidy. The value of the subsidy was not considered to be part of the retiree's "gross income" but was still deductible as an expense of the employer. For example, an employer could deduct a contribution to a Medicare Part D prescription drug plan as an expense (similar to a deduction for salary expenses) but the recipient retiree would not have to treat the subsidy as income. While subsidies will still not be income to retirees, the amount of the employer contribution will no longer be deductible, thus removing a substantial incentive for employers to offer prescription drug plans for Medicare Part D eligible retirees. The Health Reform Act also phases in changes to the Medicare Part D donut hole which will result in the hole closing completely by 2020.
- **Increased Penalties on Nonqualified HSA and Archer MSA Distributions.** The tax on distributions from a health savings account or an Archer MSA that are not used for qualifying medical expenses is increased from 10% for HSAs and 15% for Archer MSAs to 20% for both, effective for distributions made on or after January 1, 2011.
- **Modification of Itemized Deduction for Medical Expenses.** For taxpayers who itemize deductions, the "floor" for deducting unreimbursed medical expenses is being raised from 7.5% of adjusted gross income to 10%. For example, a taxpayer with adjusted gross income of $100,000 and unreimbursed medical expenses of $12,000 would be able to deduct $4,500 of those expenses under the old law. However, after January 1, 2012, the same taxpayer would only be able to deduct $2,000 of the $12,000 in unreimbursed medical expenses.
  - There is a special rule for tax years 2012, 2013, 2014, 2015, and 2016 that retains the 7.5% floor if the taxpayer or the taxpayer's spouse is or will turn age 65 before the close of the taxable year.

We expect that the coming months will see significant regulatory activity that should clarify many of the Health Reform Act's provisions. There may even be legal challenges to some of its requirements. With the extensive coverage that enactment of health care reform has received, we also expect that many employees will begin to ask questions about its benefits and requirements. As developments occur and questions arise, we remain ready to assist you in any way, whether by drafting employee communications in the short-term or helping you assess the impact that health care reform may have on your organization, your benefit plans, and your employees over the long-term. Please check the Ropes & Gray Health Reform Resource Center, in particular the employer portal, for more information, including a Health Reform Act timeline. If you would like to talk further about health care reform, do not hesitate to contact your usual Ropes & Gray advisor.

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