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Employee Benefits E-news

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Health Care Reform For Employers

The following summarizes the major provisions of the Health Care and Education Affordability Reconciliation Act of 2010 as it relates to Employers providing health care benefits for their employees.

Employer Participation in Insurance Exchanges and Premium Assistance Credits/Cost-Sharing Subsidies

- A "qualified employer" (less than 100 employees) can participate in an "American Health Benefit Exchange" ("Exchange")[1] to provide group health coverage for its employees. Beginning in 2017, larger employers may be eligible to offer qualified health plans through an Exchange.
- Effective January 1, 2014, employees who are offered affordable coverage (employer pays 60% and employee's share not exceed 9.5% of income) by their employers are not eligible for premium assistance credits or cost-sharing subsidies.[2]

Employer Mandates

- Employers that provide health insurance coverage and have more than 200 full-time employees are required to automatically enroll new employees in coverage (subject to any waiting periods authorized by law). Employees will have the opportunity to opt out of coverage.
- Effective January 1, 2014, an employer with more than 50 full-time employees ("Large Employer") which fails to provide health coverage to its full-time workforce (so long as at least one full-time employee receives a premium assistance tax credit or cost-sharing reduction), will be assessed an annual fee of $2,000 multiplied by each full-time employee. The first 30 full-time employees are exempt from the payment calculation.

  Even if the Large Employer offers coverage to its full-time workforce, if at least one full-time employee receives a premium assistance tax credit, the employer will pay an annual amount equal to the ***lesser*** of $3,000 multiplied by each full-time employee receiving a premium assistance tax credit ***or*** $2,000 multiplied by each full-time employee (subtracting the first 30 full-time employees).

- Large Employers are prohibited from imposing waiting periods in excess of 90 days.

- Employers offering coverage are required to provide a free choice voucher to employees with incomes less than 4 times the federal poverty level, and whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in the Exchange.
- Employers are prohibited from discriminating against employees in relation to the premium assistance tax credit.
- Effective January 1, 2013, employers may no longer claim a deduction for expenses allocable to the Medicare Part D prescription drug subsidy.

Elimination of Discriminatory Fully-Insured Group Health Plans

Effective for plan years that begin 6 months after the implementation of the Act, fully-insured group health plans must comply with the nondiscrimination requirements of the Code.

Imposition of Excise Tax on "Cadillac Plans"

Effective January 1, 2018, the Act imposes a 40% nonrefundable excise tax on high-cost group health plans if the aggregate value of the employer-sponsored health coverage exceeds an inflation-adjusted $10,200 for single coverage or $27,500 for family coverage. Tax equals 40% of excess cost. Limit increased in the case of a retiree or an employee engaged in a high-risk profession.

Special Rules for Small Employers

- Beginning in 2010, qualified small employers (employers who have no more than 25 full-time employees and with average annual compensation levels not exceeding $50,000) may elect a tax credit up to 35% (which will reach up to 50% by 2014) of their employee health care coverage expenses.
- Effective January 1, 2014, the Act limits deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families.

Impact on Defined Contribution Health Care Plans

- For taxable years beginning after December 31, 2012, FSA contributions will be capped at $2,500.
- Effective January 1, 2011, Over-the-counter ("OTC") drugs may no longer be reimbursed by an FSA, health reimbursement arrangement ("HRA"), Archer Medical Savings Account ("Archer MSA") or Health Savings Account ("HSA").
- Effective January 1, 2011, distributions from an HSA that are not used for qualified medical expenses will increase from 10 percent to 20 percent, while distributions from Archer MSAs will increase from 15 percent to 20 percent.

Impact on Compensation

- Effective January 1, 2013, for single taxpayers with adjusted gross income of $200,000 or more and joint filers with adjusted gross income of $250,000 or more, the reconciliation bill will add a 3.8% tax on unearned income from interest, dividends, annuities, royalties, rents, and capital gains.
- Also effective January 1, 2013, in addition to the current 1.45% Hospital Insurance payroll tax, an additional Medicare tax of 0.9% will be imposed on individuals receiving wages in excess of $200,000 (single taxpayers) or $250,000 (joint filers).
- Effective January 1, 2011, employers will be required to report the value of health care benefits on an employee's W-2 tax statement.

Improvements to Coverage

- Prior to the enactment of the Act, group health plans could impose lifetime and annual limits on benefits. However, effective January 1, 2014:
    - Group health plans are prohibited from imposing lifetime limits on benefits.
    - Group health plans are prohibited from imposing annual limits on benefits. Nevertheless, group health plans but may impose restricted annual limits on the dollar value of benefits for plan years before January 1, 2014.
- Effective for plan years beginning 6 months following enactment of the Act, group health plans are prohibited from rescinding such plan with respect to an enrollee once the enrollee is covered under the plan, except in the case of fraud or intentional misrepresentation of material fact if prohibited by the terms of the plan.
- Effective for plan years beginning 6 months after enactment, group health plans are required to make coverage available to dependents until the age of 26.
- Effective for plan years which begin 6 months after enactment of the Act, group health plans must provide coverage, without imposing any cost sharing, for the following to the extent recommended by certain governmental bodies:
    - evidence-based items and services with a rating of 'A' or 'B';
    - immunizations;
    - preventive care and screenings for infants, children, and adolescents; preventive care and screenings for women; and
    - breast cancer screening, mammography, and prevention services that were recommended prior to November 2009.
- Effective for plan years beginning on or after January 1, 2014, group health plans are prohibited from imposing a pre-existing condition exclusion from coverage.
- The Act requires qualified health plans to ensure that such coverage includes an essential health benefits package effective January 1, 2014.

- Within ninety days after enactment of the Act, the Secretary must establish a temporary reinsurance program to reimburse employer-based plans for a portion of cost of medical surgical, hospital, and prescription drug coverage for early retirees over age 55 and not eligible for Medicare, their spouses, surviving spouses, and dependents. The program will reimburse 80% of the portion of a claim above $15,000 and below $90,000, adjusted annually.

For more information about Health Care Reform, please contact your regular Butzel Long attorney, a member of the Butzel Long Employee Benefits Practice Group, or the authors of this e-news bulletin.

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[1] American Health Benefit Exchanges will be created and administered by a governmental agency or non-profit organization through which individuals who do not get coverage at work and small businesses of up to 100 employees can purchase essential health benefits from a variety of different plans with different benefit tiers.

[2] Under the Act, individuals and families whose income is between 100% and 400% of the Federal Poverty Level ($18,310 for a family of 3) are eligible for premium assistance tax credits in order to purchase health insurance through the Exchanges.

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