

Top-of-mind questions about health care reform

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In an ongoing webcast series hosted by Grant Thornton LLP, professionals address organization and employer concerns, potential penalties and new obligations surrounding the health care reform bill. Participants of the webcast series raise a number of questions. The following is a summary of the most frequently asked questions.

Employer medical coverage

- **What is required from employers?**

Beginning in 2014, large employers — those with 50 or more full-time workers — could face federal penalties for not providing insurance coverage or for providing inadequate coverage. The penalty for not offering coverage is \$2,000 per year for all employees (after subtracting the first 30) regardless of how many receive federal subsidies (as long as at least one receives a subsidy). If an employer offers inadequate coverage, the penalty is \$3,000 per year for each employee, but applies only for each employee who actually receives a federal subsidy. The penalty for providing inadequate coverage is capped at the penalty amount that applies when no coverage is offered. The penalties are assessed on a monthly basis.

- **For purposes of determining whether an employer is a “small” employer (fewer than 25 full-time employees with average wages of less than \$50,000) or a “large” employer (50 or more full-time employees), does the definition of an employee include only W-2 full-time employees or also independent contractors?**

It does not include independent contractors.

- **Why is it important to determine whether an employer is a small employer or a large employer?**

Small employers receive a credit for providing health care coverage to employees, while large employers must pay a penalty if they provide either no coverage or inadequate coverage.

- **How is the number of full-time employees determined?**

For the small employer determination, the number of full-time employees is determined by dividing the total hours for which the employer pays wages by 2,080. For the large

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employer determination, all employees who work on average at least 30 hours per week are counted. For employees who work less than this amount, the employees are aggregated and the number of full-time employee equivalents is calculated and counted towards the 50-employee threshold.

- **If a small employer offers medical coverage to its employees through a regular group plan, and not through an exchange, are they still eligible for the tax credit?**

Yes. The credit was originally conceived as a credit only for coverage through an exchange, but was later expanded to include coverage under the employer's own health plan. The credit percentage increases in 2014, when the exchanges become available. This seems to be aimed at encouraging small employers to use the exchanges. The credit is available for the years 2010 through 2013, and for any two years thereafter.

- **What are the new rules regarding the coverage of non-dependent adult children, and when do the rules go into effect?**

Plans must cover adult children up to age 26. This provision goes into effect for plan years beginning after Sept. 23, 2010. Thus, for calendar year plans, this provision goes into effect on Jan. 1, 2011.

- **Is there a penalty for having a waiting period that is longer than 30 days?**

The primary health care bill contains a provision that penalizes an employer for having a waiting period for its health plan that is longer than 30 days. However, the reconciliation bill contained a provision that eliminates the penalty.

- **What is "inadequate" coverage?**

Coverage is inadequate for purposes of the penalty if the cost to the employee exceeds 9.5 percent of household income, or the plan's share of the costs is below 60 percent.

- **Are there other new rules that apply to health coverage?**

Yes, a number of additional new requirements apply for plan years beginning after Sept. 23, 2010. These include the following:

- Plans that offer coverage for dependents must offer coverage for children up to age 26, regardless of whether the child is a dependent of the employee and regardless of the child's marital or employment status.
- Children under age 19 may not be excluded for pre-existing conditions.
- Lifetime maximum coverage amounts for "essential" benefits are prohibited. Essential benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care.
- Annual dollar limits are prohibited on essential benefits. However, prior to Jan. 1, 2014, a "restricted annual limit" on essential health benefits is permitted. The

Secretary of Health and Human Services is to issue guidance on the definition of “restricted annual limit.”

- An individual’s health insurance coverage cannot be rescinded, except in the case of fraud or material misrepresentation.
- The following additional requirements apply, starting in 2014:
 - No individual may be excluded from coverage due to pre-existing conditions, regardless of age.
 - A plan cannot have an eligibility waiting period of more than 90 days.
- **What happens if an employer currently walks away from an existing plan because the penalties are less than the current cost?**

An employer can do just that. There is no requirement for an employer to provide coverage. But if no coverage is provided, the employer will pay penalties if at least one employee receives a federal subsidy to help pay for health care coverage.

- **What is the excise tax on so-called “Cadillac” plans?**

Beginning in 2018, insurance companies will pay a 40-percent excise tax on “Cadillac” high-end insurance plans. The tax is paid on the “excess benefit,” which is the amount by which family coverage exceeds an annual cost of \$27,500, and single coverage exceeds a cost of \$10,200. Higher thresholds will apply for high-risk workers and retired workers who are not yet eligible for Medicare. Dental and vision plans are exempt and will not be counted in the total cost of a plan. The employer is responsible for calculating the amount of the excess benefit and communicating the amount to the insurance company. The threshold amounts will be indexed for inflation, starting in 2019.

- **Can an employer charge a premium for coverage of adult children?**

Yes, an employer can charge a premium for coverage of adult children. Although the law requires plans to offer coverage for adult children up to age 26, there is no requirement that the employer pay for the coverage.
- **If the adult child is employed and eligible for health coverage with their employer, do they have to enroll in the coverage offered at that employer or can they enroll in their parents’ coverage?**

The adult child is free to enroll in either plan.

Flexible spending arrangements (FSA)

- **What is the reason for not allowing over-the-counter (“OTC”) drug reimbursement through an FSA?**

Because FSA contributions and reimbursements are not subject to tax, the tax revenues are increased when FSA amounts are reduced. The prohibition on paying for OTC

drugs from FSAs will have the effect of reducing contributions, and in turn, increasing taxes. Essentially this is a revenue raiser.

- **Will there be a limit for employer contributions to an FSA?**

There is no limit for employer contributions to FSAs. The \$2,500 limit, which goes into effect in 2013, applies only to employee contributions.

Additional resources

- Grant Thornton's [tax legislative alerts](#)
- [Grant Thornton's Health Care Reform Resource Center](#) and [Health Care Alerts](#)

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