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What Employers Need To Know About the Patient Protection and Affordable Care Act

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On June 28, 2012, the United States Supreme Court upheld nearly every provision of the controversial Patient Protection and Affordable Care Act ("Health Care Act"), including the individual mandate requiring almost all Americans to have health insurance coverage by 2014 or pay a tax. It also upheld all of the new obligations now imposed on employers. The Court did limit the provisions expanding Medicaid and now each state will decide whether or not to participate in the expansion.

This article summarizes the major provisions of the Health Care Act that should be put on the radar of all employers and the date by which compliance is required.

Medical Loss Ratio Rebates – Compliance Date: August 1, 2012

Health insurers are now required to spend at least 80% to 85% of premium dollars on medical care, claims, and the improvement of health care quality. This threshold-spending requirement is known as the "medical loss ratio." As of August 1, 2012, insurers who do not meet the medical loss ratio must provide rebates to their enrollees.

Employers who may receive a medical loss ratio rebate should have procedures in place to handle how the rebates are apportioned. It is important to review all employer plan information concerning employer obligations regarding whether to pay the rebate directly to employees or otherwise use the rebate for the benefit of employees.

Individuals directly responsible for paying health insurance premiums may see rebates in the form of a reduction of premiums; a rebate check; or, if their premiums were paid by credit card, a refund to their credit card account.

Summary of Benefits and Coverage – Compliance Date: September 23, 2012

For group health plans that are open to enrollment on or after September 23, 2012, employers will be required to provide their employees a summary – written in a plain and concise manner – of their benefits and coverage. Employers with a group health plan will have the responsibility of distributing the summary to employees at enrollment, at the start of each plan year, and within seven days after an employee requests a copy of the summary.

In addition to a summary, employees must also be given, upon request, access to a glossary of industry-specific terms used in the summary and in the health care plan. The summary and glossary are intended to help employees better understand what types of benefits and coverage they will receive under their employer's plan.

The rules governing the summary of benefits and coverage are complex, and stiff penalties apply if an employer fails to provide the required information. In addition, the format of the summary has been set by rules adopted by the U.S. Department of Health and Human Services ("DHHS"). Employers must ensure that compliant summaries of benefits and coverage are provided to all employees at the appropriate times.

W-2 Reporting – Compliance Date: 2012 Tax Year

Beginning with the 2012 tax year, most employers will have to report the cost of their employees' health insurance coverage

on each employee's W-2 form. "Small businesses," defined as employers that were required to file less than 250 W-2s in the preceding tax year, will be exempt (at least for the 2012 tax year). However, it is anticipated that all employers with employer-sponsored health plans will be required to make the W-2 report for tax years after 2012.

The cost of health coverage reported on the employee's W-2 will not be taxable. It is intended to be for informational purposes only. The goal is for employees to know the total cost of their health insurance, including the portion paid by their employers.

Medicare Tax on Certain Wage Earners – Compliance Date: January 1, 2013

With respect to wages earned on and after January 1, 2013, an additional Medicare tax of 0.9% will apply to income in excess of $200,000 for a single filer and $250,000 for married individuals filing jointly. For example, if an unmarried employee makes $210,000 of includable income in a calendar year, the additional Medicare tax will apply only to the $10,000 excess. It will be the employer's responsibility to ensure the proper withholding is made.

Notice of Exchange Option – Compliance Date: March 1, 2013

Effective March 1, 2013, employers must provide written notice to their employees about any applicable state health care exchanges. State exchanges are intended to provide one-stop shopping for individuals and small businesses looking for competitive and affordable health care insurance. The state exchanges will allow employees and small businesses to compare costs of available plans; to access information on providers and hospitals; and to determine their eligibility, including eligibility for tax credits.

Employer Mandate – Compliance Date: 2014

Beginning in 2014, employers with 50 or more full-time employees (including full-time equivalent employees) must provide health insurance that meets affordability and value requirements to all full-time employees and their dependents – the so-called "play or pay" option. If an employer elects not to "play" by providing such coverage to full-time employees, then the employer will pay an annual penalty equal to the amount calculated by multiplying $2,000 by the number of full-time employees minus 30 employees.

However, merely providing a group health care plan to employees and their dependents will not be enough. The offered health insurance must meet the affordability and value requirements established by the Health Care Act. If an employer provides insurance that is determined to be unaffordable or of low value, and an employee receives a subsidy through a state exchange, then that employer will be subject to a penalty which will be the lesser of (a) the amount calculated by multiplying $3,000 by the number of full-time employees who receive subsidies under the exchange; or (b) the amount calculated by multiplying $2,000 by the number of full-time employees (whether or not they received subsidies under the exchange) minus 30 employees.

Employers who currently do not offer health insurance coverage to employees or who offer plans that do not meet the affordability and value requirements, and who are considering whether to "play" by offering a plan or just "pay" the penalty, should begin a cost-benefit analysis now to determine which alternative best suits the employer's business. Make no mistake, whichever alternative is chosen, both the cost of "playing" and the cost of "paying" may have a significant economic impact on some businesses. Employers should anticipate the unavoidable costs and take these employer mandate costs into account as part of their budgeting and financial planning going forward.

High Cost Health Care Plans – Compliance Date: 2018

Starting in 2018, employers will pay a 40% excise tax on the value of health coverage provided to employees that exceeds a maximum amount. This is commonly referred to as the "Cadillac Tax," and the amount of the tax will be calculated not only on the amount the employer contributes, but also on the total value of the benefits. In general, the tax will apply if the

employer's plan has an aggregate value of more than $10,200 for individual coverage or $27,500 for family plans. Higher aggregate values are set for retirees over the age of 55 who do not qualify for Medicare and employees in certain high-risk professions.

Other Requirements for Which Guidance will be Forthcoming but Should be on All Employers' Radars Now

There are other key provisions of the Health Care Act which are not currently effective because DHHS has yet to issue guidance regarding them, but which nevertheless will impact employers.

Nondiscrimination Requirement. The Health Care Act prohibits employer-sponsored health plans from discriminating in favor of highly-compensated employees. Although the nondiscrimination requirement was set to take effect in 2014, compliance has been delayed pending the issuance of further guidance.

In the meantime, employers should take a look at the types of benefits offered to their employees. Are different plans offered to different groups of employees? Are there different eligibility requirements among employees? Are there different premium subsidies offered to different groups of employees? If the answer to any of these questions is "yes," then the employer's current plans may discriminate in favor of highly-compensated employees and the employer should implement changes to them.

Automatic Enrollment for Employers with More Than 200 Full-Time Employees . Before the passage of the Health Care Act, it was common practice for employers to require their employees to affirmatively opt-in to employer-sponsored benefits. The Health Care Act mandates automatic enrollment for employers with more than 200 full-time employees unless an employee affirmatively opts-out. This provision further requires the employer to provide a notice of automatic enrollment and of the procedures for opting-out of the plan. At this time, compliance with respect to automatic enrollment is delayed pending DHHS issuance of implementing regulations.

Conclusion

The provisions outlined in this article do not address all of the provisions of the Affordable Care Act that may apply to employers. Due to the expanse of the Health Care Act and the severity of penalties for noncompliance, it is important for employers to plan ahead of the compliance deadlines, starting with the requirements and prohibitions set out in this article.

Full compliance with the Health Care Act will take a complete understanding of the full scope of the Act, how it applies to each employer, and a working knowledge of the employer's current plans and benefits.

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