Aftermath: New Realities for Businesses in the Wake of the Health Care Law

Now that both the "Patient Protection and Affordable Care Act" (PPACA) and the reconciliation "fixer" bill, the "Health Care and Education Reconciliation Act" have been signed into law, employers must take a new look at the offering of health insurance benefits. This document is not legal advice, but is intended to serve as an outline to the new realities employers face in this landscape of compliance responsibilities.

Important Choices for Businesses

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To Offer, or Not to Offer?

Small Business Tax Credits: Employers of different sizes have different concerns here. The smallest employers (those with 25 or fewer employees and an average workforce salary of $50,000 or less) may wish to consider utilizing the small business health insurance tax credits. These credits may pay for up to half of the costs of providing health insurance to employees, and will last two years past the creation of Exchanges (the credit is 35 percent before 2014 and 50 percent for two years after). However, there is no transition after the two year cutoff, so for some firms costs could double the next year, or they may be forced to drop a benefit that employees had relied upon or grown accustomed to.

Employers with between 25 and 50 employees are not eligible for subsidies, and will not be fined for failing to offer health insurance; however, if they do offer a plan, the plan will need to meet essential benefit and actuarial standards, or employees will still be subject to the individual mandate penalty.

Plan Requirements: In order to be a qualified health plan (and thus to exempt an individual from the individual responsibility penalty and an employer from the shared responsibility penalty), a health plan must meet both the actuarial requirements enacted in the PPACA (generally a 60 percent actuarial value), as well as cover all of the "essential benefits." The essential benefits will be promulgated by the Secretary of Health and Human Services prior to the mandates taking effect in 2014.

Plan Costs vs. Penalty Costs: For employers with more than 50 employees who choose not to offer coverage, no fines will be levied if all employees' incomes are above 400 percent of the Federal Poverty Level (FPL). If any employees are below 400 percent of FPL, the likely fine will be $2,000 times the number of employees minus 30 (provided that at least one employee gets an Exchange credit). The same goes for employers who have plans that do not meet government requirements. An employer's number of employees is calculated via adding all employees who work 30 or more hours a week, to the number of "full-time equivalent" workers (roughly translated as, if one adds up the hours per week of all the part-time employees, how many times this can be divided by 30).

Vouchers and Affordability Credits for Offering Firms: Employers with more than 50 employees who do offer qualified health insurance to employees will also have new concerns. Many employers pay large portions of health insurance premiums on behalf of employees, and employees pay the remaining portion. If any employee's contribution constitutes between 8 and 9.8 percent of his or her income, the employer is required to offer this employee a voucher that is equal to the employer's expected contribution, to be used to purchase health insurance in an Exchange. If an employee's contribution exceeds 9.8 percent of his income, he may (if income is below 400 percent of FPL) obtain an Exchange subsidy, incurring a $3,000 fine for the employer. If enough employees have low enough incomes and get Exchange credits, an employer offering a qualified plan could be fined just as much as an employer offering no health insurance and paying the free-rider penalty.

Employees' Subsidy Eligibility: Employees who do not meet these two specific "affordability" requirements and otherwise have an offer of a qualified plan from an employer are not eligible for Exchange credits. Thus the offer of an employer plan may be disadvantageous to some employees, who would be eligible for more generous subsidies if they were not offered a qualified plan through their employer. Further, in many cases the $2,000 per employee fine will be significantly less than the average employer contribution to employees' premiums. An offering employer will also need to list the value of the benefit on employee W-2s starting in 2011. Employers will now need to weigh the decision whether or not to offer plans against the possible savings the employer could obtain by opting for the penalties, the possible fines that low-income employees could generate, and the possible subsidies that employees could receive if there is no plan offered.

Managing Plan Costs and Avoiding Penalties

Employers will need to take specific steps to make sure their plans meet new requirements in order to protect employers from "shared responsibility" penalties (the "free-rider" or employer

mandate) and to protect employees from "individual responsibility" penalties (requiring individuals to have qualified health insurance). Further, the structure and value of a plan may have serious implications for employers as well.

Purchasing Traditional Insurance: Employers purchasing a fully-insured plan (a traditional health insurance product in which the insurer pays claims and takes on the risk) will need to verify that said plan is a qualified benefit going forward – by October of 2010 plans will need to meet new requirements relating to lifetime/annual limits, rescissions, and excess waiting periods. They will need to allow individuals up to the age of 26 to be listed as dependents. When the shared responsibility provisions kick in, in 2014, employers will need to verify that plans meet the essential benefits requirement (to be defined by the Secretary of HHS) and the actuarial requirements laid out in the law. There will be limitations on imposing annual limits, and first-dollar coverage of prevention with no cost-sharing will be mandated for everything selected by the U.S. Preventative Services Task Force. Starting in 2011 these plans will need to have new limits on Health Savings Accounts and Flexible Spending Arrangements as well. Also, starting in 2014, there will be a tax specifically on fully-insured products, which could result in increased costs associated with these plans.

Self-Insuring: The alternative will be to self-insure (employer can form an ERISA plan in which the employer pays claims, manages risk, and will likely use an insurance company only to administer claims and offer stop-loss insurance for high-cost claims), which will shield employers from both state coverage mandates and the new health insurance tax, but will entail two key new risks: the employer will then become responsible for seeing to it that the plan meets all the new requirements (as well as new outside requirements under the Genetic Information Nondisclosure Act, the Mental Health Parity Act, and others), and, if the plan's costs per beneficiary exceed certain amounts after 2017, the plan sponsor will be fined by the so-called "Cadillac tax." Self-insured plans will need to report their costs and may be forced to "rebate" money to beneficiaries if the plan's administrative costs exceed 15% starting in 2011. Depending on what definitions are developed for administrative costs, this could potentially be very challenging for plans attempting to innovate cost-containment strategies.

Sending Employees to the Exchange: Employers wishing to have a firm grasp on health insurance costs will have the option of offering Exchange plans to their employees – small employers will be eligible at the outset, and states may allow large employers to participate starting in 2017. This may allow a defined contribution from employers, provided the contribution was significant enough to avoid "responsibility" penalties.

Offering Other Health-Related Benefits

Long-Term Care: Employers continue to report very low enrollment in long-term care benefits offered to employees. Starting in 2011, employers will be permitted to automatically enroll employees into the new CLASS program, which will on average every month deduct between $146 (CBO) and $240 (CMS) from employee's pay checks. If an enrollee (after a five-year vesting period) becomes eligible (meaning he needs help with a major life activity like bathing, eating, or dressing) he or she may receive around $75 per day from the program. Employees will need to be given a notice that they can affirmatively opt-out to avoid auto-enrollment.

Retiree Prescription Drugs: Employers who offer Part D prescription drug plans to their retired employees currently receive a 28% subsidy from the Medicare program, which has been excluded from taxation. In 2013 this exclusion will be removed, so the net subsidy from Medicare will be in effect reduced (meaning the overall costs to employers to provide Part D programs will be increased). Employers currently offering these benefits or considering beginning to offer these benefits should take these new costs into account. If a business ceases offering a Part D prescription drug plan, retirees will still be eligible to use the Part D program on their own.

Compensation: Effective within 90 days of enactment, individuals with pre-existing conditions will have access to high-risk pools. Starting in 2014, with the creation of Exchanges, all plans generally will be subject to guaranteed issue and community rating. This will have the effect of eliminating barriers to care for those who wait until they are sick to enroll; in other words, employees may enroll in an Exchange plan at any time and they will not be turned away or charged higher prices due to periods of being uninsured. The individual responsibility requirement, which also kicks in starting 2014, will max at the higher of $695 or 2.5 percent of an individual's salary. Due to the removal of risk in having uninsured periods, and the low penalty for failing to obtain insurance, many employees may prefer compensation through income rather than through health benefits.

Consumer-Directed Account Options: Starting in 2011, there will be some important changes to Health Savings Accounts (HSAs), Flexible Spending Arrangements (FSAs), and the high-deductible health plans (HDHPs) that are paired with them. First (in 2011), the penalty for non-qualified purchases from HSAs (buying things not approved for tax-free purchase) is increased to 20 percent. At the same time, HSA and FSA funds will no longer be permitted to purchase certain items, including most over-the-counter medication without a prescription. In 2013 FSA contributions will be limited to $2,500 per year, although the amount will be adjusted every year for inflation. In late 2010 HDHPs will need to meet the new rules relating to 100 percent coverage of preventative services, no lifetime and annual benefits, and no rescissions. New out of pocket limits could limit the usefulness of HDHPs to employers by distancing enrollees from their actual costs. As a result of these changes, HDHPs will be more expensive, and the accounts will be less flexible for consumers – so some employees may be less interested in using these rather than traditional PPO plans.