Health Care Reform: Implications for Employers After the 2012 Election

While the regulatory landscape of the Affordable Care Act (ACA) continues to evolve, employers must focus on implementing upcoming group health plan mandates. This article provides a high-level checklist of the most common long-term requirements facing employers and some strategic considerations, outlining the three possible health care strategies employers generally should consider for 2014 and later. Although specific implementation will depend on each employer’s particular situation, group health plan design, and regulatory guidance, the complexity involved means that employers are well advised to begin this process sooner rather than later.

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With the fanfare of the presidential inauguration behind him, President Barack Obama will continue to face a Democratic Senate and a Republican House of Representatives. While some are concerned that little legislation will pass due to the congressional split, it’s possible Congress could pass technical correction legislation affecting the Affordable Care Act (ACA). That said, regulatory action related to ACA continues at a rapid pace. And while employers should continue to monitor the release of new guidance by the government, they must also focus on complying not only with currently effective ACA employer mandates, but also with the mandates that will become effective in the coming years. While some of these mandates are relatively straightforward, compliance with other requirements will require financial analysis, coordination with third parties and strategic planning. This article provides a checklist of many of the major long-term requirements facing employers and some strategic considerations.

Required for Plan Years Beginning on or After January 1, 2014

No Annual Dollar Limits on Essential Health Benefits

Sponsors of group health plans that currently impose permissible annual dollar limits on essential health benefits (EHBs) (i.e., $2 million for plan years beginning on or after September 23, 2012 but before January 1, 2014) will have to eliminate those limits. In addition, the waivers that plans with lower limits received from the Department of Health and Human Services (HHS) and the class exemption for standalone health reimbursement arrangements (HRAs) will expire. Recently released frequently asked questions (FAQs) provide that HRAs will not violate the prohibition on annual and lifetime dollar limit on EHBs if the HRA is integrated with group health plan coverage that complies with the rules and the employee is enrolled in both coverages.

Also, for 2014, employers that currently impose annual
or lifetime dollar limits on benefits that they believe are not EHBs, such as bariatric surgery or infertility treatments, will have to ensure that their plan’s definition of EHB is authorized by HHS.

**No Preexisting-Condition Exclusions for Any Enrollee**

Sponsors of group health plans that currently impose a preexisting-condition exclusion on enrollees aged 19 and older will have to eliminate that exclusion.

**Coverage of Children up to the Age of 26 Even if Eligible for Other Health Coverage**

Grandfathered plans will have to make coverage available to children under the age of 26 even if they are eligible for other employee coverage.

**No Waiting Periods in Excess of 90 Days**

Sponsors of plans that currently require otherwise eligible employees to wait more than 90 days to enroll will have to shorten those waiting periods to no more than 90 days. This includes plans that currently provide coverage to begin on the first day of the month following 90 days of employment.

**Coverage for Individuals Participating in Approved Clinical Trials**

Nongrandfathered plans will be required to cover routine patient costs incurred in connection with approved clinical trials. Routine patient costs include items and services typically provided under the plan for a participant not enrolled in a clinical trial and do not include the investigational item, device or service itself.

**No Discrimination Against Providers Acting Within the Scope of Their Licenses**

Nongrandfathered plans will be prohibited from discriminating against health care providers acting within the scope of their licenses when providing services covered by the plan.

**Autoenrollment of Full-Time Employees**

Following the issuance of regulations, employers with at least 200 employees will be required to automatically enroll full-time employees into one of their health plans following the completion of any applicable waiting period. The Department of Labor has indicated that employers will not need to comply with this requirement until final regulations are issued.

**Required in 2015**

**Annual Reporting of Availability of “Minimum Essential Coverage” to IRS and Statements to Full-Time Employees**

In 2015, employers subject to the shared-responsibility penalties and certain other employers that offer "minimum essential coverage" will be required to submit a report to the Internal Revenue Service (IRS) that contains information about the coverage provided or made available to their full-time employees in 2014. In addition, by January 31, 2015, the employers will have to provide a written statement to each full-time employee whose name appears on the report to IRS regarding that coverage. IRS is working on its approach, but the information will be used for purposes of administering the individual mandate and the shared-responsibility penalties. This annual reporting/disclosure requirement will also apply for subsequent years.

**Effective in 2018**

**Excise Tax on High-Cost Employer Plans (“Cadillac Tax”)**

Beginning in 2018, an excise tax will be imposed on the aggregate value of employer-sponsored health coverage that exceeds certain thresholds. The tax will be equal to 40% of the aggregate value in excess of $10,200 for individual coverage and $27,500 for family coverage. These thresholds are subject to adjustment, and there are also higher thresholds for certain retirees and individuals in high-risk professions.

In the case of an insured plan, the tax will be assessed on the insurer providing the coverage. In the case of a self-insured plan, the tax will be assessed on the third-party administrator or on the employer if the plan is self-administered.

**Other Design Considerations**

**Availability of Exchange Coverage**

One of the most significant long-term strategy issues for plan sponsors is to determine the extent to which they will...
consider the availability of health coverage through the health benefit exchanges when fashioning their active and retiree medical offerings. Beginning in 2014, the exchanges will be the health insurance marketplace where individuals and small employers (i.e., generally employers with 100 or fewer employees) will be able to purchase coverage. Although large employers (i.e., those with more than 100 employees) will not be able to sponsor a plan through an exchange initially, their employees and retirees can purchase coverage through an exchange even if eligible for employer-sponsored coverage. Starting in 2017, ACA permits (but does not require) states to open exchanges to large employers.

States have the option of establishing their own exchanges, partnering with the federal government or, if a state is not certified or has indicated that it either will not be ready or will not establish an exchange, the federal government will step in to implement and run the exchange. The federal government has provided states with flexibility in establishing, coordinating, partnering and running exchanges. In order to be ready for open enrollment, these exchanges must be operational by the fall of 2013.

**Federal Assistance for Employees and Retirees**

**Purchasing Exchange Coverage**

Lower income individuals who buy coverage through an exchange may be eligible for federal subsidies in the form of a premium tax credit and/or cost-sharing assistance. A premium tax credit, which decreases as income increases, will be provided to individuals with household income from 100% to 400% of the federal poverty limit (FPL) while cost-sharing assistance is available to those individuals with household income less than 250% of FPL. Individuals eligible for employer-sponsored coverage are not eligible for these federal subsidies unless the employer’s coverage is deemed unaffordable (i.e., the employee contribution for “employee-only coverage” exceeds 9.5% of the individual’s household income) or if the employer plan does not provide minimum value (i.e., have an actuarial value of at least 60%).

**Exchanges and the Shared-Responsibility Penalties**

Beginning in 2014, large employers (i.e., employers that employed an average of at least 50 full-time employees on business days during the preceding calendar year) may be subject to one of two “shared-responsibility” penalties. An employer that fails to offer health coverage to its full-time employees and their dependents may be subject to a nondeductible “play-or-pay” penalty if any full-time employee (generally, an employee who works on average at least 30 hours per week) enrolls for coverage through an exchange and receives a premium tax credit or reduced cost sharing. The maximum annual play-or-pay penalty is $2,000 for each full-time employee of the employer, disregarding the first 30.

Large employers that offer health coverage to their full-time employees and their dependents will potentially be subject to a nondeductible play-or-pay penalty for each full-time employee who enrolls in exchange coverage and receives a premium tax credit or reduced cost sharing because the coverage fails to provide minimum value or is unaffordable. The maximum annual play-or-pay penalty is $3,000 for each full-time employee who enrolls in exchange coverage and receives a premium tax credit or reduced cost sharing, subject to the maximum penalty that could be imposed if no coverage had been offered. IRS recently issued proposed regulations on employer shared-responsibility penalties.

**Employer Strategies**

There are generally three possible health care strategies that employers should consider for 2014 and later:

1. Drop employer-sponsored health care coverage
2. Drop employer-sponsored health care coverage and subsidize exchange coverage
3. Continue employer-sponsored health care coverage.

The approach an employer takes could vary depending on the nature of the employer’s business, operations and workforce. Any adopted strategy needs to reflect the employer’s overall benefit philosophy and maintain its ability to attract and retain a productive workforce.

**Drop Coverage**

One strategy an employer can consider is to stop offering employer-sponsored health care coverage for all employees and retirees and let them purchase coverage through the exchanges. Large employers could be subject to the play-or-pay penalty. However, in some cases, it could
be more economically advantageous for an employer to pay the penalties.

Subsidize Exchange Coverage

Employers that discontinue offering health coverage may want to provide additional compensation to employees to offset the loss of those benefits. However, determining how to appropriately compensate employees will be difficult since not only will the cost of exchange coverage vary by demographic factors such as age, family size and location, but subsidies provided through the exchange will also vary significantly. Higher income employees will not be eligible for exchange subsidies. An increase in compensation will also be taxable income for the employee, which will reduce the value of the compensation.

Continue Employer-Sponsored Coverage

An employer’s third option is to continue to offer health coverage to its employees. This will require the employer to make any required modifications to its group health plans and plan administration to comply with ACA requirements that are effective in 2014 and later. Employers that offer coverage only to full-time employees, and define full-time work as more than 30 hours a week, will need to determine whether they are excluding some employees who will be considered full-time for purposes of the shared-responsibility penalties. Similarly, employers with large part-time populations will need to track work hours carefully or realign work schedules to avoid potential penalties. Some employers are also considering the advantages of private exchanges, a relatively new product in the marketplace that combines administrative ease and cost control.

Conclusion

While the regulatory landscape of the health care reform law continues to evolve, employers must focus on implementing upcoming group health plan mandates. The specifics will depend on each employer’s particular situation, group health plan design and regulatory guidance, but there is little doubt that many of the mandates will require detailed financial analysis, coordination with third parties and strategic planning with trusted advisors and legal counsel. Given this complexity, employers are well advised to begin this process sooner rather than later.

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