PPACA Is (mostly) Constitutional ... SO NOW WHAT?

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On June 28, 2012, the U.S. Supreme Court issued a 5-4 decision that ruled the requirement to purchase health insurance under the Patient Protection and Affordable Care Act ("PPACA") to be constitutional under Congress' power to tax the citizenry. With that ruling, the law began marching forward, and insurance companies and employers began a mad scramble to comply. Unless PPACA is repealed or significantly modified through the legislative process, it is sure to change the landscape of the employer-sponsored health insurance world forever.

Without getting into the pros and cons of this sweeping law, I would like to discuss the law's five main parts and some of the implications they have for employers. These bullet points are merely a brief summary of some of the requirements of the law, and areas employers should be studying. This article should not be considered legal advice or a thorough summary of the law's requirements.

Five Major Parts of PPACA:

- **The individual mandate**, which requires Americans to purchase health insurance (either individually, through their employer, or through a government program) or pay a penalty (*i.e.*, tax) if they don't.
- **The employer mandate,** which requires employers with 50 or more full-time equivalent employees ("FTEs") to provide health insurance to their employees or pay a penalty. This part is often referred to as the "play or pay" requirement.
- **Restrictions and requirements for health insurers,** which require, among other things, that health insurers accept all applicants; pay rebates to employers in a given state if they don't satisfy certain prescribed medical loss ratios ("MLR") by spending at least 80% of premiums on claims (85% for employers with 50 or more employees); limit and eventually remove pre-existing condition limitations; charge all insured groups the same rate (with a few limited exceptions for age, tobacco use, family structure and geographic area); and offer certain government-mandated health plans.
- **Small Business Health Option Program ("SHOP") Exchanges:** By **January 1, 2014**, each state is required to develop and implement an internet-based health insurance exchange. If a state chooses not to do so, the federal government will set one up and run it for that state. The Exchanges are being touted as a "one-stop marketplaces of private health insurers" that will allow individuals and small businesses to compare and purchase health insurance at an affordable price. Exchanges are expected to be opened up to employers with more than 100 employees no earlier than **January 1, 2017**.
- **Subsidies:** There are three types of subsidies (in the form of a tax credit) available to individuals who purchase their health insurance through a SHOP Exchange: (1) premium limits; (2) cost sharing limits (*e.g.*, deductibles, co-payments and co-insurance); and (3) out-of-pocket spending limits. The amount of the subsidy depends on the individual's income in relation to the federal poverty level guidelines, but for 2012, an individual with income of nearly $45,000, and a family of four with income of slightly more than $92,000, could qualify for a subsidy.

Employer Requirements of PPACA:

- **Employer "Play or Pay" Mandate:** Beginning in 2014, employers with 50 or more FTEs (generally) will have to either offer a minimum level of health insurance, or be subject to a financial penalty. FTEs are those who work 30 or more hours per week, and include part-time employees based on their aggregate monthly hours divided by 120. There are two types of penalties: (1) employers that do not offer health coverage to FTEs will pay a penalty of $2,000 per FTE (with the first 30 FTEs being exempt from the penalty); and (2) employers that offer coverage that is deemed inferior to the government-mandated coverage or that is unaffordable will pay a penalty of $3,000 per FTE who receives a government subsidy (with the maximum penalty being no more than $2,000 times the number of FTEs).
- **Shared Responsibility Mandate (Individual):** Although this requirement isn't directed at employers, it is certain to affect employers. This mandate requires individuals to obtain "minimum essential coverage" or pay a penalty. There are some exemptions to this requirement, but generally, the penalty will be the greater of a dollar penalty, or a percentage of the household's income. In **2014**, the penalty is the greater of $95 or 1% of household income. In **2015**, the penalty increases to $325 or 2% of household income, and in **2016**, the penalties go to $695 or 2.5% of household income.

- **Nondiscrimination requirement (grandfathered plans exempt):** PPACA prohibits insured group health plans from discriminating in favor of highly-paid employees, and imposes an excise tax and/or civil penalty of up to $100 per day per individual. This restriction has applied to self-funded plans for years, but PPACA extended it to non-grandfathered fully-insured plans. This provision, which would prohibit differences in eligibility, waiting periods, and benefits, was slated to go into effect in 2010, but has been postponed by the IRS until further guidance can be issued.

- **W-2 Reporting:** Beginning **January 2013**, employers that furnish 250 or more W-2s must annually report the aggregate cost of the applicable employer-sponsored health coverage to each employee. The first such W-2 will report the cost for the 2012 calendar year. This information is for "informational" purposes only, and will not affect amount includible in income.

- **Tax Credits:** PPACA tax credits have been available from 2010-13, but in 2014, the rules will change. Effective **January 1, 2014**, the federal government will offer tax credits to certain employers with 10 or fewer FTEs and average annual wages of up to $25,000 (partial credit is available up to 25 FTEs and an average annual wage of up to $50,000). The credit is up to 50% of the employer's contribution toward the health insurance premium, but it is prorated based on the number of FTEs and the applicable average wage. Employees must enroll in the employer's health plan through a SHOP Exchange, and the tax credit is only available for two consecutive tax years.

- **Automatic Enrollment:** PPACA requires certain large employers (more than 200 full-time employees) to automatically enroll new full-time employees in one of the employer's health benefit plans (subject to the applicable waiting period), and to continue the enrollment of current employees. Although PPACA doesn't specify the effective date of the automatic enrollment provisions, it is expected that this requirement will become effective in 2014 or later.

- **Uniform Summary of Benefits and Coverage ("SBC"):** For any plan year enrollment period on or after **September 23, 2012**, the group health plan and insurer must provide applicants and enrollees a uniform summary of benefits and coverage. If the plan is fully insured, the responsibility for disseminating the SBC lies with both the insurer and the employer. If the plan is self-funded, it is solely the responsibility of the plan administrator (*i.e.*, the employer that is the plan sponsor) to provide the summary to the applicants and enrollees. The summary must be provided on initial enrollment, renewal, re-enrollment, and/or on request. The penalty for non-compliance with this requirement is stiff at up to $1,000 for each failure, and a failure with respect to each participant or beneficiary constitutes a separate offense.

- **Medical Loss Ratio Rebates:** If an insurer is required to rebate a portion of premiums due to the MLR provisions of PPACA, the employer must figure out how to handle the rebate. When it comes to handling MLR rebates, great caution is warranted. If the employees have contributed to the premium during the relevant MLR period, the employer must ensure an appropriate portion of the rebate goes to the exclusive benefit of the plan and participants. Because such funds are subject to the fiduciary requirements of the Employee Retirement Income Security Act ("ERISA"), non-compliance with this requirement can have serious consequences for the employer and for individuals. This penalty/tax is determined on a monthly basis.

- **Additional tax and withholding:** As of **January 1, 2013**, an additional tax of 0.9% will apply to individuals who earn $250,000 or more (married and filing jointly). Employers are required to withhold the tax on wages above $200,000.

- **Health Flexible Spending Account ("FSA") Cap:** Effective for plan years beginning on or after **December 31, 2012**, there will be a $2,500 limit on salary contributions toward FSAs offered under cafeteria plans.

- **Preventive Health Coverages (grandfathered plans exempt):** Effective for plan years on or after **August 1, 2012**, new preventive health services for women (*e.g.*, contraception, breastfeeding support, and domestic violence support) must be covered with no cost sharing.

- **Clinical Effectiveness Fee:** A fee of $2.00 per covered life ($1.00 in the first year) will be imposed on all covered lives. Insurers are going to have to pay the fee if the plan is insured, and employers will have to pay the fee if the plan is self-funded.

- **The Cadillac Tax:** In 2018, the federal government will impose a penalty on employer-sponsored health coverage that is deemed "too rich." The penalty will be in the form of a non-deductible excise tax that will be 40% of the excess benefit per covered employee. This excess benefit is the aggregate cost (adjusted annually) of the benefit in excess of the threshold amounts of $10,200 for single coverage and $27,500 for family coverage.

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