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Health-Care Reform Changes Affecting Employers

While the new health care reform law does not require employers to provide employee health benefits, the law does impose penalties and offers incentives to encourage employer participation.

The 2010 Patient Protection and Affordable Care Act (ACA) is in many ways little more than a framework for change. Regulation and guidance is ongoing, and will ultimately shape this initiative. The following is a brief overview of some of the ACA provisions that employers should be aware of.

Small employer tax credit

As of 2010, if you employ fewer than 25 full-time equivalent employees (FTEs) with average annual wages of less than $50,000, and you contribute at least 50% toward the cost of your employees' health insurance, you may qualify for a small employer tax credit. Through 2013, the credit is up to 35% (25% for tax-exempt eligible small employers) of the lesser of your actual cost for health insurance coverage, or the amount of contributions you would have made during the taxable year if each employee had enrolled in coverage based on a benchmark premium.

The full credit is available if you have 10 or fewer FTEs with average annual wages below $25,000. The credit is reduced if you have more than 10 FTEs (but less than 25 FTEs) and/or pay average annual wages greater than $25,000 (but less than $50,000).

For taxable years beginning with 2014, the maximum credit increases to 50% (35% for qualified charitable employers), but only if you purchase health insurance through a state-sponsored health insurance Exchange, and it is only available for two consecutive years thereafter.

Play or pay

While employers are generally not required to offer health insurance to employees, effective January 1, 2015, if you're a large employer (you have an average of at least 50 full-time employees) and do not offer health insurance to your employees, you may have to pay a monthly fee of $166.67 ($2,000 per year) per full-time employee (excluding the first 30 employees) for any month coverage is not offered. The fee applies if at least 1 of your full-time employees enrolls in a state-sponsored health insurance Exchange and qualifies for a premium tax credit or cost-sharing reduction. Part-time employees are included when determining if you have 50 employees, based on the total hours worked per month divided by 120.

Even if you do offer coverage, you'll be assessed a fee for each month that at least 1 full-time employee enrolls in an Exchange and qualifies for a premium tax credit or cost-sharing reduction, because your plan's share of total cost is less than 60%, or as a result of the coverage you provide being considered unaffordable for that employee. In this case, the monthly fee is equal to the lesser of $250 ($3,000 per year) per full-time employee receiving a credit or reduction, but no more than the fee you would be subject to if you offered no health-care insurance at all.

Also beginning in 2014, employers with more than 200 full-time employees that offer health insurance must automatically enroll new full-time employees, subject to a waiting period of no longer than 90 days.

Other employer incentives

By 2014, in an effort to promote wellness and decrease health insurance costs, employers will be able to offer employees rewards, such as premium discounts and added benefits, for participating in wellness programs and meeting certain health-related standards. The value of the rewards can equal as much as 30% of the cost of coverage and may even reach 50% in some cases.

Employers who provide insurance for retired employees who are age 55 or older, but not yet eligible for Medicare, may receive reimbursement for 80% of retiree claims between $15,000 and $90,000. This temporary reinsurance program begins in 2010 and is available until 2014. On the other hand, employers who currently receive a tax deduction for Medicare Part D drug subsidy payments will see that deduction eliminated in 2013.

SHOP Exchanges

Small Business Health Option Programs, or SHOP Exchanges, are scheduled to be in each state by 2014. These state-run Exchanges allow employers with fewer than 100 full-time employees the option of buying health insurance for their employees as part of a "purchasing pool" in an effort to lower premium costs.

Group health plan coverage requirements

Group health plan requirements under the health-care legislation directly apply to insurers. However, most of these provisions are incorporated by reference into ERISA and the Internal Revenue Code, extending their application to employers offering group health insurance. Beginning in 2010, some important group health plan requirements include:

- As of 2010, group plans that offer coverage for dependent children must extend the age for dependent coverage to age 26. For plans in existence prior to March 23, 2010 (the date of legislative enactment), the extension of dependent coverage applies only if an adult child is not eligible to enroll in any other eligible employer-sponsored health plan.
- As of 2010, coverage for a plan participant cannot be rescinded except for fraud or intentional misrepresentation, and plans may not impose pre-existing condition exclusions with respect to children under age 19.
- As of 2010, plans may not impose lifetime limits on the dollar value of essential health benefits for plan participants and beneficiaries. Essential health benefits are intended to include those benefits customarily provided under a typical employer health plan, as defined by the Secretary of Health and Human Services. Beginning in 2014, plans cannot impose annual coverage limits for essential health benefits.
- Most preventive care services and immunizations recommended by the U.S. Preventive Services Task Force will not be subject to deductibles, co-pays, and co-insurance. (Plans in existence on or before March 23, 2010, are exempt from this provision.)
- By 2012, most employers must meet certain reporting and disclosure requirements, which include providing a summary of plan benefits and annual reports to participants; reporting annual enrollment and claims practices to the Secretary of Health and Human Services; and providing premium and coverage information to the IRS.
- For plan years beginning on or after January 1, 2014, plans may not impose pre-existing conditions on any plan participant or beneficiary.

Tax provisions

For taxable years beginning January 1, 2011, you must include the aggregate cost of group health plan benefits (with some exclusions) provided to employees on Form W-2. And, effective January 1, 2013, employers will be responsible for collecting and reporting an increase of 0.9% in FICA taxes on wages above $200,000. The increase applies only to the employee-paid portion of FICA taxes.

If you sponsor a group health plan, you may be assessed a tax of two dollars or more per average number of insured lives beginning in 2012. The tax is intended to finance a comparative effectiveness research program measuring the value of various medical interventions. The tax is scheduled to sunset after September 30, 2019.

Health-care legislation makes changes to health savings accounts (HSAs), Archer medical savings accounts (MSAs), flexible spending accounts (FSAs), and health reimbursement accounts (HRAs) that affect both plan participants and employers. Beginning January 1, 2011, over-the-counter drugs no longer qualify for distributions/reimbursements under HSAs, Archer MSAs, health FSAs, and HRAs. In addition, the tax on nonqualified distributions from HSAs or Archer MSAs increases to 20% in 2011. Beginning in 2013, contributions to health FSAs are limited to $2,500 per year.

In 2018, a 40% excise tax is imposed on certain group health plans (excluding long-term care, vision, and dental plans) if the annual cost exceeds $10,200 for single coverage and $27,500 for family coverage, indexed for inflation.
