Special Report –

Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Affordability Reconciliation Act
The Employer Mandate Explained - April 19, 2010

The recently enacted Patient Protection and Affordable Care Act as amended by the Health Care and Education Affordability Reconciliation Act (referred to as PPACA) will have a significant impact on midsize and large employers. It will be costly and burdensome for these employers in the near and midterm.

PPACA contains numerous benefit mandates, new recordkeeping and reporting obligations that are stunningly complex. The single biggest financial impact for mid and larger size employers will be the employer mandate that is effective for plan years after December 31, 2013.

Employer Mandate

The Patient Protection and Affordable Care Act (PPACA) requires that effective December 31, 2013 (or the first plan year anniversary thereafter) that large employers (see definition below) must provide coverage to their full-time employees or pay a financial penalty.

Large Employers

The mandate applies to "large employers." An employer is large if it employed an average of at least 50 full-time employees on business days during the preceding calendar year.

There is, however, an exception where (1) the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and (2) the employees in excess of 50 employed during the 120 day period were seasonal workers. (It is odd, and perhaps an error, that this rule refers to a workforce in excess of 50, whereas the general rule requires only 50 full-time employees to be large.)

For this purpose, a seasonal worker is one who performs labor or services on a seasonal basis as defined by the Secretary of Labor.

The term includes retail workers employed exclusively during holiday seasons.

Solely in determining whether an employer is a large employer for purposes of the penalty tax, an employer must count not only its full-time employees for a month, but must add to that a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

That is, employees must be counted in terms of full-time equivalents.

In determining an employer's size, companies will be aggregated as a single employer under the Tax Code's control group and similar aggregation rules.

For an employer that was not in existence throughout the preceding calendar year, the determination will be based on the average number of employees the employer is reasonably expected to employ on business days in the current calendar year.

An employer will be considered to include a predecessor employer.

A full-time employee for this purpose is one who is employed on average at least 30 hours of service per week.

The Secretary of HHS, in consultation with the Secretary of Labor, is to prescribe guidance for determining an employee's number of hours of service, including rules for employees not compensated on an hourly basis.

Employer Liability

There are two scenarios in which a large employer may be required to pay a penalty (in the form of a nondeductible excise tax).

First, it will be liable for a penalty if (a) it fails to offer its full-time employees (and their dependents) the opportunity to enroll in "minimum essential coverage" under an "eligible employer-sponsored plan" for any month, and (b) at least one full-time employee has been certified to the employer as having enrolled for that month in a qualified health plan with respect to which the employee is entitled to a premium tax credit or cost-sharing reduction.

In this event, the employer must pay an amount for the month equal to the product of (a) the "applicable payment amount," and (b) the number of full-time employees employed by the employer during the month, reduced by 30 employees.

The "applicable payment amount" means, with respect to any month, 1/12th of $2,000 (or $166.67).

For calendar years after 2014, this dollar amount, and the other employer penalties described below, will be increased to the extent appropriate under an indexing scheme described in the new law.

The second way in which a large employer may be assessed a payment is where (a) it offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan for a month, but (b) one or more full-time employees has been certified to the employer as having enrolled for that month in a qualified health plan with respect to which the individual is entitled to a premium tax credit or cost-sharing reduction.

In that event, the employer must pay an amount, but only for those full-time employees enrolled in a qualified health plan who were allowed a premium tax credit or cost-sharing reduction.

The penalty for the month will equal the product of (a) the number of the employer's full-time employees in a qualified health plan who are entitled to a premium tax credit or cost-sharing reduction, and (b) 1/12th of $3,000 (or $250).

There is an overall limit on the aggregate amount of tax for any month for which the employer offers the opportunity to enroll in minimum essential coverage. That overall limit is the product of (a) the "applicable payment amount" (1/12th of $2,000), and (b) the number of individuals employed by the employer as full-time employees during the month, reduced by 30 employees.

Note that for a large employer to avoid an excise tax under the employer mandate, it must offer full-time employees (and their dependents) the opportunity to enroll in "minimum essential coverage" (and it cannot have any full-time employees purchasing qualified health plans who receive a premium tax credit or cost-sharing reduction).

Though the law is not entirely clear on this point, it appears that "minimum essential coverage" may be a pretty low bar to clear.

This term is different from the term "essential health benefits." The latter describes the benefits that must be included in qualified health plans offered through an exchange.

The "minimum essential coverage" requirement seems basically to be a requirement that the coverage not be "excepted benefits" under the Public Health Service Act, though for non-grandfathered plans there is some chance the term could be interpreted to mean any coverage of a type sold by insurers in the large group market (whether or not through an exchange).

Generally, "excepted benefits" are the following:

- Coverage only for accident, or disability income insurance, or any combination thereof
- Coverage issued as a supplement to liability insurance
- Liability insurance, including general liability insurance and automobile insurance
- Workers' compensation or similar insurance
- Automobile medical payment insurance
- Credit-only insurance

- Coverage for on-site medical clinics
- Other similar insurance coverage specified in regulations, under which benefits for medical coverage are secondary or incidental to other insurance benefits
- Any of the following if provided under a separate policy, certificate, or contract of insurance:
- Limited scope dental or vision benefits
- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof
- Other limited benefits similar to those in the two bullets above, to the extent specified in regulations
- Coverage only for a specified disease or illness
- Hospital indemnity or other fixed indemnity insurance
- Medicare supplemental health insurance, coverage supplemental to TRICARE, or similar coverage supplemental to coverage under a group health plan

At bottom, the effect of the employer mandate rules is that large employers must either offer coverage to all full-time employees or run the risk of having to pay a nondeductible excise tax.

For reasons we will explain below (relating to which employees are eligible for a premium tax credit or cost-sharing reduction), to be certain to avoid a penalty an employer must offer “affordable” health coverage to all its full-time employees (and their dependents), and the plan must be structured so participants do not pay more than 40 percent of covered claims costs.

For this purpose, coverage will be considered affordable only if an employee’s premium is no more than 9.5 percent of the employee’s household income. (This percentage will be indexed to the per capita growth in premiums for the health insurance market.)

Though not clear, it appears the 40 percent limitation is intended to be measured by the percentage (or perhaps expected percentage) of covered claims plan participants must pay, taking into account any deductibles, co-pays, and coinsurance levels they are required to pay under the terms of the plan.

In other words, it appears this means that the plan must bear at least 60 percent of the cost of covered claims.

If a large employer fails to offer all its full-time employees affordable coverage under a plan bearing at least 60 percent of the cost of covered claims, the employer will likely need to pay an excise tax.

In particular, it must pay an excise tax if any of its full-time employees purchases health insurance through the new insurance clearinghouses to be set up by the states (that is, the "exchanges") and the employee receives a premium tax credit or cost-sharing credit from the government in that connection.

The reason this is likely to occur is that most individuals will be required to have coverage, and they will typically be eligible for some credit if their household income is between 100 percent and 400 percent of the federal poverty level (the "FPL").

The FPL depends on family size, but for the 48 contiguous states and the District of Columbia, the FPL for 2010 for a family of one is $10,830. For a family of three the FPL is $18,310.

For a family of five it is $25,790. For a family of seven it is $33,270. These are examples; there is a fuller table published by the federal government.

Since individuals with household incomes as high as 400 percent of these numbers may be eligible for a premium tax credit or cost-sharing credit from the government, it seems likely that most employers will have to pay an excise tax unless they provide the mandated health coverage to all their full-time employees, or at least to all full-time employees whose household incomes are between 100 percent and 400 percent of the FPL.

Otherwise, an employer runs the risk an employee will not have the required coverage under a spouse's employer's plan, and will therefore use the premium tax credit to purchase coverage under an exchange, which in turn will subject the employer to penalty.

Penalty Amount

Remember, as noted above, the amount of the penalty (the excise tax) an employer must pay will depend on whether the employer offers coverage (whether or not that coverage is affordable, and whether or not the plan pays at least 60 percent of covered claims costs).

If it does not offer its full-time employees and their dependents the opportunity to enroll in health coverage, the annual penalty is the product of (a) the employer's total number of full-time employees in excess of 30, and (b) $2,000. So, for example, assume that in 2014 a large employer does not offer its full-time employees coverage.

Let's say it has 100 full-time employees, 10 of whom receive a tax credit for the year for enrolling in a state exchange-offered health plan. For each full-time employee over 30, the employer would owe $2,000, for a total penalty of $140,000 (this is (100-30), multiplied by $2,000).

Although full-time equivalent employees are counted in determining whether an employer is large, they are not counted in calculating the excise tax. As noted earlier, the $2,000 figure will be indexed for years after years 2014.

If an employer does offer its full-time employees and their dependents coverage (again, whether or not that coverage is affordable, and whether or not the plan pays at least 60 percent of covered claims costs), but one or more of those full-time employees nevertheless chooses instead to purchase coverage through an exchange and receives a premium tax credit or cost-sharing reduction for doing so, the employer must pay a penalty of $3,000 for each such employee.

This $3,000 figures will be indexed for years after 2014. Unlike the $2,000 penalty applicable to an employer that does not offer coverage, and which applies to the total number of full-time employees in excess of 30, this $3,000 penalty applies only to those full-time employees who actually receive the premium tax credit or cost-sharing reduction.

This penalty is capped at the amount the employer would be required to pay if it did not offer coverage, which is its number of full-time employees in excess of 30, multiplied by $2,000.

So, let's assume that in 2014 a large employer offers coverage and has 100 full-time employees, 20 of whom nevertheless receive a tax credit for the year for enrolling in a state exchange-offered plan. For each employee receiving a tax credit, the employer would owe $3,000, for a total penalty of $60,000.

The maximum penalty for the employer would be capped at the amount of the penalty it would be assessed for a failure to provide coverage, which would be $140,000 ($2,000 multiplied by 70 (100-30)). Because the $60,000 penalty is less than this cap, the employer would owe $60,000.

Avoiding the Potential for Any Penalty

Importantly, an employee is not entitled to a premium tax credit (or cost-sharing reduction) if her or his employer offers to the employee affordable coverage, and the plan's share of the total costs of benefits is at least 60 percent.

Because an employer is not responsible for any excise tax unless one of its full-time employees receives a tax credit for purchasing coverage through an exchange, if an

employer offers all its full-time employees affordable coverage under which the plan's share of the total cost of benefits is at least 60 percent, the employer cannot owe any penalty.

This will be true even if some of the employer's full-time employees decline coverage and instead purchase coverage through an exchange. Their doing so would not hurt the employer because those employees would not be eligible for a premium tax credit since the employer offered them adequate coverage.

Of course, offering "affordable" coverage raises an administrative difficulty since whether a plan is affordable for an employee depends on the employee's household income, which the employer typically will not know.

The law is, unfortunately, not clear as to which of the two penalties regimes ((a) $2,000 multiplied by all full-time employees over 30, or (b) $3,000 multiplied only by the number of full-time employees receiving the premium tax credit or cost-sharing reduction) applies where an employer offers coverage to some, but not all, of its full-time employees.

Under what seems to us the more logical reading of the law, where an employer offers some but not all of its fulltime employees coverage, the applicable rules are probably those that apply where an employer offers no coverage.

That is, the more logical result would seem to be to apply the rules subjecting the employer to a penalty of $2,000 multiplied by the total number of its full-time employees in excess of 30.

Automatic Enrollment

The legislation modifies the Fair Labor Standards Act (the "FLSA") to require that an employer with more than 200 full-time employees that offers employees enrollment in one or more health benefit plans automatically enroll new full-time employees in one of those plans (subject to any permissible waiting period) and continue the enrollment of current employees.

Employees must be provided with adequate notice of this automatic enrollment program and of the employees' opportunity to opt out of coverage in which they were automatically enrolled.

State laws are superseded to the extent they would prevent an employer from instituting automatic enrollment.

This preemption provision is presumably addressed in part at state prohibitions on taking deductions from employees' paychecks to pay for coverage without the employees' express consent.

The effective date of this requirement is unclear. One possible reading is that it is not effective until the Secretary of Labor issues regulations providing guidance on the requirement.

Notice to Employees

The Fair Labor Standards Act was amended to provide that an employer subject to the FLSA must, effective March 1, 2013, provide to each employee at the time of hiring (or with respect to current employees, no later than March 1, 2013), a written notice with certain information concerning health coverage.

This notice must inform an employee (1) of the existence of an exchange, including a description of the services to be provided by that exchange and the way in which the employee may contact the exchange to request assistance, (2) if the employer's plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of those costs, that the employee may be eligible for a premium tax credit and a cost-sharing reduction if she or he purchases a qualified health plan through the exchange, and (3) if the employee purchases a qualified health plan through the exchange, that she or he will lose any employer contribution to any health benefits plan offered by the employer, and that all or a portion of that employer contribution may be excludible from income for federal income tax purposes.

At least for 2013, this new notice will need to be carefully drafted to avoid confusion. That is because the exchanges may not be operational until 2014, yet employers will be providing notices as early as March 1, 2013, when the particulars of how the exchanges will operate may not yet be fully clear.

Reporting of Employer Health Insurance Coverage

Effective for periods beginning after December 31, 2013, the Tax Code reporting requirements have been modified to require large employers (generally, those with at least 50 fulltime employees) to provide information about any health coverage they offer.

In particular, a large employer must include a certification as to whether it offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan.

If the employer does offer such coverage, it must describe the length of any waiting period with respect to that coverage, the monthly premium for the lowest cost option

in each "enrollment category" under the plan, and the employer's share of the total allowed cost of benefits provided under the plan.

A large employer must also report the number of its full-time employees for each month, and provide certain information about each of its full-time employees covered under any of its health plans.

In addition to reporting this information to the Treasury, the employer must provide a statement to employees covered under the plans with respect to which the employer was required to report. This statement must be provided to employees by January 31 of the year following the calendar year for which the return was required to be made by the employer.

Reporting Cost of Health Coverage on W-2

Effective for years beginning after December 31, 2010, an employer must report on an employee's W-2 the aggregate cost of the employee's health insurance coverage sponsored by the employer, excluding the amount of any salary reduction contribution to a flexible spending arrangement.

Free Choice Vouchers

Effective January 1, 2014, employers that offer minimum essential coverage through an eligible employer-sponsored plan and pay a portion of that coverage must provide qualified employees with a voucher the value of which can be applied by an employee to purchase of a health plan through an exchange.

Qualified employees are employees (a) whose required contribution for employer-sponsored minimum essential coverage exceeds eight percent, but does not exceed 9.5 percent, of the employee's household income for the taxable year, and (b) whose total household income does not exceed 400 percent of the poverty line for the family. In addition, the employee must not participate in the employer's health plan.

For years after 2014, the eight percent and the 9.5 percent figures are indexed to a measure of excess premium growth over "income growth."

The voucher must have a dollar value equal to the employer's contribution to the employer-offered health plan.

If multiple plans are offered by the employer, the value of the voucher is the dollar amount that would be paid if the employee chose the plan for which the employer would pay the largest percentage of the premium cost.

The value of the voucher is for self-only coverage unless the individual purchases family coverage in the exchange.

Vouchers may be applied toward the monthly premium of any qualified health plan offered in the exchange.

The value of the voucher, to the extent it is used for the purchase of a health plan, is not includable in the employee's gross income.

If the value of the voucher exceeds the premium of the health plan chosen by the employee, the employee is paid the excess value of the voucher.

That excess amount received by the employee is includible in the employee's gross income.

If an individual receives a voucher, the individual is disqualified from receiving any tax credit or cost-sharing reduction for the purchase of a plan in the exchange. Similarly, if any employee receives a voucher, the employer will not be assessed a penalty under the employer mandate rules with respect to that employee.

If you are interested in obtaining more information about how PPACA will impact your organization or would like to discuss any other impact of the health care reform legislation please contact your IBP team or our practice leader.

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