OBAMA CARE, WHAT EMPLOYERS SHOULD DO NOW*

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Many of the provisions of the Patient Protection and Affordable Care Act ("ACA") relative to employers were scheduled to become fully effective by January 1, 2014. On July 2, 2013, the "employer mandate" provisions for employers of more than 50 employees were postponed to January 1, 2015. This historic legislation, enacted on March 23, 2010, fundamentally alters health care coverage provided by employers and changes it from essentially a privately arranged fringe benefit to a highly regulated government entitlement. Employers who have reviewed the ACA appreciate the significant impact this law can have on their business operations and employee compensation.

In the past, employers were free to offer a number of types of health insurance coverage to employees or to allow employees to elect other fringe benefits. Employees were free to decline health insurance coverage and to save their share of premium cost to be spent in other ways. Employees could elect to be covered only on the plan offered by their spouse's employer. Employers could allow employees to choose from an array of health care plans and could offer plans at different costs to different classes of employees and to offer coverage from more than one insurance company or health plan, including plans limited to catastrophic coverage. The only regulation of health insurance has been by various state Insurance Commissioners. Some of this flexibility continues but is now subject to complete control by the terms of the ACA.

Current health coverage selections may be limited but are likely to be sustainable choices into the future. For the most part, employers should rely on experienced benefits consultants for advice and expect that health insurance companies and health plans will offer coverage that meets the requirements of ACA. Employers are advised not attempt to master the complex and rapidly changing regulations and technical requirements being promulgated without competent assistance.

This paper focuses solely on current strategies to prepare for eventual compliance by employers with the various requirements of ACA. There are many other important provisions that are beyond the scope of this article such as the details of several plan options that would qualify under the ACA, amendments to Medicare and Medicaid, the creation of health insurance "exchanges," payments to hospitals and physicians and an array of new taxes. Finally, this discussion is not intended to be a comprehensive guide to ACA compliance, the Appendix of requirements, attached, is provided solely to illustrate the complexity of this law and the general nature of its requirements. The purpose of this paper is to provide recommendations regarding what to do now, in advance of implementation, in a time of considerable uncertainty.

*(The Department of the Treasury acted on July 2, 2013 to postpone the requirement that all employers of more than 50 employees must offer health insurance to their full time employees. As additional major administrative changes are made to the ACA, this paper will be revised to reflect those actions. This paper is current as of July 3, 2013.)

A Summary of the Affordable Care Act

Effective on January 1, 2015, all employers of more than 50 full time or full time equivalent employees must either offer a qualifying "affordable" health plan that meets detailed coverage standards to its full time employees, i.e. those regularly working more than 30 hours a week. To be "affordable" the employer must cover at least 60% of the cost of the coverage and the cost to employees cannot exceed 9.5% of their family or "household" income.

If an employer of more than 50 employees does not offer affordable health coverage, it may be required to pay a fine currently set at approximately $2000 per full time employee per year for all employees over 30 in number not so covered. Employees who do not have an available employer sponsored plan may, in most states, have the option of purchasing health insurance coverage from a government sponsored "Exchange." If employees purchase health insurance from an Exchange, they may be eligible for a subsidy that reduces the cost that coverage, based on household, not individual, income. These exchanges are in various stages of development by each state.

These are my recommendations to employers:

1. Retain the Services and Advice of an Experienced, Capable Benefits Consultant

The current volume of information required to be considered in order to understand the impact of ACA on a particular business is far beyond the capacity of most moderate size business and even the most sophisticated human resources program. Further, since Congress has already enacted amendments to this law, and is predicted to enact more changes as problems continue to surface, it is imprudent to base benefits decisions on either the internal assessment of HR staff or on the advice of a broker whose expertise is limited to health insurance selection. An employer needs the support of an organization that can provide continuous advice on a myriad of regulatory, program and policy changes. This will be a process of frequent adaptation.

This law impacts many more subjects than simply which health plan to offer your employees. What is needed is a broader perspective that includes advice on overall compensation strategies, the identification and treatment of different job classifications, spending accounts, payroll and time records and the means and methods for frequent adjustments to this law. The support and advice of a full service benefits consultant should be retained and the contract should require accurate and complete advice regarding compliance with ACA and other legislation that impacts employee benefits. Much of the responsibility for adhering to the obligations of this law should be transferred to the consultant by written agreement.

2. Put Your Employment Lawyer on the Team

At this juncture, my belief is that most employment attorneys are not fully up to speed on the obligations of employers under the ACA. Nonetheless, the requirements of this law will

become as important an expertise for lawyers who specialize in advising employers as, say the FLSA or the ADA. It is not too soon to bring them in if only as a learning experience. And there is work to do now. Your employment lawyer should review all of your outstanding employee communications regarding health benefits to determine exactly what long term commitments, if any, you have made. Also, any executive employment contracts should be reviewed with the same focus. There may be adjustments in the hours, assignments, staffing and compensation of your existing employees and the prospect of hiring additional staff which are all actions that your employment attorney should now be part of.

Employment attorneys do not sell insurance and cannot show you the cost of various options you may have for compliance with the ACA that are also appropriate for your business situations. Benefits consultants should be relied upon for that information. Nonetheless, bringing your employment into the discussion of plan coverage, benefits, cost and flexibility prepares that attorney for the long road ahead as the ACA comes to dominate employee health benefits.

Some seminar speakers are predicting that making changes in employment arrangements solely to avoid the requirements of the ACA, such as moving full time employees to part-time status, will be seen as discrimination under the ACA when regulations on that subject are issued, possibly later this year. Your employment attorney should guide you through adjustments in your workforce that have an immediate and direct impact on ACA obligations.

3. Obligations to Offer Health Benefits

If the employer has fewer than 51 full time employees, it may decline to offer any health coverage and, at the moment, it may offer health coverage that does not comply with ACA requirements. Further, employers are not required to offer health coverage to spouses, domestic partners, part time employees or independent contractors. The discontinuation of coverage for any group of employees, or for spouses, can pose an extraordinary hardship to employees and their families, especially if alternative coverage is not yet available through the new Health Exchanges.

It should continue to be possible for an employer to offer one level of health benefits to senior management, another to full time office staff, another to hourly employees and another to part time employees. Such an arrangement should be scrutinized under basic employment discrimination standards to avoid a compensation arrangement that, for example, evidently favors male employees over female employees. ADEA requirements continue to prohibit benefit programs that discriminate against older workers. Special non-discrimination rules may be issued under the aegis of ACA that relate specifically to health benefit plans.

The more complex the arrangement, the more potential exists for mistakes and employee dissatisfaction. Nonetheless, for example, an employer of less than 51 employees may want to provide more cash compensation to one group and higher pre-tax health coverage to another, and that should still be possible. Groups of employees not covered by ACA can, nonetheless, be included in a health coverage plan as an option or as a basic employment benefit, but care is needed to make changes in any health plan as the ACA evolves.

4. Protect the Employer's Right to Make Changes

Employee Handbooks may spell out employee health benefits in some detail. This is a mistake in the current situation. The employee benefits section of the Handbook should only recite the employer's retained right to alter, amend or discontinue employee benefits in its discretion and should reference to how employees can obtain specific information regarding various categories of benefits, and little else.

As ACA is rolled out, employers need to retain complete flexibility to change health and other benefits both to achieve continuing compliance with ACA requirements and to avoid making promises to employees that cannot be kept from a financial point of view. The courts have consistently held that if an employer states that a benefit will be provided, even if that statement is a mistake, such as being in excess of what is covered by the insurance the employer has purchased, the court will nonetheless enforce that promise. Employers need to stop drafting their own summaries of health benefits and to depart from statements that create firm commitments into the future. Rely on the source of health care insurance coverage for that information and provide your employees with a means to directly contact your insurer or health plan.

5. ERISA Still Applies but More is Required

One of the basic requirements of the Employee Retirement Income Security Act ("ERISA") is that employees be told clearly and completely of the scope of health, disability and related benefits. Employees must be provided a summary plan description for each employee benefit. Employers are advised to rely on the insurer or plan administrator to publish this information. This is especially true as the complexity of ACA coverage requirements unfolds.

Further, Section 18B of ACA requires a more detailed statement of health benefit information than ERISA has required. On April 23, 2013, the Departments of Health and Human Services, Labor and the IRS published a six page outline of employee health plans, i.e. a nationally standard format that describes what must be provided to all employees. This "Summary of Benefits and Coverage" ("SBC") is a document that should be available from the health insurer or plan and should be used by an employer in lieu of any other handout or other guide to health coverage. Under current ACA requirements, employers must distribute their SBCs by October 1, 2013.

6. Provide Advance Notice of Changes

It is anticipated that employers may wish to make significant changes in the level of health coverage, those included in the plan and the amount of employee premium cost on a yearly basis, perhaps for some time. For example, under ACA, spouses need not be covered. ERISA and many state laws require advance notice of such changes. Employee morale can be devastated by, for example, information that family coverage will no longer be offered in a situation where an employed spouse's "open season" has just passed, and family coverage was available from that second employer but is now not an option for a full calendar year.

The exact notice requirements depend upon the nature of the change but the point here is to give your employees as much notice of potential changes as possible and to invite feedback from employees who can envision problems or coverage gaps with certain changes.

7. Existing Health Care Coverage

As enacted, ACA provided that contracts with health insurance companies and health plans that were in existence when ACA became law, i.e. on March 23, 2010, would not be required to meet the new requirements unless major changes are made. Thus there may be some health plan arrangements that are "grandfathered" on some ACA requirements at least for a few years, but this status could disappear with amendments to the law. See "FAQ's About the Affordable Care Act Implementation, Part II" on the Department of Labor website.

8. State Insurance Law

State health insurance requirements such as the Maryland Mandated Benefits Law, as described on the Maryland Insurance Administration website, remain on the books, but are now subject to scrutiny and possible preemption to the extent that there is any conflict with ACA. At least one federal court has held that a Missouri law that exempted conscientious objectors from the requirement to provide mandatory reproductive health coverage was invalid, since it conflicted with ACA requirements on the same subject. Many states are enacting legislation that is intended to prevent the implementation of all or part of ACA, as listed by the National Conference of State Legislators on its website, updated most recently in April, 2013. Litigation on the subject of preemption is arising nationally and the eventual resolution of this issue is destined for consideration by the Supreme Court.

Conclusion

In summary, many employers are just becoming aware of the enormous impact of ACA on their entire compensation structure and the cost of doing business. There is no "one size fits all" solution to this law and what works in the first few years will probably be replaced as Congress responds to perceived problems with administration, cost and benefit structures. For example, the Benefit Exchange available in the employer's jurisdiction may not be fully operational until 2015.

At this time, an employer should do its utmost to understand the ACA and its implications for its employees, but should bear in mind that currently there is an array of opinion on the best way of doing this. Seeking the best employee benefit, legal, financial and management advice available is necessary, especially as the changes scheduled for 2014 are implemented. As of this writing, there is an array of proposals to change the ACA. In this somewhat confusing and fluid circumstance, bear in mind that your employees have an awareness of what you face as an employer and it is not a mistake to bring them into the discussion as the best solution for your company is developed.

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Appendix: a Chronological Schedule of ACA Requirements*

Provisions Effective on September 23, 2010

A number of changes to health insurance plans were required shortly after enactment. These changes should be in effect in all employer sponsored plans that are covered by third party insurance:

a) Lifetime dollar limits to various categories of benefits are prohibited. Thus a 100 day limit on inpatient hospitalization cannot be imposed.

b) Children may remain on their parents' policies until their 26th birthday regardless of where they live, whether or not they are married, or a student or taken as a dependent for tax purposes. If such a child is to be covered, employers may require the employee to pay a portion of the premium for "family" coverage.

c) Pre-existing conditions in children under age 19 may not be excluded from coverage should they be covered by their parents' policy.

d) Preventive care and screenings must be covered by all health insurance without any co-payment or deductible.

e) Most spending limits, such as annual and lifetime maximums and caps on the cost of particular services must be removed and all such limits come off by 2014.

f) A formal, fair appeals process, similar to that required by ERISA, must be written into the insurance contract.

Provisions Effective January 1, 2011

a) Flexible spending accounts, health reimbursement plans and health savings accounts (Section 125 plans) cannot be used for non-prescription over the counter drugs except insulin.

b) Insurers must spend 80 to 85% of their premium dollars for benefits, depending upon the size of the insured group and must refund any excess to the policy holder.

*** (This listing of ACA requirements is for illustration purposes only, it is not a complete guide to all aspects of compliance. This extremely complex law simply cannot be summarized in a few pages in outline form. For a compete statement of the current requirements of the ACA go to the Department of Labor's website at ebsa/healthreform.)**

Provisions Effective January 1, 2012

a) The value of health benefits provided to employees must be disclosed on the employee's W-2 form for all employers of more than 250 employees.

Provisions Effective August 1, 2012

a) Specific additional preventive services must be covered, especially for women, including mammograms, colonoscopies, well-woman visits, gestational diabetes screening, HPV, HIV and DNA testing and counseling, sexually transmitted disease and contraception testing and services, breastfeeding support, domestic violence screening and counseling, all without any deductible or co-payment.

b) Religious organizations have been given until August 1, 2013 to implement these coverage requirements. That requirement is currently in litigation.

Provisions Effective January 1, 2013

a) Income in excess of $200,000 for an individual or $250,000 for a married couple filing jointly will be subject to a tax of .09%.

b) Unearned, investment income, such as dividends, royalties, sales of investments and real estate will be taxed at a rate of 3.8% applied to the lesser of net investment income or the amount of adjusted gross income in excess of $200,000 for individuals or $250,000 for married couples filing jointly.

c) The limit on pre-tax contributions to healthcare flexible spending accounts is $2,500.

d) Health insurance carriers and plans will be required to use standardized summary plan descriptions of costs, coverage and benefits.

e) Children with access to other coverage, e.g., employed elsewhere, can remain on parents' policy until age 26.

Effective October 1, 2013

a) Health Exchanges will begin offering individual policies of health insurance that can be subsidized by as much as nearly $8,000, based on Federal Poverty standards and family size. (Delays in the establishment of such Exchanges may prevent compliance in some jurisdictions.)

b) For example, in a state that has a Health Exchange, an individual with one child whose income is 200% of the Federal Poverty standard is required to pay a maximum health coverage premium of 6.3% of income and no more than $1,365 per year.

c) Limits on in-network out of pocket health care costs to $6,250 for individuals and $12,500 for families for co-pays, deductibles and other coinsurance costs, not premium costs.

d) Health coverage costs to employees must be "affordable." For example, for individual making $55,125 to $66,150, with family of 4, employee premium cost should not exceed $4,438 or 8.05% of income with a potential subsidy of $1,930.

Effective January 1, 2014

a) Insurers are prohibited from surcharging or discriminating in any way on the basis of gender or pre-existing condition for all covered individuals.

b) Any remaining annual spending caps are prohibited.

c) All individuals, regardless of employment, must be covered by some form of health insurance, plan or program. Every person must be enrolled in a qualifying health insurance policy, health plan, Medicare, Medicaid or other program that meets minimum standards.

d) Tiers of coverage are established: bronze, silver, gold and platinum, based on percentage of premium costs covered by employer, i.e. 60% to 90%.

e) Essential health benefits ("EHB's") are minimum coverages to be defined by each state and create a mandatory statement of benefits by broad category with no dollar limits if a type of service is required to be covered as an EHB.

f) Premiums must be based on age of covered individuals, number of family members and tobacco use, with no consideration of health status.

g) Federal excise taxes and local taxes on health insurers to support health exchanges, and state fees for the same purpose will begin and will be passed on to policy holder. (A total of such taxes is estimated at 6% of premiums.)

h) Any individual that is not covered by a qualified health plan must pay an annual penalty, at this time, $95 per year or up to 1% of income over the filing minimum of $9,350. This penalty amount will increase to a minimum of $695 for individuals and $2,085 for families (or 2.5% over the joint filing minimum of $18,700) by 2016.

i) Eligibility waiting periods for group health plans, such as for new employees, cannot exceed 90 days. However, other criteria for eligibility, apart from the passage of time, may be applied.

j) Any employer of more than 51 employees must offer a qualifying health coverage plan to their full time workers, defined as employees who regularly work more than 30 hours per week. (Postponed to January 1, 2015.)

k) An annual report to the IRS must be submitted in January of 2015 concerning several aspects of each employer's workforce, hours of work, dates of employment, health benefits and perhaps other information. The form for this report has not yet been published.

l) Deductibles may not exceed $2,000 for plans that cover individuals and $4,000 for all other plans.

m) Medical expenses that may be deducted by employees who itemize deductions on Schedule A must exceed 10% of adjusted gross income, up from 7.5%.

Effective January 1, 2018

a) All health plans must cover a wide range of preventive care and health maintenance services without co-pay or deductible.

b) A 40% excise tax is imposed on "Cadillac" plans premiums excess of $10,200 for individuals and $27,500 for families. Thus an employer that offers an individual policy with premiums of $1,000 per month would pay a tax of 40% on $1,800 or $720. (The average cost of individual coverage in a group plan is between $5,000 and $6,000 per year and between $14,000 and $16,000 for family coverage.)