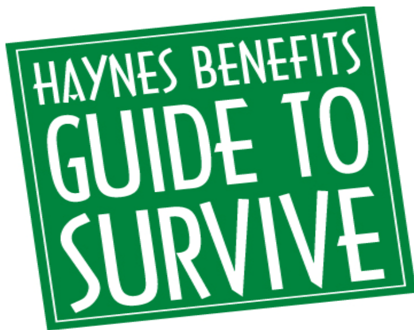

. . . Health Care Reform 2010

Week 5: Individual and Employer Responsibilities

Our fifth alert will provide a summary of the rules relating to the individual and employer mandates under the Patient Protection and Affordable Care Act (the "Act"). These provisions are sometimes referred to as the Play or Pay provisions. Our comments are in italics.

Individual Responsibilities. The Act requires most U.S. citizens and persons lawfully present in the United States and their dependents, to have "minimum essential coverage" or to pay a "shared responsibility payment" on their Federal income tax return. The only persons who are excepted from this mandate are incarcerated individuals, persons not lawfully present in the United States, health care sharing ministry members and religious conscientious objectors.

Minimum Essential Coverage. Minimum essential coverage for this purpose includes coverage under government sponsored programs, such as Medicare, Medicaid, the Children's Health Insurance Program ("CHIP"), TRICARE for Life, the Federal Veteran's health care program and the Federal program relating to Peace Corps volunteers. Health plans must provide coverage documentation to both the covered individuals and the IRS.

Penalties. The penalty for the failure to satisfy this requirement for 2014 to 2016, determined on a monthly basis, is the lesser of the following annual dollar amount or percentage of "household income":

Year	Dollar Penalty	Percentage of Household Income
2014	$95	1%
2015	$325	2%
2016	$695	2.5%

Household income means the aggregate adjusted gross income for Federal income tax purposes for the individual, spouse and dependents, modified to include tax exempt interest income.

After 2016, the dollar penalty is adjusted for inflation. The penalty is 1/2 of the applicable amount for individuals under 18.

The intent of the individual mandate is universal coverage and to protect insurers against adverse selection. These objectives may not be achieved because the penalties will probably be considerably less than the cost of coverage in the state exchanges.

However, the publicity surrounding this differential may cause Congress to raise the penalty in order to assure more compliance.

Employer Responsibilities

Automatic Enrollment. The Act requires employers of more than 200 full time employees who offer one or more health benefit plans to automatically enroll new full time employees (subject to any waiting periods authorized by law) and to continue the enrollment of current employees. The automatic enrollment program must include notice of the program and the opportunity to opt out of coverage. Once an employee is enrolled, the employee may not be required to reenroll each year. This is sometimes referred to as an "evergreen" provision. The Act does not supersede any state law relating to payroll practices, unless the state law would prevent an employer from instituting an automatic enrollment program.

Opt Out Notice to Employees: Effective March 1, 2013, new hires and current employees must receive a written notice of the following:

- The existence of an exchange and how an employee may contact the exchange;
- If the employer's share of the total costs of benefits under the plan is less than 60%, that the employee may be eligible for a premium tax credit and a cost sharing reduction if the employee purchases coverage through the exchange; and
- If the employee purchases a qualified health plan through an exchange and the employer does not offer a free choice voucher, the employee will lose the contribution the employer would make to the plan, which may be excludable from income for tax purposes.

We described the state exchanges in our Week 4 alert.

Once again, there is some confusion on the effective date of these provisions. The automatic enrollment provision may be effective either on date of enactment or when the Secretary of Labor issues regulations. The opt out notice requirement is effective March 1, 2013 which is ten months before the exchanges must be established. These effective dates should be clarified in Labor Department regulations.

It appears that both automatic enrollment and the opt out notice requirement apply to grandfathered plans.

Employer Mandate: Effective for plan years beginning in 2014, every "applicable large employer" must either offer its full time employees and their dependents "minimum essential coverage" under an "eligible employer sponsored plan" or the employer will be subject to an assessment. An applicable large employer is an employer with 50 or more full time employees, whose average hours of service per week are at least 30 hours. Part time employees must be counted, to the extent they are full time equivalent employees, for the sole purpose of determining whether an employer has 50 or more full time employees. This is accomplished by determining the aggregate hours of all part time employees during a month and dividing this number by 120.

Eligible Employer Sponsored Plans. An "eligible employer sponsored plan" is a governmental plan, a grandfathered plan, a nongrandfathered plan or other coverage offered through either the small or large group market within a state.

Penalties. The assessment, if an eligible employer sponsored plan is not offered and at least one full time employee is certified to the employer as qualifying for a tax credit or a cost sharing reduction for that month, is calculated as 1/12 of $2,000 (or $166.67) multiplied by the number of full time employees, reduced by 30. Part time employees are not included in this calculation.

The assessment for applicable large employers who offer coverage, but who have at least one full time employee who is certified to the employer as having received either a premium tax credit or a cost sharing reduction during the month, is 1/12 of $3,000 multiplied by the number of full time employees who received a premium tax credit or a cost sharing reduction for such month.

Free Choice Vouchers: Beginning in 2014, employers who offer minimum essential coverage and who pay any portion of the cost of coverage must offer free choice vouchers to an employee who satisfies each of the following requirements:

- The required employee contribution for plan coverage exceeds 8% of the employee's household income; but is not more than 9.8% of the employee's household income;
- The employee's household income is not more than 400% of the poverty level for a family of the size involved; and
- The employee does not participate in the employer plan offered.

Household income is defined above at the end of the discussion of Individual Responsibilities.

Free choice vouchers only apply to employees whose required premiums are more than 8% of household income, but not more than 9.8%, because in this donut hole, the employee is not eligible for either an individual mandate subsidy (which is initially capped at 8% of household income), or a premium reduction subsidy (which is only provided if the required employee premium is more than 9.8% of household income).

The poverty level for a family of four in May, 2010 for all states other than Hawaii or Alaska is $22,050. Therefore 400% of the poverty level is currently $88,200.

The free choice voucher must be in an amount equal to what the employer contribution would have been under the employer's plan for the type of coverage the employee intends to elect under an exchange. The employee then uses the free choice voucher as a credit towards the premium for the exchange coverage the employee elects. If the amount of the voucher exceeds the premium for the exchange coverage elected, the excess will be paid to the employee.

Information Tax Reporting: Employers and other providers of minimum essential health benefits coverage must file an information return for each calendar year beginning on or after 2014. This information return will include the name and taxpayer identification number of each covered individual. A written statement must also be provided to each individual by January 31 of each year with respect to whom information is included on the form.

This tax information return will be filed on a calendar year basis, regardless of the plan year of the health insurance coverage or group health plan. The first written statement to covered individuals will be due by January 31, 2015.

Our Week 6 alert will describe some of the Revenue provisions in the Act.

June 8, 2010