The Affordable Care Act

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (together, the Affordable Care Act), was landmark legislation that dramatically affects how health care is delivered in the United States. Provisions of the legislation affect not only those directly involved in providing health care, but also most individuals and employers.

The health care reform legislation is extremely complex, and many items in the legislation change rules and regulations that were already in place. The IRS, Department of Labor (DOL), Department of Health and Human Services (HHS), and other agencies have the monumental task of interpreting the legislation and providing guidance. Many temporary and proposed regulations, as well as some final regulations, have been issued.

The purpose of this legislation was to provide affordable minimum health care benefits to all individuals. With that in mind, the legislation provides for the establishment of qualified health plans that must provide essential health benefits consisting of minimum essential coverage.

Caution: Some of the rules originally enacted have already been repealed and the effective date of other rules has been modified. It is possible that more changes will occur as these rules are implemented. This information is current as of July 11, 2013.

Employer Responsibility

Beginning in 2015, certain applicable large employers (i.e., generally those who had an average of at least 50 full-time employees in the previous calendar year) that do not offer health insurance coverage to their full-time employees (and their dependents), or employers that offer health insurance coverage that is unaffordable or does not provide a certain minimum value, must pay a penalty if the employer is notified that any full-time employee receives a premium assistance credit to purchase health insurance in the individual market through a state insurance exchange or a cost-sharing-reduction subsidy to help with out-of-pocket expenses. Any penalty paid under this provision is not deductible as a business expense for federal income tax purposes.

To determine if an employer is an applicable large employer, the full-time equivalent value of the hours worked by part-time employees must be calculated and added to the employer's number of full-time employees. This calculation can be challenging. Although part-time employees must be considered when determining applicable large employer status, applicable large employers only need to offer full-time employees (and their dependents) adequate health insurance coverage to avoid paying a penalty. However, the rules for determining full-time status can be complicated for certain variable-hour employees. Employers will be subject to many new notice and reporting requirements.

Individual Mandate for Health Coverage

The health care reform legislation requires most U.S. citizens and legal residents (i.e., applicable individuals) to have minimum essential health insurance coverage every month beginning on or after January 1, 2014. Those who do not have such health insurance will be subject to a penalty for each month they do not have minimum essential coverage. The penalty will be the greater of a flat fee amount (for each individual not covered by health insurance) or a percentage of household income over a threshold amount. For applicable individuals who are at least age 18, the maximum applicable annual dollar amount is $95 for 2014, $325 for 2015, and $695 for 2016 and later years. An inflation adjustment will be applied in calendar years beginning after 2016. For individuals under age 18, the maximum applicable penalty is 50% of these amounts.

Individuals who meet certain financial or hardship criteria are exempt from the mandate. In addition, members of an Indian tribe and individuals who are members of certain religious sects or members of certain health care sharing ministries are exempt from the mandate.

Premium Assistance Credits and Cost-sharing-reduction Subsidies

To assist individuals in meeting the mandate for having minimum essential health insurance coverage, the legislation also provides for premium assistance credits and cost-sharing-reduction subsidies. Beginning in 2014, some individuals will qualify for a premium assistance credit to help them pay the premiums on health insurance purchased in the individual market through the state insurance exchanges that will be operational beginning October 1, 2013. Individuals can elect to have this credit payable in advance directly to the insurer.

The premium assistance credit will be available (on a sliding scale basis) for individuals and families with incomes up to 400% of the federal poverty level ($45,960 for an individual or $94,200 for a family of four, using 2013 poverty level figures) who are not eligible for Medicaid, CHIP, a state or local public health program, employer-sponsored insurance that is both affordable and provides a certain minimum value, or other acceptable coverage.

Excise Tax on High-cost Employer-sponsored Health Coverage (Cadillac Plans)

Beginning in 2018 under the current law, a nondeductible 40% excise tax will be levied on so-called Cadillac plans. These plans are employer-sponsored health plans with annual premiums (i.e., excess benefits) exceeding $10,200 for self-only coverage and $27,500 for any other coverage. Slightly higher premium thresholds apply for retired individuals age 55 and older who are not eligible for enrollment in Medicare or entitled to Medicare benefits, and for plans that cover employees engaged in high-risk professions. For coverage under a group health plan, the 40% excise tax will be imposed on insurance companies, but it is expected that employers (and their employees) will ultimately bear this tax in the form of higher premiums passed on by insurers. Employers will be responsible for the tax if coverage is provided by employer contributions to HSAs or Archer MSAs.

Employers will be responsible for calculating the excess benefit amounts and reporting those amounts to the applicable insurer. Employers that currently offer generous health benefits (especially if the benefits are to the owners and related persons) should carefully analyze their plans to see if changes are needed to avoid having plans that will be subject to this tax. Additional guidance will be issued on this excise tax (additional legislation may change some of these provisions).

2014 HSA Amounts

Health savings accounts (HSAs) were created as a tax-favored framework to provide health care benefits mainly for small business owners, the self-employed, and employees of small- to medium-sized companies who do not have access to health insurance.

The tax benefits of HSAs are quite substantial. Eligible individuals can make tax-deductible (as an adjustment to AGI) contributions to HSA accounts. Funds in the account may be invested (somewhat like an IRA), so there is opportunity for growth. The earnings inside the HSA are free from federal income tax, and funds withdrawn to pay eligible health care costs are tax free.

An HSA is a tax-exempt trust or custodial account established exclusively for paying qualified medical expenses of the participant who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan. Consequently, an HSA is not insurance; it is an account that must be opened with a bank, brokerage firm, or other provider (i.e., insurance company). It is therefore different from a flexible spending account in that it involves an outside provider serving as a custodian or trustee.

The 2014 inflation-adjusted deduction for individual self-only coverage under a high-deductible plan is limited to $3,300, while the comparable amount for family coverage is $6,550. This is an increase of 1.5% and 1.6%, respectively, from 2013. For 2014, a high-deductible health plan is defined as a health plan with an annual deductible that is not less than $1,250 for self-only coverage and $2,500 for family coverage, and the annual out-of-pocket expenses (including deductibles and copayments, but not premiums) must not exceed $6,350 for self-only coverage or $12,700 for family coverage.