By Patrick D. Souter and Jennifer Gurevitz

The U.S. Supreme Court's ruling on President Barack Obama's health care reform legislation has left many questions for employers, due to the complexity of the legislation and the rationale behind the decision. The answers to those questions can provide valuable guidance to businesses and their management moving forward.

As a result of the Court's decision, the reform bill remains generally the same as when passed by Congress, except that the decision addressed two separate matters contained in the legislation. The first issue was whether what was termed a penalty in the legislation is actually a penalty or a tax.

The requirement that individuals have insurance — commonly referred to as the individual mandate — goes into effect in 2014. For the purposes of determining the legislation's constitutionality, the Court held the charge for noncompliance was a tax, and therefore within the power of Congress to pass under its taxing powers.

The second issue pertains to Medicaid eligibility expansion and what steps the federal government could take against those states that do not implement the expansion. The federal government now provides funds to each state to use in providing Medicaid to those who meet the requirements, currently those whose income is below the federal poverty line.

The legislation allows for increased funding to each state that expands Medicaid eligibility to include those within 133 percent of the federal poverty line. The purpose of expanding eligibility requirements is to offer the ability to participate in the program to the uninsured who currently cannot afford health insurance and do not qualify for Medicaid.

The Court mandated that if a state chooses not to expand its eligibility, the federal government may only withhold additional funding the state would be entitled to under the legislation. The money a state already receives may not be impacted by its decision not to expand eligibility.

What it Means for The Uninsured

The decision does not change the amount owed by uninsured individuals. Those who do not have insurance will be subject

While the Supreme Court ruling on health reform left the law largely intact, it affirmed that major changes are coming to U.S. companies big and small on a host of health care administration and tax-related issues.

to an annual financial charge that once it is fully phased in will be the greater of $695 per person (up to a maximum of $2,085 per family), or 2.5 percent of household income, each year, to be collected by the Internal Revenue Service.

Interestingly, the IRS does not have

the same collection authority and tools at its disposal to collect these charges as it does for failure to pay income tax. It cannot pursue criminal penalties, file liens against property or issues levies to collect the tax. As of right now, the IRS has not stated how it will pursue those who do not pay, but the only likely remedy is to employ offsets against federal tax refunds.

States and Expanded Medicaid Eligibility

There are three categories of states that have considered Medicaid eligibility expansion, following the lead of each state's governor. There are those states that had already set in motion the expansion (California and Massachusetts among them), others that had delayed action until the Court had decided and others that have indicated they haven't decided to implement the expansion, or will not do so.

Texas Gov. Rick Perry, for example, has announced he has no intention of implementing the expansion, as have the governors of Florida, Wisconsin and several others.

If a state does not proceed with Medicaid expansion, its residents who would have qualified for Medicaid under the expansion would be eligible for federal subsidies, through income-based tax credits to allow them to afford participating in their state's health insurance exchange.

In light of such gubernatorial opposition to the Medicaid expansion, U.S. Department of Health and Human Services Secretary Kathleen Sebelius announced that low-income citizens in states that opt out will not be subject to the individual mandate's penalty as a result of the unintended consequence resulting from such state action.

Effect of Health Insurance Exchanges

A health insurance exchange is an organized effort at the state level that, in 2014, will provide a marketplace for various insurance options that may be offered to individuals and some employers. The exchange may be through a governmental agency or a nonprofit corporation. A state may have multiple exchanges as long as one serves each geographic location within the state.

If a state chooses not to implement an exchange, the federal government may establish one. From all indications, most states opposed to enacting the Medicaid expansion will not form a health insurance exchange.

Employers with fewer than 100 employees (some states may limit it to 50 employees through 2016) will be able to shop for health care coverage through the exchanges.

These exchanges have the option of including employers with more than 100 employees, beginning in 2017, and will allow employers to choose the level of coverage they will provide and to offer their employees choices among qualified health plans within that level. This will let employers offer plans from multiple insurers but receive a single bill and write a single check.

Employers purchasing coverage through an exchange may be eligible for a tax credit of up to 50 percent of their premium payments if they have 25 or fewer employees, pay employees an average annual wage of less than $50,000, offer all full-time employees coverage and pay at least 50 percent of the premium.

The Impact on Taxes

Increased tax for some employees and investors. Beginning in 2013, individual taxpayers with incomes in excess of $200,000 ($250,000 for couples [filing married] filing jointly) will pay an additional 0.9 percent Medicare tax on the excess. In addition, they'll pay a new 3.8 percent Medicare tax on unearned income, such as interest, dividends, rents, royalties and certain tax gains.

Health insurance premium tax credit. Refundable tax credits are available to eligible taxpayers to help cover the cost of premiums for individuals and families purchasing insurance through a health exchange.

Credits are available for people with incomes above Medicaid eligibility and below 400 percent of the poverty level ($92,200 for a family of four in 2012) who are not eligible for or offered minimum essential coverage. The credits apply to both premiums and cost-sharing.

Cap on flexible spending accounts. Beginning in 2013, flexible spending account contributions will be capped at $2,500 and future caps will be tied to increases in the Consumer Price Index.

Health savings account withdrawal penalty. The tax penalty for an unqualified withdrawal from an HSA account has been increased effective Jan. 1, 2011, from the current level of 10 percent to 20 percent.

What it Means for Businesses

Whether employer or employee, the health care reform legislation will have

substantial impact in the workplace. Employers are now faced with addressing different requirements based upon the number of employees, types of insurance and benefits offered and implementation periods.

The legislation created additional disclosures regarding insurance and other employee benefits that must be provided. There are requirements for employer obligations to make available such insurance, as well as penalties for not providing coverage. These issues create a myriad of sliding scales for the employer to address, which will in turn impact employees.

Employers with fewer than 50 employees. Employers with fewer than 50 full-time employees — those who work 30-plus hours per week — or full-time equivalent employees (determined by dividing the total number of hours worked in a month by part-time employees by 120) are not responsible for providing health care coverage for their employees and don't face a fine for failing to do so.

Employers with 50 or more employees. Beginning in 2014, employers with 50 or more full-time or full-time equivalent employees will have the option of providing health insurance for all of their employees or paying a fine.

Fine for employers offering health insurance. Employers must pay a non-deductible penalty of $3,000 per year for each full-time employee who obtains health insurance through an exchange and receives the premium tax credit if the employer does not offer minimum essential coverage to its full-time employees and their dependents.

An employer does not offer minimum essential coverage if the employer medical plan contributions equal less than 60 percent of allowed costs, or if an employee pays more than 9.5 percent of his or her household income for health coverage. This penalty is limited to an amount equal to $2,000 multiplied by the number of full-time employees of the employer (less the first 30 employees).

Fine for employers who do not offer health insurance. Employers that don't offer health coverage will be required to pay a non-deductible penalty of $2,000 per employee. An employer's first 30 employees who would otherwise qualify will not be included in the assessment.

Employers with more than 200 employees. Beginning sometime in 2014 after the IRS issues regulations, employers with more than 200 employees that offer health coverage must automatically enroll new full-time employees in a coverage option and must also automatically continue existing elections for current full-time employees from year to year.

Reporting requirements. Beginning in 2013 (for 2012 Forms W-2), employers providing health insurance to employees — whether the employer or the employee pays the premiums — must disclose the value of health benefits on each employee's Form W-2. Employers filing fewer than 250 W-2s for the previous calendar year are currently exempt from this new reporting requirement until the IRS issues regulations stating otherwise.

What the Law Means for Health Care Providers

There are only two certainties relating to health care providers: there will be more individuals presenting themselves to physicians and hospitals, and there should be more funding to provide for the increased care burdens. Whether increased funding for the additional health care services will match the needs for the services provided is yet to be seen.

Whether the current facilities and providers will be sufficient to address the new participants is in and outside the health care field. Short term, there should not be a substantial recognizable change.

But as the different implementation periods come into effect, the health care provider and health insurance industries will need to evolve to address the mandated changes.

Additional Legislative Changes

Any additional changes to the current legislation depends on certain avenues and pending events. These different avenues include legal challenges, regulatory change and political events that might create change. From a legal perspective, there is current litigation questioning the legality of certain aspects of the legislation, though these cases are not proceeding as quickly as the recent litigation decided by the Court.

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Change could occur as the federal government issues regulations regarding how certain aspects of the legislation should be implemented.

Finally, the November elections may lead to change. If Republicans take control of the Senate and/or presidency, they have stated they will repeal and replace the current law. So there may be instances where current legislation could be reviewed and revised.

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