HEALTHCARE REFORM IN THE WORKPLACE:
From Employer Compliance to Comprehensive Strategies
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Healthcare reform in the United States is real—and here to stay.

Like any sea change in economic policy, there will be an adjustment period. But a “wait and see” attitude holds no virtue.

There are many aspects of the Patient Protection and Affordable Care Act (ACA) healthcare reform laws. For individuals, there are more options. For companies, there are more hoops to jump through. Whether it will be easy or hard to jump through these hoops has less to do with the design of the hoop than it does the preparedness of the jumper.

Prepared, Not Scared

Companies that are well-informed will save money and manage risk by preparing for current ACA requirements and building a strategy for the unsteady healthcare seas ahead. Some regulations are being implemented gradually, and secondary costs and options will continue to shift as markets respond to how individuals and companies purchase insurance in the years ahead. The only option is to be informed and prepared.

Companies prepared for the future will not only avoid compliance penalties, but they will, more importantly, plan strategies that will yield the best results for the least investment. Every situation will be different, so planning ahead means finding a strategy that’s a good fit for today while being adaptable to tomorrow. This strategy brief focuses on the sweet spot of “large” companies (100 to 1,000 employees) that might have the most penalty pitfalls and the most savings opportunities.

Hitting the High Points

The ACA is now a permanent fixture in this nation’s healthcare landscape. But it’s not just about compliance; it’s about making the most of a complicated situation. Here we’ll provide a brief synopsis of important employer provisions of the ACA that will be implemented in the years to come.

In this strategy brief, we’ll focus on five topics that employers would do well to get ahead of. In the following pages, we’ll take you through the basics, then find out where your company is currently and tell you what you need to plan for coming down the pike. The five topics are:

1. **Affordability** – Employers are responsible for supplying “affordable” healthcare policies to their employees under the ACA. What you don’t know might cost you.

2. **Minimum Essential Value (MEV) of a Plan** – The law requires employers to supply plans with a minimum “value,” calculated a specific way. But the letter of the law may be open to some interpretation.

3. **Pay or Play Mandate** – Should your company just ignore compliance and pay the fines? That’s not a viable long-term strategy under any present or future realities for large employers. And even companies that try to “play” may have to “pay” anyway.

4. **2018 Excise Tax** – Don’t be fooled into ignoring this so-called “Cadillac Tax.” Its broader implications in future years may surprise you.


Let’s get started…
1. AFFORDABILITY

Employers are responsible for supplying “affordable” healthcare policies to their employees. Do you know the four main factors in this equation?

Beginning on January 1, 2014, each state was tasked with implementing state health insurance exchanges, which are government agencies or nonprofit entities through which states make qualified health plans available to individuals and small employers.

Individuals who purchase insurance on an exchange may be eligible for health insurance subsidies. The premium tax credit will generally be available to individuals earning between 100% and 400% of the federal poverty level. Additional cost-sharing reductions will generally be available to individuals with household incomes between 100% and 400% of the federal poverty level, and who purchase a certain level of coverage on the exchange.

What’s a Large Employer?

The main threshold that affects the compliance regulations, reporting, notifications, and penalties discussed here is 50 employees (in the previous calendar year). For the purposes of the ACA, states can choose whether employers with over 100 employees can participate in healthcare exchanges.

States have the option of opening their exchanges to large employers. For plan years beginning before January 1, 2016, states may choose to define large employers as those with 51 or more employees. After that, large employers will be defined as ones having at least 50 employees in the preceding calendar year, but states will still have the same option.

Does W-2 Reporting Change?

Beginning with the 2012 tax year, employers are required to report the aggregate cost of employer-spon-
sored health coverage on their employees’ W-2 Forms. While reporting was voluntary for the 2011 tax year, it is mandatory for the 2012 tax year. Pending further notice by the Internal Revenue Service, this requirement only applies to those employers who had to file 250 or more Form W-2s in the previous tax year. W-2 reporting is for informational purposes only and does not render an employee’s health coverage taxable.

Limitations on Waiting Periods

Healthcare reform prohibits employer-sponsored health plans from imposing waiting periods of greater than 90 days. The Departments of the Treasury, Labor, and Health and Human Services issued joint guidance on the prohibition of extended waiting periods for participation in employer-sponsored plans.

In general, employers subject to the FLSA include employers that employ one or more employees who are engaged in, or produce goods for, interstate commerce and that have $500,000 in annual dollar volume of business.

Among other things, the new guidance describes the interaction of this rule with the no-coverage penalty discussed above. It clarifies that the use of properly designed measurement periods will not be deemed to be a violation of the 90-day waiting period limitation. It also provides additional information about how this rule should be applied in practice, including with respect to part-time employees.

Auto-Enrollment

Employers subject to the Fair Labor Standards Act (FLSA) with more than 200 employees will be required to automatically enroll new full-time employees in their employer-sponsored health coverage. An employee must affirmatively opt out of employer-sponsored coverage in order for an employer to cease covering that employee. Until final regulations are issued and become applicable, employers are not required to comply.

Limits on Health Flexible Spending Accounts

Effective for plan years beginning after December 31, 2012, the ACA will impose a $2,500 limit on salary reduction contributions to an employee’s health flexible spending account. This limit will be indexed for cost-of-living adjustments beginning in 2014.

Failure to Provide Affordable/Adequate Coverage

If a large company offers all of its full-time employees coverage, but that coverage is too expensive or deemed inadequate, there is a stiff penalty. For purposes of this rule, coverage is deemed to be “unaffordable” if the employee premium for the lowest price “employee only” plan option available through an employer exceeds 9.5% of that employee’s household income.

The penalty, $3,000 per year (assessed on a monthly basis), applies only with respect to those full-time employees who actually receive subsidized health coverage through an exchange. This penalty is also triggered if the coverage provided through an employer-sponsored plan does not provide “minimum value.” More on these topics in the next two sections.

Reporting

Effective 2015, the ACA law requires every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs, and other entities that provide minimum essential coverage to file an annual return with the IRS reporting information for each individual who is provided with this coverage. The entity filing the report must also provide a written statement to each individual listed on the return that shows the information reported to the IRS. This reporting will allow the IRS to implement ACA’s individual mandate.
ACTION ITEMS:
• Find out if your company is reporting W-2s correctly.
• Find out if your company is instituting the proper waiting periods.
• Find out if your company is offering the full advantage of Health Flexible Spending Accounts.

2. MINIMUM ESSENTIAL VALUE (MEV) OF A PLAN
The law requires employers to supply plans with a minimum “value” calculated a specific way. But the letter of the law may be open to some interpretation.

By the letter of the law, an employer plan fails to provide minimum value if the plan’s share of the total allowed costs of benefits provided under the plan is less than 60% of such costs. The government issued a calculator for making these determinations, but final, definitive guidance has not yet been issued. In addition, the government has suggested that certain safe-harbor checklists will be issued to allow employer-sponsored plans to confirm that they offer minimum value without performing any calculations.

What is a “skinny” plan?
Some employers are considering offering a low-cost plan covering only preventive health services, especially employers with a fully-insured large group or self-insured health plan. In essence, offering this type of low-cost—or “skinny”—plan does not violate the law.

More specifically, employers subject to the so-called employer mandate would not be subject to the punitive first prong of the employer mandate penalty tax (often referred to as the “no-coverage” penalty). In other words, these employers would be found to be offering “minimum essential coverage”—and thus would avoid a penalty tax—provided the employer offers these low-cost, skinny plans to at least 95% of its full-time employees and their dependent children (under age 26).

So, how is this permissible under the ACA? First, we must piece together various aspects of ACA, starting with the definition of “minimum essential coverage,” and explain why this definition is so important. ACA generally requires all individuals (and their dependents) to maintain “minimum essential coverage” each year. “Minimum essential coverage” includes health insurance coverage provided under:
• a governmental program (e.g., Medicare, Medicaid, SCHIP, or TRICARE)
• an employer-sponsored plan (i.e., a group health plan)
• individual coverage offered by a health plan in the individual market
• “grandfathered” individual or group market coverage, and
• any other coverage as specified by the Department of Health and Human Services (HHS).

If an individual and their dependents fail to obtain “minimum essential coverage,” the individual will be subject to a penalty tax for himself/herself (and their dependents, if any), unless a specific exemption from the penalty tax applies.

What does this have to do with skinny plans?
Recently proposed regulations implementing the individual mandate penalty tax indicate that an employer-sponsored plan (i.e., “minimum essential coverage”) is a “group health plan” as defined under the Public Health Services Act (PHSA). The PHSA provides that a group health plan means an “employee welfare benefit plan” as defined under the Employee Retirement Income Security Act (ERISA). ERISA defines an employee welfare benefit plan as “any plan, fund, or program… established or maintained by an employer… for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits…”
A plan that covers only preventive health services would be considered a plan, fund, or program established and maintained by an employer that provides medical care or benefits through the purchase of health insurance or otherwise. As a result, a low-cost, skinny plan would be considered a group health plan under the PHSA, and thus, “minimum essential coverage” for purposes of ACA. Therefore, an individual employee (and their dependents, if any) covered under this type of arrangement (i.e., a low-cost, skinny plan) would satisfy the individual mandate requirement and would not be required to pay a penalty for the year.

“Minimum essential coverage” and the employer mandate

Nothing under ACA requires an employer to offer health coverage to its employees. Providing an employee benefit (i.e., health insurance coverage) is still voluntary. But, an employer employing more than 50 “full-time equivalent employees” (FTEs) will be subject to a penalty tax if:

• it does not offer “minimum essential coverage” to at least 95% of its full-time employees and their dependent children under age 26 (known as the “first prong” of the employer mandate).

OR
• the employer offers “minimum essential coverage,” but the coverage…

a. is “unaffordable” (i.e., the employee contribution for the lowest cost self-only health plan exceeds 9.5% of the employee’s household income (or certain other “safe harbor” measures).

OR
b. does not provide “minimum value” (i.e., the plan fails to pay at least 60% of the cost of benefits under the plan) (known as the “second prong” of the employer mandate).

The employer mandate penalty tax is only triggered if a full-time employee purchases an individual market health plan through an exchange created under ACA and accesses the premium subsidy for health insurance now available under the law (provided the employee is eligible based on income). Importantly, the amount of the penalty tax depends on whether the employer is offering “minimum essential coverage” or not. For example, if an employer fails the first prong of the employer mandate, the penalty tax is equal to $2,000 multiplied by all of the employer’s full-time employees (minus 30). Under the second prong, the penalty tax is equal to $3,000 for every full-time employee that accesses the premium subsidy.

Does offering a skinny plan avoid all penalties?

No. As stated, under the second prong of the employer mandate, if an employer is offering “minimum essential coverage,” but the coverage is unaffordable or does not provide minimum value, the employer would be subject to a $3,000 penalty tax for every full-time employee that purchases an individual market health plan through an ACA-created Exchange and accesses a premium subsidy for health insurance. In the case of a low-cost, skinny plan, this arrangement would likely be affordable. However, this type of arrangement would not satisfy the minimum value test.

When will the other shoe drop?

This is unclear. Federal agency officials have stated that employers may offer a low-cost, skinny plan and at least avoid the first prong of the employer mandate. But, the Federal regulators are certainly not approving of this practice.

So, will the Federal regulators try to shut this practice down? If they do, how can they do it? The Federal agencies may provide that this type of practice violates the new nondiscrimination rules that apply to fully insured group health plans. To date, Treasury has not issued regulations detailing these rules.
For now, it appears that offering a low-cost, skinny plan is a viable strategy when it comes to an employer’s overall approach to offering health insurance benefits to its employees and complying with the new requirements under ACA, including certain aspects of the employer mandate.

**ACTION ITEMS:**
- Find out if your company has calculated the minimum essential value of the policies it offers.
- Find out if your company provided a statement to each individual about IRS reporting.
- Find out if your company is exposed to penalties if it tries to implement an inappropriate skinny plan.

### 3. PAY OR PLAY MANDATE

*Should your company just ignore compliance and pay the fines? That’s not a viable long-term strategy under any present or future scenarios. And even companies that try to “play” may have to “pay” anyway.*

The employer-sponsored health coverage mandate is designed to require “applicable large employers” to provide employees with adequate and affordable health coverage or to require those employers to pay certain penalties for their failure to do so. The employer mandate takes effect January 1, 2015. Specifically, penalties are triggered if:
- An employer fails to offer all of its “full-time employees” the opportunity to enroll in an employer-sponsored health plan;
- OR… the employer-sponsored health plan offered to “full-time employees” is “unaffordable” or fails to provide “minimum value”;
- AND… any employee impacted by such a failure purchases individual health insurance coverage through a state-based or federally-facilitated Healthcare Exchange and qualifies for a subsidy.

#### Failure to Offer Employer-Sponsored Health Coverage

Employers who fail to provide coverage to all of their “full-time employees” are subject to a penalty of $2,000 per year (assessed on a monthly basis) multiplied by their total “full-time employee” count. For employers that provide health coverage, the challenge with respect to this rule is identifying all of their “full-time employees”—and making sure all such employees are offered coverage.

In the event that even one “full-time employee” is not offered coverage and subsequently attains subsidized coverage through an exchange, the penalty is applied.
to all “full-time employees.” Thus, with respect to any employees who do receive employer-sponsored coverage, the employer could end up “playing” and “paying.”

The guidance provides a safe harbor for determining if an employee is full-time that allows employers some relief from the need to monitor employee status on a monthly basis. This is especially useful for those employers with high turnover and a significant number of variable-hour employees. Specifically, the guidance allows an employer to monitor the hours of a variable-hour employee over a three- to twelve-month “measurement” or “look-back” period to determine if the employee averaged 30 or more hours per week during that period.

The employer can then rely on those results for purposes of determining whether coverage should be offered to that employee during a subsequent six- to twelve-month “stability period” to avoid the no coverage penalty.

Failure to Offer Adequate Coverage

A separate fine will be assessed against employers who offer inadequate coverage, or coverage that is either unaffordable or fails to provide minimum essential value.

Failure to Provide Affordable/Adequate Coverage

The second penalty under the play or pay rules applies to employers who offer all of their full-time employees coverage, but such coverage is too expensive or deemed inadequate. The penalty, $3,000 per year (assessed on a monthly basis), applies only with respect to those full-time employees who actually receive subsidized health coverage through an exchange.

For purposes of this rule, coverage is deemed to be “unaffordable” if the employee premium for the lowest price “employee only” plan option available through an employer exceeds 9.5% of that employee’s household income. Recently, new guidance confirms that employers do not have to actually determine an employee’s household income for purposes of administering this rule. Instead, an employer can assume that an employee’s household income is equal to the W-2 income provided to that employee by the employer for purposes of determining if the coverage it offers is affordable.

This penalty is also triggered if the coverage provided through an employer-sponsored plan does not provide “minimum value.” A plan fails to provide minimum value if the plan’s share of the total allowed costs of benefits provided under the plan is less than 60% of such costs. The Department of Health and Human Services (HHS) has released a minimum value calculator for determining if an employer’s plan provides adequate value.

The assessable payment for offering inadequate coverage is capped at the amount an employer would have had to pay if it failed to offer coverage at all.

Employer Reporting

Avoiding penalties is not as simple as merely providing coverage. It is also necessary for employers to evaluate which employees are eligible for coverage under existing plans, track the hours of any excluded employees, monitor the income of low-paid full-time employees in relationship to plan premiums, and (once further guidance is issued) confirm that their plan offers adequate coverage. This is no small task, but with thorough planning, employers can implement the required plan changes and tracking systems necessary to avoid penalties.

Employers subject to the employer mandate will be required to submit a form certifying whether they offer employer-sponsored healthcare to their full-time employees and their dependents.

ACTION ITEMS:

• Find out if all “full-time employees” are covered.
• Find out if your company qualifies for a safe harbor “look-back” period in determining full-time status of employees.
• Find out if your company tracks eligibility of ALL employees.

**4. 2018 EXCISE TAX**

*Don’t be fooled into ignoring the so-called “Cadillac Tax.” Its broader implications in future years may surprise you.*

A key provision in the Affordable Care Act (ACA) is the tax on high-cost insurance plans. The Excise Tax is commonly known as the “Cadillac Tax,” and this aspect of ACA has two goals. First, the tax will generate revenue to help pay for the uninsured population. Second, the tax will make the most expensive plans less attractive in the marketplace.

Under ACA, health insurers offering a plan that costs more than $10,200 for an individual and $27,500 for a family would be subject to a 40% tax on the value of anything over that threshold. This will include medical premium, employer contributions to flexible spending accounts, and health savings accounts. Dental and Vision plans would be exempt if they are separate contracts from the medical plan.

**Secondary Effects of the 2018 Excise Tax**

While this tax would be imposed on insurers, the effects will trickle down to the consumer. The tax would be paid by the employer through increased premiums on an insured plan or a surcharge levied by the administrator of a self-funded health plan.

While this component does not go into effect until 2018, many employers will need to make significant changes to their benefit programs now in order to avoid the sticker shock.
In this model, a plan with a 2013 single coverage cost rate of $7,634.00 will rise to $11,477.75, assuming an average increase of 8% by 2018 results in a tax of $511. For a group of 1,000 employees, this represents a $510,000 tax bill on top of its healthcare spend.

It’s not too early to prepare for this tax; in fact, many companies have been doing just that. According to the International Foundation of Employee Benefit Plans, 17% of employers have revised their plans as a result of the tax this year up from 11% in 2011. Developing a long-term strategy to prepare for the 2018 Excise Tax is a valuable component to any employer’s Healthcare Reform strategy.

**ACTION ITEMS:**

- Find out if your company offers high-cost health insurance policies.
- Map out how those costs might increase in the coming years.
- Determine if your company should revise its plan to accommodate future healthcare cost increases.

**5. EMPLOYER NOTIFICATION RESPONSIBILITIES**

The **ACA promotes transparency and communication—and protecting employees. Non-compliance comes with penalties.**

Clear communication is essential at all times. If employers are currently providing affordable healthcare to their employees, they should do all they can to ensure that this message is communicated to all employees.

Employers should be prepared to answer questions and concerns, and address the concepts of affordability and minimum value to employees who think they may qualify for subsidies. A proactive analysis and communication strategy of an employer’s current plan offering and contribution structure can help address these questions.

Penalties for failing to supply proper notices to employees can add up quickly. Some violations can be fined up to $100/person/day.

**Employer Notice Requirements**

The Department of Labor has issued guidance requiring employers to provide notification no later than October 1, 2013 to current employees. Thereafter, each new employee is required to be provided notification at the time of hiring.

Employers subject to the Fair Labor Standards Act (FLSA) must provide notice to their employees of the existence of state health insurance exchanges, the employee’s eligibility for premium tax credits or cost-sharing reductions, and the possible loss of excludable employer contributions if the employee purchases health insurance on the exchange.

More specifically, the Notice of Exchanges advises employees:

- About information regarding the existence of the Exchange, including a description of the services provided by the Exchange, and the manner in which the employee may contact the Exchange to request assistance.
- If the employer plan’s share of the total allowed costs of benefits provided under the plan is less than 60% of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code (the Code) if the employee purchases a qualified health plan through the Marketplace.
- If the employee purchases a qualified health plan through the Marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

**Model COBRA Notice**

Under COBRA, a qualified beneficiary covered by a group health plan on the day before a qualifying event,
such as a termination of the employee’s employment, must be offered to continue coverage through COBRA. As part of COBRA a group health plan must provide qualified beneficiaries with an election notice describing their rights under COBRA.

The Department of Labor has revised the COBRA model election notice to include information about government-run healthcare exchanges under ACA. Employers need to provide written notification to all employees in the form of a notice. This notice must be sent to all employees.

Review of primary requirements

This checklist is a guide for previous and upcoming healthcare reform requirements and is designed to help you navigate through them.

**NOTICE OF EXCHANGES** – It is the employer’s responsibility to provide the Notice of Exchange to all employees whether enrolled or at time of hire or within 14 days of hire date.

**STATEMENT OF GRANDFATHERED STATUS** – Grandfathered (GF) plans are those that existed on March 23, 2010 and have not made certain prohibited changes. In order to retain GF status, these plans must provide a statement of GF status to participants.

**SUMMARY OF BENEFITS AND COVERAGE** – Health plans (both insured and self-funded) must provide a Summary of Benefits and Coverage (SBC) to participants and beneficiaries.

**60-DAY NOTICE OF PLAN CHANGES** – A health plan or issuer must provide 60 days’ advance notice of any material modifications to the plan that are not related to renewals of coverage. Specifically, the advance notice must be provided when a material modification is made that would affect the content of the SBC and the change is not already included in the most recently provided SBC.

**RESCISSIONS** – A “rescission” is a cancellation or discontinuance of coverage that has a retroactive effect.

Group health plans and health insurance issuers may not rescind coverage for covered individuals, except in the case of fraud or intentional misrepresentation of a material fact.

**ACTION ITEMS:**

- Find out if your company has complied with all employee notification requirements.
- If the Fair Labor Standards Act applies, has the company advised employees of the possible consequences of purchasing individual policies on the Healthcare Marketplace?
- Find out if the company provides a Model COBRA Notice to all employees.

**THE ONLY THING TO FEAR...**

Many fear that the ACA is a Pandora’s box full of surprises. This fear may be warranted, but it is manageable. And the only way to conquer fear is with knowledge... and a strategy.

**Devising a Strategy**

Proactive planning can reduce previously unforeseen headaches and costs associated with the ACA. It’s important to have a vision—one that is consistent with your corporate culture. Most companies find a three- to five-year plan to define its issues in context and be prepared for contingencies that arise.

**Who is AHT?**

AHT Insurance are insurance brokers and consultants with uniquely strong insights into the Affordable Care Act. We were in the room when the laws were formulated, so we know all the ins and outs. And we know the difference between the high-minded spirit of the law and the hard realities on the ground.

**What Can AHT Do for Your Company?**

We have developed strategic employer healthcare
plans for manufacturing companies across the United States. We may be one of the largest brokers, but offer customized solutions.

We save employers money in both short-term compliance and long-term management strategies. We’ll guide you through the minefield of the ACA with a preliminary checkup on what laws currently apply to you. Then we’ll advise you on immediate and future actions to ensure that you minimize penalties and minimize costs while maximizing value for your employees.

**QUICK CHECKS ON FACTS**

**Fact:** The healthcare reform law has had a massive impact on the healthcare system in the U.S. and different employers have different compliance needs.

**Quick Check:** How do you stay up to date on changes in legislation? On what sources do you rely for accurate and timely information?

**Fact:** Under the healthcare reform law, large employers who do not offer affordable healthcare coverage to their full-time employees will face a penalty (called a “shared responsibility payment”).

**Quick Check:** Do you offer affordable health coverage to your full-time employees? Do you know how many full-time equivalent employees you have? Have you decided if you will continue offering coverage and has your current broker helped you evaluate your best options?

**Fact:** Under the Affordable Care Act (ACA), most health plans are not permitted to impose pre-existing condition exclusions, or lifetime or annual limits on enrollees.

**Quick Check:** Does the health plan you offer violate this condition? Does your plan impose “restricted annual limits” that meet the guidelines for the current year? Has your broker given you guidance about this provision of ACA?

**Fact:** The healthcare reform law requires health plans to file statements certifying their compliance with HIPAA’s electronic transaction standards and operating rules.

**Quick Check:** Are you aware of the deadlines for HIPAA certification? Are you in compliance with HIPAA’s electronic transaction standards and operating rules?

**Fact:** The Patient’s Bill of Rights provides three new requirements for group health plans and health insurance coverage that are referred to as “patient protections.”

**Quick Check:** Do you know what protections your employees now have under this bill? Do you know if this bill applies to your plan?

**Fact:** In addition to penalties for not offering affordable healthcare coverage to full-time employees, large employers will face penalties if the affordable coverage they offer does not provide minimum value.

**Quick Check:** Will your plan incur these penalties? Do you know how to determine whether or not it provides minimum value?

**Fact:** Many of the core healthcare reform regulations take effect in 2014 and 2015.

**Quick Check:** Do you know what they are? Has your broker helped you prepare for them? Are you aware of the deadlines for complying?