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LABOR AND EMPLOYMENT

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With the U.S. presidential election behind us, it is clear that the Patient Protection and Affordable Care Act ("Affordable Care Act") is likely here to stay, having survived a U.S. Supreme Court case challenge last June. While affected employers can avoid facing penalties until 2014 for not making health care coverage available to their workforce, the U.S. Department of Labor ("DOL") has begun auditing employers' group health plans for compliance with other requirements of the law that are already in effect. As the DOL steps up its audit efforts under the leadership of the reenergized Obama administration, below are five actions that employers should consider taking in 2013.

1. Assess the Workforce

The Affordable Care Act requires that "applicable large employers" provide minimum essential coverage to their full-time employees or pay a penalty based on the number of full-time employees that they employ (the "pay or play" mandate). An "applicable large employer" is defined as an employer with 50 or more full-time or "full-time equivalent" employees in the prior calendar year. Unlike other laws, the Affordable Care Act defines "full-time employees" as employees who work on average at least 30 hours per week. Although employers are not required to provide health coverage to their part-time employees, part-time workers can be crucial in determining whether the employer meets the threshold number of employees triggering coverage under the Shared Responsibility provisions of the Affordable Care Act. For purposes of this coverage determination, the total number of part-time employees' hours worked in a month are aggregated and divided by 120 to determine the number of full-time equivalents. The number of full-time equivalent employees is then added to the number of traditional full-time employees to determine whether the employer is an "applicable large employer" subject to the pay-or-play provisions. Thus, while full-time equivalent employees are used to determine whether an employer is subject to the law, an employer has no obligation to provide coverage and cannot be penalized for not providing coverage to part-time employees. Lastly, seasonal employees who work 120 days or less are not counted for purposes of coverage determination.

On August 31, 2012, the Internal Revenue Service ("IRS") and other federal agencies issued new guidance providing important safe harbors for employers in determining

whether their employees work an average of 30 hours per week, which would affect their standing as an "applicable large employer" for purposes of the Affordable Care Act. Specifically, the safe harbors allow an employer to look to prior periods in order to determine the number of full-time employees. With respect to existing employees, employers may use measurement periods (measuring full-time status looking back) and stability periods (counting full-time employees) of up to 12 months. Employers may also use an administrative period of up to 90 days following a measurement period and apply a three-month grace period for new employees. For new hires, the 90-day wait period cannot extend the time beyond a year from the date of hire to enroll full-time employees.

There is also a special safe harbor for determining whether variable-hour and seasonal workers are considered full-time employees. Specifically, if a new variable-hour or seasonal employee is determined not to be a full-time employee during the initial measurement period, the employer is permitted not to treat the employee as a full-time employee during the stability period that follows the initial measurement period. This stability period must not be more than one month longer than the initial measurement period and must not exceed the remainder of the standard measurement period (plus any associated administrative period) in which the initial measurement period ends. In these circumstances, allowing a stability period to exceed the initial measurement period by one month is intended to give additional flexibility to employers that wish to use a 12-month stability period for new variable-hour and seasonal employees and an administrative period that exceeds one month. To that end, such an employer could use an 11-month initial measurement period (in lieu of the 12-month initial measurement period that would otherwise be required) and still comply with the general rule that the initial measurement period and administrative period combined may not extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date. For additional information regarding this new guidance and the 90-day limit on waiting periods for group health coverage, see the post on Epstein Becker Green's *Health Employment & Labor Law Blog* entitled "Important New Guidance for Employers Under the Affordable Care Act on the Employer Shared Responsibility Penalties and the 90-Day Waiting Period Limitation."

The determination of whether an employer will be considered an "applicable large employer" going forward helps define an employer's exposure under the Affordable Care Act. As such, this is a critical time to assess the workforce. Employers that are close to the coverage threshold may choose to restructure their workforce by utilizing more independent contractors and seasonal workers, and/or to monitor the working hours of their employees to limit the number of full-time and full-time equivalent employees. Care should be taken to assure that anyone classified as an independent contractor meets all applicable federal and state tests for such classification, particularly given the aggressive enforcement actions that federal and state agencies are taking against employers that misclassify their workers.

2. Choose Whether to "Pay" or to "Play"

In preparation for January 1, 2014, employers subject to the Shared Responsibility Provisions will have to make a choice—to pay or play. Their selection will depend, in large part, on whether the cost of providing benefits to their workforce is outweighed by the potential penalties. In addition, there are other considerations if an employer elects to drop its health plan, such as the effect on workplace morale, susceptibility to union organizing, and issues with recruitment and employee retention.

Employers electing to "pay" will not offer their full-time employees the opportunity to enroll in minimum essential coverage under an employer-sponsored plan. Such employers will be subject to a penalty of $2,000 per employee per year, if one full-time employee who is eligible for a tax credit or cost-sharing benefit purchases coverage through the state-based American Health Benefit Exchanges ("Exchanges"). Although the statutory text provides that such penalty will be triggered even if a single full-time employee purchases coverage through an Exchange, regulatory agencies have indicated that that they are unlikely to adopt such a strict reading. Further, it is likely that a "good faith" standard will be applied in instances of mistake and/or miscalculation. Should the penalty be triggered, however, it will be fully applied to all full-time employees after the first 30.

With the alternative choice—to "play"—an employer elects to provide coverage that is "affordable" and supplies the requisite level of value to its full-time employees. The plan is considered "affordable" as long as it does not exceed 9.5 percent of the employee's household income and provides the requisite level of value, with the employer paying at least 60 percent of the actuarial value of the plan.

It is important to consider that an employer choosing to "play" may also end up paying a penalty if the coverage it offers does not conform to the affordability and minimum value requirements of the law. Specifically, effective January 1, 2014, employers will be subject to a $3,000-per-year tax if one or more of its full-time employees who are eligible for a tax credit or cost-sharing benefit purchases coverage through an Exchange, if the employer-sponsored plan fails to provide a sufficient amount of coverage or is merely too expensive for the employee. This penalty structure is designed to ensure that employers provide competitive plans to their employees.

All of the penalties outlined above are assessed on a monthly basis, and these penalties are likely to increase over time.

3. Evaluate Existing Wellness Programs and/or Implement New Wellness Programs to Enhance Employees' Health Profiles and to Avoid or Minimize the "Cadillac Tax"

In November 2012, the IRS, the DOL, and the Department of Health and Human Services ("HHS") released a Notice of Proposed Rulemaking ("NPRM") implementing the Affordable Care Act's modifications to the Health Insurance Portability and Accountability Act's ("HIPAA's") wellness program authority and providing clarification of the non-discrimination standards for health-contingent programs. For employers, the

proposed rules increase the maximum permissible reward for the cost of health coverage from 20 percent to 30 percent, and increase the maximum reward to up to 50 percent for tobacco-cessation programs. The NPRM would be effective for grandfathered and non-grandfathered plans starting on or after January 1, 2014.

The NPRM maintains the same basic structure of HIPAA's nondiscrimination regulations, which have been in effect since 2006. These proposed rules identify two classes of wellness programs: "participatory wellness programs" and "health-contingent wellness programs." Participatory wellness programs are programs that are made available to all similarly situated individuals and either do not provide a reward or do not include any condition for obtaining a reward that is based on an individual satisfying a standard that is related to a health factor. For example, a participatory wellness program may reimburse all or a part of the cost of a gym membership.

Unlike participatory wellness programs, health-contingent wellness programs require an individual to either satisfy a standard related to a health factor in order to obtain a reward or do more than a similarly situated individual based on a health factor in order to obtain the same reward. For example, a health contingent wellness program may be a program that uses biometric screening or a health risk assessment to identify employees with specified medical conditions or risk factors. The program would then provide a reward to employees who are within a normal or healthy range based on the identified factor, while requiring employees who are outside the normal or healthy range to take additional steps, such as participating in nutrition or health coaching to obtain the reward. Further, under the NPRM, health-contingent wellness programs must provide the following:

1. An Annual Opportunity to Qualify: Health-contingent wellness programs must give individuals eligible for the program the opportunity to qualify for the reward at least once every year.
2. Limits on the Size of a Reward: For insured plans, the maximum total reward offered to an individual under a health-contingent wellness program may not exceed 30 percent of the total premium cost of employee-only coverage, starting with the plan year on or after January 1, 2014. If the employee and any dependents participate in the wellness program, the reward cannot exceed 30 percent of the total cost of coverage in which the employee and the dependents are enrolled. For health-contingent wellness programs geared toward tobacco cessation or reduction, the maximum reward can be as high as 50 percent of the total cost of coverage, starting in 2014.
3. Uniform Availability and Reasonable Alternative Standards: The NPRM requires that any reward under a health-contingent wellness program be available to all similarly situated individuals. Accordingly, plans must provide for a "reasonable alternative standard" so that a full reward is available to individuals for whom it is "unreasonably difficult" or "medically inadvisable" to attempt to satisfy the standard conditions for reward. The purpose of the "reasonable alternative standard" is to ensure that health-contingent wellness programs are reasonably designed to improve health

and do not act as a subterfuge for underwriting or reducing benefits based on health status.

4. A Reasonable Design: The NPRM requires that health-contingent wellness programs (i) be reasonably designed to promote health or prevent disease, (ii) not be overly burdensome, (iii) not be a subterfuge for discrimination based on a health factor, and (iv) not be highly suspect in the method chosen to promote health or prevent disease.
5. Notice of Other Means for Qualifying for the Reward: The plan must disclose the terms of the wellness program in all plan materials and the availability of other means of qualifying for the reward or avoiding the penalty. However, if the plan materials merely mention that a program is available without describing its terms, this disclosure is not technically required.

Five years from now, effective for tax years beginning in 2018, the Affordable Care Act's "Cadillac Tax" will take effect, imposing large excise taxes where a plan's premium costs exceed a certain threshold. Specifically, group health plans will be subject to an excise tax of 40 percent of the value of the coverage that exceeds $10,200 for self-only coverage and $27,500 for family coverage. Higher limits ($11,850/$30,950) apply for certain high-risk professions and retirees aged 55 through 64. Many of the plans in place today will trigger the excise tax, and it will be difficult to avoid this tax by adjusting the deductibles and other cost-sharing features of a plan. In order to avoid this tax, employers will need to reduce the risk in the health plans by enhancing the health profile of their employees. Wellness programs can be a very effective tool for such enhancement, but they need time to work. As such, because the Cadillac Tax does not become effective until 2018, this is an opportune time for employers to implement properly designed wellness programs to help reduce future costs and to potentially avoid these large excise taxes altogether. In addition, employers that fail to embrace wellness programs and the movement to higher rewards could find themselves at a significant competitive disadvantage as compared to their industry competitors that elect to implement these programs.

4. Understand and Be Ready to Comply with New Tax-Related Changes and Requirements

There are several new changes and requirements that a covered employer must be aware of and comply with. For example:

- **Limits on Flexible Spending Account ("FSA") Salary Reductions**. For plan years commencing *after December 31, 2012*, a $2,500 annual limit on salary reduction contributions applies to health FSAs. Dependent Care FSAs, which were unaffected by the Affordable Care Act, remain limited to $5,000 per year.
- **W-2 Form Reporting of Employer-Provided Health Coverage.** Commencing with the 2012 tax year, employers issuing 250 or more Forms W-2 must include the cost of employer-sponsored health coverage on each worker's Form W-2. This must be prepared and provided to

employees in *January 2013*. The amount reported does not affect tax liability, as it is for informational purposes only.

- **Elimination of the Employer Deduction**. As of *January 1, 2013*, the employer deduction for subsidized retiree prescription drug expenses is eliminated.
- **Federal Insurance Contributions Act ("FICA") Tax Increase (Unearned Income Medicare Contribution).** As of *January 1, 2013*, the FICA tax for 2013 will increase by 3.8 percent on certain unearned income (e.g., capital gains, dividends, and gains from sale of a home) of high-income individuals with adjusted gross income over $200,000 annually; $250,000 if married and filing jointly; or $125,000 if married and filing separately.
- **Medicare Tax Increase**. In 2013, the employee portion of Medicare tax on wages will increase by 0.9 percent for high-income individuals earning wages over $200,000 annually; $250,000 if married and filing jointly; and $125,000 if married and filing separately. The Medicare tax increase will apply to wages in excess of such thresholds.
- **Notice of Exchanges.** No later than *March 1, 2013*, employers must provide employees and new hires with a written notice of the availability of the Exchanges. The notice must describe the services provided by the Exchanges and inform employees of their potential eligibility for a premium tax credit or a cost-sharing reduction. The HHS is expected to issue a model notice, which must meet certain readability and accessibility requirements and be in writing.

On January 1, 2014, additional and much-anticipated Affordable Care Act mandates will take effect, including, the employer "pay or play" mandate, auto-enrollment, 90-day waiting period limits and the elimination of annual dollar limits on essential health benefits. For a comprehensive list of the upcoming deadlines, see the post on Epstein Becker Green's *Health Employment & Labor Law Blog* entitled "Timeline of Highlights for Employer Group Health Plan Compliance with the Affordable Care Act."

5. Conduct Self-Audits to Ensure Compliance

The DOL has already begun auditing employers' group health plans and is expected to step up its auditing efforts this year. As is typical of a DOL group health plan audit, the DOL is seeking documentation that demonstrates an employer's compliance with the Affordable Care Act. An insufficient response to a DOL audit request could lead to additional inquiries and even lawsuits. Moreover, various penalties could be imposed by the DOL and/or the IRS for failure to implement certain Affordable Care Act-related coverage mandates.

As such, employers are strongly encouraged to conduct self-audits to ensure compliance with all of the applicable provisions and mandates of the Affordable Care Act. It is equally important for employers to ensure that their compliance efforts are well documented by (i) preserving all records relating to the plan administration, design, and

maintenance, including contracts with third-party service providers; (ii) preserving all documents distributed to employees that provide notice of the Affordable Care Act's provisions; and (iii) ensuring that all written policies that implement any Affordable Care Act mandates are easily obtainable for production.

For a listing of examples of information and documents requested by the DOL from grandfathered and non-grandfathered health plans, see a recent post on Epstein Becker Green's *Health Employment & Labor Law Blog* entitled "Obama Reelected: The Department of Labor Wants to Know if You Are Taking Steps to Comply With Healthcare Reform."

To stay up to date on the latest regulatory developments, please consult Epstein Becker Green's Health Employment & Labor Law *and* PPACA Impact and Opportunities *blogs.*

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