What Every Employer Should Know About the Affordable Care Act

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What Every Employer Should Know About the Affordable Care Act

Background

Key Provisions of the ACA Affecting Employers

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Segment Overview

- Background
- Key provisions of the ACA affecting employers
  - Individual responsibility requirement
  - Employer shared responsibility requirement
  - Exchanges
  - Automatic enrollment requirement
  - Private insurance reforms
    - Grandfathered Plans
  - Summary of Benefits and Coverage (SBC) requirement
- Q&A

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Background – Supreme Court and Elections

- U.S. Supreme Court
  - In March, the Supreme Court heard over six hours of argument in litigation over the ACA
  - The four main questions addressed were:
    - Do the federal courts have **jurisdiction** to hear the challenge at all?
    - Is the **individual mandate constitutional**?
    - If so, can the mandate be **severed** from the remainder of the law?
    - Is the **Medicaid expansion constitutional**, or is it coercion of state decision-making, inconsistent with the Tenth Amendment and principles of federalism?
  - On June 28, in a 5-4 decision, the Supreme Court issued its opinion:
    - Yes, the federal courts **have jurisdiction** to hear the challenge to the ACA today;
    - Yes, the individual mandate is **constitutional;**
    - As a result, the court **need not address** the issue of severability; and
    - The Medicaid expansion is **not constitutional, but only because of the way that it is enforced.**
- Effect of the elections

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Key Provisions of the ACA Affecting Employers

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Individual Responsibility Requirement

- The requirement is constitutional *post-NFIB v. Sebelius*

- Individuals will be required to maintain "minimum essential coverage" for themselves and their dependents beginning in 2014.
  - If minimum essential coverage is not maintained, the individual will have to pay a penalty (included on their federal tax return) for each month he or she does not maintain such coverage.

- "Minimum essential coverage" includes:
  - Coverage under government sponsored programs (e.g. Medicare, Medicaid, TRICARE)
  - An eligible employer-sponsored plan
  - Health plan offered in the individual market
  - Grandfathered health plans
  - Certain other coverage, such as state health benefits risk pool.

- There are certain exemptions from the requirement and penalty, for example when coverage is "unaffordable" – i.e. the individual's required contribution is over 8% of household income for that month (in 2014).

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Employer Shared Responsibility Requirement

- "Applicable large employers," i.e. 50 or more full-time employees (FTEs), beginning in 2014 must offer coverage to FTE and their dependents, or else pay a penalty.
- Penalty assessed annually for each FTE (excluding the first 30 employees, and adjusted yearly based on premium growth)
  - Assessed for any month that any FTE is certified to receive a premium tax credit or cost-sharing reduction for coverage purchased through an Exchange **if**:
    - Employer failed to offer minimum essential coverage through eligible employer-sponsored health plan, (highest penalty) or
    - Employer offers minimum essential coverage, but it is either unaffordable (i.e. employee contribution >9.5% of their household income), or does not provide "minimum value" (i.e. health plan's share of health care expenses is < 60% of total covered health care costs) (lower penalty).
      - Policy regarding "household" income
- Treasury and IRS have described a proposed safe harbor allowing employers, to use an employee's Form W-2 wages instead of household income in determining whether coverage offered is affordable.
- Using a defined contribution model to satisfy the coverage requirement

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Exchanges

- What is an Exchange?
  - State-operated Exchanges v. "Partnership Exchange" v. Federally Facilitated Exchange

- Required notice to employees – employers must give written notice to current employees by March 1, 2013 and to all new hires at the time of hiring informing them of:
  - (1) Existence of an Exchange, its services, how to contact the Exchange for assistance;
  - (2) Availability of premium tax credits and cost sharing reductions if the employer's health plan covers less than 60% of total allowed costs of benefits, and if employee purchases a QHP on the Exchange; and
  - (3) If the employee purchases a health plan through the Exchange, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer.

- Penalties for employers whose employees purchase a QHP on an Exchange and are certified as eligible for the tax credit or subsidies (see previous slide)

- Essential Health Benefits – required in non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges beginning in 2014.

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Automatic enrollment requirement

- An employer subject to the Fair Labor Standards Act (FLSA) and have more than 200 full-time employees must
  - Automatically enroll new employees in one of its health benefit plans (subject to any waiting period authorized by state law), and
  - Continue enrollment for current employees
- Employer must also provide the employee with adequate notice and opportunity to opt out of any coverage in which the employee was automatically enrolled
- IRS notice stated that employers need not comply with this provision until the Department of Labor issues regulations
  - Regulations are expected to be completed in 2014

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W-2 Reporting

- Purpose of the requirement: informational only, to provide employees useful and comparable consumer information on the cost of their healthcare

- Employers that provide applicable employer-sponsored coverage under a group health plan are required by the ACA to report the cost of coverage under their plans on Form W-2, effective for calendar year 2012 (i.e. Form W-2 generally provided to employees in January 2013).

- Transition relief: IRS has delayed the requirement for employers who file fewer than 250 Forms W-2 for 2012 and until further guidance is issues.

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Private Insurance Reforms

- Many private insurance market reforms of the ACA have already been implemented.
  - For grandfathered and non-grandfathered health plans, these include, for example:
    - Coverage must be extended to adult children up to age 26.
    - Lifetime and annual limits on essential health benefits are prohibited (certain exceptions apply for plan years beginning before 2014).
    - Pre-existing conditions exclusions for enrollees under age 19 are prohibited
    - Retroactive rescissions of coverage are prohibited except for fraud, misrepresentation, or nonpayment of premiums.
- Medical Loss Ratio
  - Health insurers must spend a certain percentage of premiums on health care services and activities to improve health care quality
    - For insurers in the individual and small group markets – 80 percent.
    - For insurers in the large group market – 85 percent.
  - If the required percentage is not met, health insurer must rebate the difference.
  - For employers with fully insured plans: consider whether the plan or the employer is entitled to the refunds, whether refund is a “plan asset” to be shared with employees, and whether plans should be amended to allow refunds to be retained solely by the employer.
- Aggregation through Professional Employer Organizations (PEOs)

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Grandfathered Plans

- Grandfathered health plans refer to certain group health plans and health insurance coverage that existed as of March 23, 2010.
- Certain provisions of the ACA apply to grandfathered plans (e.g. excessive waiting periods, lifetime limits, rescissions, and extension of dependent coverage), whereas other provisions do not (e.g. requirement to provider coverage without cost sharing for preventive services for women).
- Departments of the Treasury, Labor, and HHS issued an interim final rule in 2010 recognizing that plans should be able to make some changes and still remain grandfathered health plans.
  - The Departments listed examples of changes which a grandfathered health plan can make that will either: cause the plan to lose its "grandfathered health plan" status, or allow the plan to remain "grandfathered."
- Employers that offer grandfathered health plans should consider whether any plan design changes they may wish to make could cause the plan to lose its grandfathered status.

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Summary of Benefits and Coverage (SBC)

- Purpose: to ensure individuals have a simple, easy-to-understand summary of the benefits and coverage available under their health insurance plan.
- Group health plans and health insurance issuers in the group and individual markets are subject to the SBC requirement.
- Requirement applicable the first day of the open enrollment period that begins on or after September 23, 2012 (or for participants and beneficiaries who enroll outside of an open enrollment period, the first day of the first plan year that begins on or after September 23, 2012.)
- Final rule details the required content elements of the SBC, appearance and form, when a notice of modification must be provided to plan enrollees, beneficiaries and insured individuals, and common definitions.
- Penalties specified in the statute; however, for the first year of implementation, a good faith policy toward compliance.

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Questions and Answers

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Immediate Changes to the Work Environment

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Segment Overview

- Lactation breaks
- W-2 reporting
- New summary of benefits & coverage and related issues
- Defining “large” employer
- Defining “full-time” employee
- Tax credit issues
- Issues related to Massachusetts health care reform

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Lactation Breaks

- Effective in March 2010 as an amendment to the FLSA
- Employers must provide “reasonable break time” for nursing mothers for up to1 year after the child’s birth
- Time is not compensable unless employer provides paid breaks or if employee is not relieved from duty
- Provide a private location; not a bathroom
- Temporary, as-needed space is ok, but must be functional and free from intrusion
- Law does not specify number or length of breaks
- Employers with fewer than 50 employees may be exempt if “undue hardship” due to significant difficulty or expense in complying with the law

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W-2 Reporting

- Employers must report cost of providing benefits on W-2 form
  - Health
  - Dental
  - Vision
  - HSA and HRA
  - Do not have to include employee salary reduction contributions to FSAs
- Supposed to be effective 2011
- Was optional for 2011
- Mandatory for 2012 W-2 unless subject to transition relief
  - Key exception is if you filed fewer than 250 W-2 forms in 2011

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New Summary of Benefits & Coverage

- Health plans must provide a “SBC” to participants and beneficiaries upon the first day of coverage, upon renewal or upon request
- Content & form
  - Cannot be more than 4 pages long and must be in 12 point font
  - Presented in a culturally and linguistically appropriate manner
  - Provide a description of coverage, exceptions and cost sharing
  - Provide coverage examples
- Plan must give notice of material modifications that affect the content of the SBC
- A willful failure to provide a compliant SBC to a participant or beneficiary is subject to a fine of up to $1000 per failure

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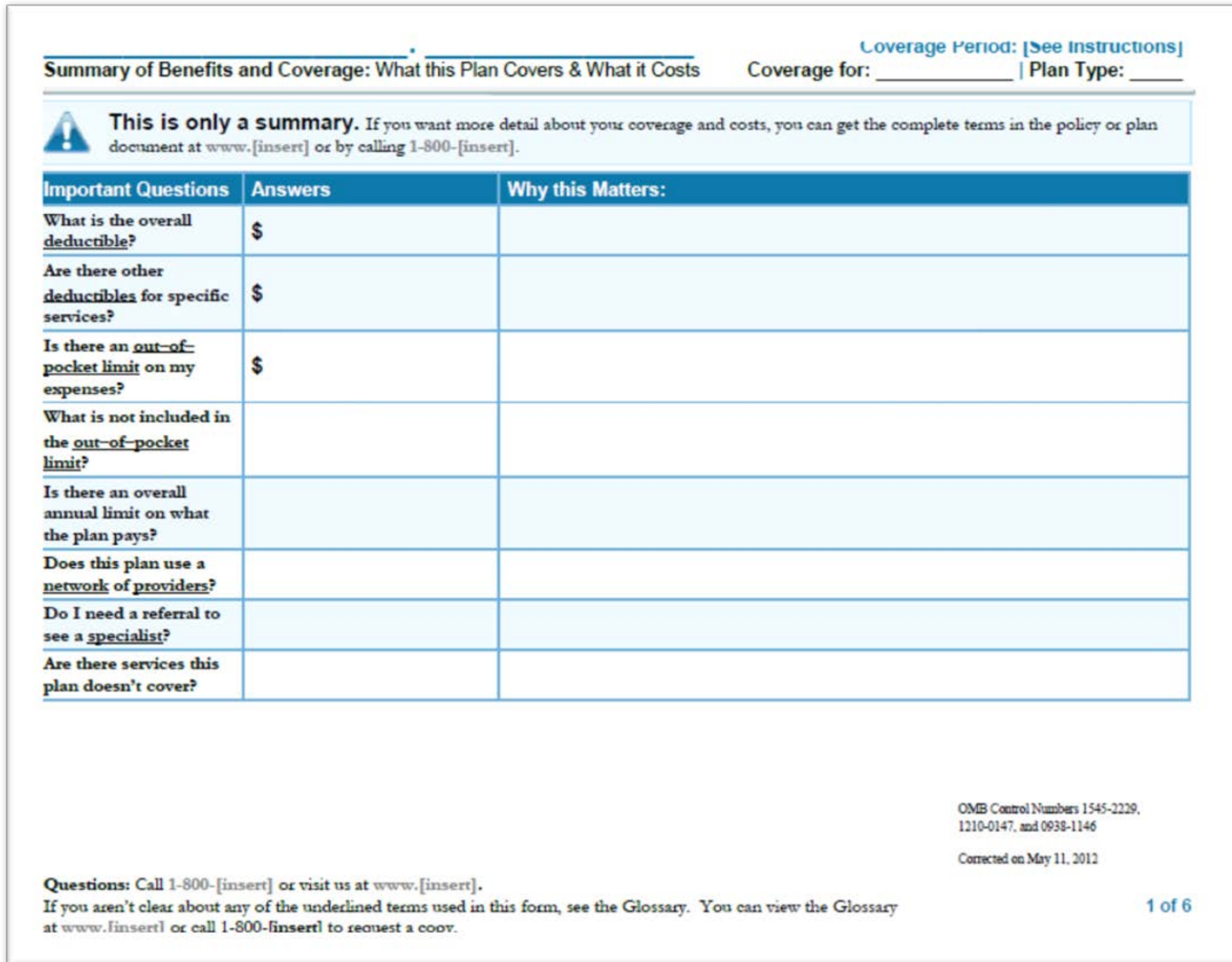
Summary of Benefits Template


Coverage Period: [See Instructions]

Summary of Benefits and Coverage: What this Plan Covers & What it Costs   Coverage for: ____________ | Plan Type: _____

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$	
Are there other deductibles for specific services?	$	
Is there an out-of-pocket limit on my expenses?	$	
What is not included in the out-of-pocket limit?		
Is there an overall annual limit on what the plan pays?		
Does this plan use a network of providers?		
Do I need a referral to see a specialist?		
Are there services this plan doesn't cover?		

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

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Employer Responsibilities

- No regulations have issued; only technical guidance
- DOL, IRS and HHS are trying to gather information to coordinate approach to three issues:
  - 90-day waiting period
  - Automatic enrollment (on hold)
  - Employer shared responsibilities
- Fundamental issue is how to determine who is a “full-time” employee
- Recognition that employers will need time to adjust
- Technical guidance gives employers flexibility through 2014
- Regulations likely will issue soon since election is over

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90-Day Waiting Period

- Beginning on January 1, 2014, a group health plan cannot impose a waiting period that exceeds 90 days
- Rule does not require the employer to offer health insurance to any particular class of employees
- 90-day period runs from when the employee or dependent is eligible for coverage
- Eligibility based on number of hours worked is acceptable, provided that the condition is not designed to avoid the 90-day limitation
- An employer can use a measurement period to determine eligibility (i.e. to assess whether employee is working full-time and eligible for benefits) provided that coverage is effective within 13 months from start date
- Employers can rely on this technical guidance through the end of 2014

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Employer Mandate

- Covers “large“ employers meaning those with 50 or more FTEs
- Pay an assessment for each full-time employee who receives a premium tax credit or cost-sharing reduction payment. This occurs if:
  - the employer does not offer full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan OR
  - the employer offers minimum essential coverage under the employer plan but the plan is unaffordable relative to employee’s household income or does not provide minimum value
- Full-time is defined as 30 hours per week
- Fine is $2000 or $3000 per employee, excluding the first 30 employees from calculation

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What is a "Large" Employer?

- Problem of a seasonal workforce
- If employer exceeds 50 FTE for 120 days or fewer in a year and the excess were seasonal workers, then not a large employer
- Work must be seasonal in nature and not performed continuously throughout the year

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Who is a Full-Time Employee?

- Different rules depending on whether the employee is an on-going employee or a new employee
- For on-going employees, an employer is expected to determine an employee's full-time status by looking back at a "standard measurement period"
- The standard measurement period must be between 3 and 12 months
- A "full-time" employee is one who works on average 30 hours per week across the standard measurement period
- The employer must treat the employee as full-time during a subsequent "stability period" of at least six months and no shorter than the standard measurement period
- Employers may use different periods for different categories of employees (i.e., salaried vs. hourly, employees in different states)

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Who Is a Full-Time Employee

- If a new employee is reasonably expected to work full time, then she is a “full-time” employee
- An employer will not owe the assessment for imposing a waiting period of up to 90 days
- For new, variable hour employees, the employer may use an initial measurement period of 3 to 12 months plus an administrative period
- Total time period cannot exceed about 13 months from date of hire
- Must be treated as full-time during the stability period used for on-going employees
- A variable hour employee includes a seasonal employee who works full-time during the seasonal period but not during the remainder of the initial measurement period

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The Challenge for Employers

- Employers can rely on this technical guidance through the end of 2014
- But employers need to plan how they are going to approach calculation of full-time status
- Employers have flexibility, so opportunity to be strategic to avoid payment of any fees
- For example, if you are a retail employee with a high number of seasonal employees, you want a longer measurement period
- Technical guidance also provides guidance on how to schedule variable hour employees to avoid full-time status

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Tax Credit for “Small” Employers

- Employers with fewer than 25 FTEs and average annual wages of $50,000 per FTE
- Must pay 50% or more of the premium cost
- Credit calculated by a formula
- Prior to tax year 2014, the credit is capped at 35% of the employer’s premium expense
- Cap is increased to 50% beginning in 2014

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What about MA Health Care Reform?

- Employer coverage is different
- Technical guidance is not fully consistent with the Fair Share Contribution
- Cannot have a waiting period longer than 90 days
- Full-time definition is different
- Determination of whether an employee is full-time is not based on a look-back period or an average
- Federal rules do not affect FSC liability (unless preempted)
- Employers who do not offer health insurance could pay both the FSC and the federal $2000 fine

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Overall Program Conclusion

- Now that President Obama has been re-elected, implementation of health care reform will proceed ahead.
- Multiple ACA regulations pending in Departments; OMB:
  - Final Exchange regulation
  - Definition of essential health benefits
  - Exchange certification
- Most of these regulations will be issued between now and the end of the year.
- Employers should anticipate that regulations will go into effect as proposed.

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