Leavitt Group

Benefit Trends

HEALTH CARE REFORM – SPECIAL EDITION

Health Care Reform: Be Prepared It's Later Than You Think

LEGISLATIVE BRIEF

January 28, 2013

Most employers must prepare now to greet the full implementation of the Affordable Care Act (ACA) and its related guidance (Health Care Reform). Employers with more than 50 employees must develop their strategies regarding future hires, choice of plans, and financial impacts. Employers approaching the 50 employee threshold must prepare for the eventuality of becoming subject to their obligations under the 2014 employer shared responsibility rules. To make that determination, employers must understand and apply the recently issued proposed regulations on the definition of employees and how to count them, as well as what their responsibilities and potential risks will be if they have at least 50 full time employees or equivalents (FTEs) in 2014. Part One of this Benefit Trends will discuss the current regulatory guidance regarding the 50 employee threshold. Part Two will discuss the employer obligations resulting from becoming subject to the employer's shared responsibilities under ACA.

Discussion Part One: The 50 Employee Threshold

1. **Employers Subject to the Shared Responsibility Rules**. Whether the employer (or successor employer) will be subject to the shared responsibility rules (ESR Rules) and potential exposure to financial penalties (excise taxes) under Internal Revenue Code (IRC) § 4980H, depends on whether the employer employs, on average, 50 or more full time employees (including FTEs) who work 30 or more hours per week. For example, an employer may have 40 full time employees (30 hours) and 20 half time (15 hours) employees. Since this would equate to 50 FTEs, this employer would be subject to the ESR Rules in 2014.

2. **"On Average" Defined**. For purposes of compliance in 2014, employers may use any six month consecutive period to count employees. If that period results in confirming employment at 50 or more full time employees, then the employer must choose to offer group health plan coverage to substantially all (95%) full time employees for 2014 and beyond. In subsequent years, the employer can use the average number of employees in the previous year.

3. **"Employee" Defined**. Employee means a common law employee. The employer does not have to offer coverage to employees scheduled to work less than 30 hours. Special rules:

    - **Breaks in Service**: Countable if return to work within 26 weeks;
    - **Paid Leave**: Must count all paid leave towards full time status;
    - **Full-Time Collectively Bargained Employees**: Must count only if the bargained plan fails the minimum essential benefit test, as discussed later in this Benefit Trends;
    - **Seasonal Workers**: Countable if they are FTEs for (a) more than 90 days, or (b) work more than 120 days during the six month consecutive measurement period. Employers may use a good faith standard here;
    - **Partners, Sole Proprietors**: 2% S-Corp shareholders not countable; and,
    - **Leased Employees**: Countable.

4. **What About 1099 Employees?** Some employers hire independent contractors (1099 employees) to round out their workforce. Unfortunately, the use of independent contractors as a way to avoid crossing the 50 life threshold is risky business. If a government audit finds that these individuals do not qualify as independent contractors, the employer would not only pay back payroll taxes but also become subject to penalties under the employer shared responsibility rules. The Department of Labor is waiting in the wings, here.

5. **Controlled Group of Employers.** If there are 50 or more full time employees or FTEs employed by the combined employers with a common owner or for ownership-related companies, then the entire group of employers becomes subject to the ESR Rules. The regulations provide detail on what constitutes common ownership. If an employer or group of employers has less than 50 employees in the United States, but many more worldwide, even with U.S. citizens working abroad, the ESR Rules will NOT apply.

6. **The Meaning of Full Time.** The regulations involving the 30 hour/90 day requirement contain a number of complex rules, especially with regard to variable hour employees. In brief, individuals hired on a full time basis are presumed to be at 30 hours or more a week. However, certain industries rely on variable hour workers (e.g. hospitals, retail stores, agri-biz, etc.). The regulations allow employers to use a look back period. Employers with variable hour workers must use 2013 payroll data to identify how many full time workers are there in 2013 that will then be there in 2014. This is a critical step for employers with variable hour workers on their payroll. These rules apply to new employees as well as on-going employees on a year by year basis.

7. **Transitional Relief for Employers Crossing the Threshold.** If the employer offered group health coverage to its employees on or before December 27, 2012 (e.g. policy renewal: 7/1/2012) and the coverage either is renewed or replaced in 2013, the employer does not become subject to the ESR Rules until that plan's next anniversary (July 1, 2014), subject to the following additional conditions:

    - The coverage offered on or before December 27, 2012 was offered to at least one third of its employees, without regard to the definition of full time for purposes of eligibility; or,
    - The plan actually covers at least one quarter of its employees at its most recent open enrollment.

    THE DUAL CHOICE ISSUE: If the employer offers two or more plans and if they have the same ERISA plan year, the employer can combine participation to meet these criteria to circumvent issues of low participation. It is our understanding that the regulations actually intend to use the term plan year (e.g. Plan No. 501) and not renewal years. In other words, an employer could have a plan renewal

date of July 1 for Kaiser Permanente and September 1 for Aetna as long as both policies are reportable for 5500 purposes under the same plan number with a July 1 plan year. If these conditions are met, this non-calendar year plan would become subject to the ESR Rules on July 1, 2014.

8. **Coverage for Dependents**. The December 28, 2012 regulations state that employers must offer health care coverage for dependents as a part of meeting the ESR requirements. The regulations clarify that dependents means children up to age 26 as defined at IRC § 151(f)(1) and does not include spouses. On the basis that this change may require time for employers who previously offered only single coverage to implement, the IRS will waive any associated penalty for plan years beginning in 2014, solely associated with the failure to offer coverage to dependents for that year.

Discussion Part Two: Shared Responsibility and Related Obligations

1. **Shared Responsibility Requirements**. Employers with 50 or more full time employees (including FTEs) must offer adequate and affordable health care coverage to all employees who are scheduled to work 30 hours per week (including variable hour employees who average 30 hours per week) and who have been employed for at least 90 days. Failure to meet this standard will result in the imposition of non-deductible excise taxes pursuant to IRC § 4980H. The ESR Rules provide the following safe harbors:

    - To be adequate, the plan must cover essential benefits and provide a minimum value of at least 60% of the total expected costs of the plan as a benefit to the plan participant. The minimum value calculation, takes into consideration, plan design/benefits standards as well as deductible and co-pay requirements. Both the Health and Human Services (HHS) and the Department of Treasury will provide uniform calculators for employers to use to determine whether their plans meet these standards. Regulations also allow independent actuarial certification.

    - To be affordable, the employee contribution must not exceed 9.5% of his/her W-2 wages (Box 1) toward the cost of employee-only coverage. It's worth noting there is no contribution limit on the amount an employer can charge for dependent coverage. In today's world, the cost of dependent coverage could, in practice, make dependent coverage unaffordable for some workers.

2. **How the Penalty Works**. Beginning in 2014, every employer with 50 or more employees must offer health care coverage. The excise tax under IRC § 4980H attaches if:

    - At least one employee obtains coverage through a public Exchange (e.g. the California Health Benefit Exchange);

    - And, one of the following occurs:

        - The employer fails to offer minimum essential coverage to all its full time employees and dependents (IRC § 4980H(a)).

          The penalty is $166.67 for each full time employee for each month that coverage is not available (excluding the first 30).

        - OR, the employer does offer minimum essential coverage to its full time employees and dependents but it is either unaffordable or does not provide minimum value (IRC § 4980H(b)).

          The penalty is $250 per month per employee who buys coverage through an Exchange and qualifies for a premium tax credit or cost sharing reduction, not to exceed the collectible penalty accruable if the employer offered no coverage (IRC § 4980H(a)).

PENALTIES IN THE CONTROLLED GROUP ENVIRONMENT: The December 28, 2012 rules indicate that penalties will be assessed on a plan by plan basis. So, in the event one employer's plan becomes subject to a penalty under IRC § 4980H, the penalty will apply only to that employer's plan and not to all plans offered by related employers in a controlled group.

FAILURE TO PAY PREMIUM: An employer is not subject to the penalty for any employee whose coverage terminates due to non-payment of any required contribution.

MULTI-EMPLOYER PLANS: Plans subject to collective bargaining will not be subject to penalties for 2014, under the 4980H excise tax rules, as long as the employer is required to make a contribution to a multi-employer plan for full time employees and the coverage offered to the employees and their dependents is affordable and meets the minimum value standard.

3. **The Premium Tax Credit**. At the time an employee applies for health care coverage through an Exchange, the employee will provide evidence of his/her household income (most recent Modified Adjusted Gross Income as reported for income tax purposes). If that income is below 100% of the poverty line they are not eligible for the tax credit since they would be Medicaid eligible. If the household income level is between 100% of the poverty line (for example, $11,170 for single individuals and $23,050 for a family of four in 2012) and 400% of the poverty line ($44,680 for single individuals and $92,200 for a family of four in 2012), the employee will qualify for the tax credit or cost sharing reduction. The tax credit or cost reduction is also available to lawfully present aliens with household income below 100% of the federal poverty line since they are not eligible for Medicaid. The least amount payable by the lowest paid qualifying employee will be 2% of premium, increasing by income level to not more than 9.5% of premium, for single coverage.

   On January 22, 2013, the Centers for Medicare and Medicaid Services (CMS) published proposed rules for Exchanges to use for enrollment purposes. The CMS rules provide state Exchanges with more flexibility in administering the premium tax credit requirements.

4. **The Exchange Process**. In brief, the Exchanges offer only Qualifying Health Plans to its applicants (i.e. plans containing benefits which meet all federal minimum standards). When an individual applies for coverage and potentially meets the standards to qualify for a premium tax credit, the Exchange notifies HHS. HHS then sends a notice to the employer. The employer can dispute the finding, procedure yet to be announced.

5. **The 9.5% Problem**. The regulators do provide some relief for employers with fiscal year plans who currently charge more than 9.5% of wages as a contribution for single coverage. The December 28, 2012 rules allow for fiscal year 2013 plan years, a midyear change of IRC § 125 pre-tax contributions to allow participants to revoke or modify their accident and health plan elections once, without regard to the change in status rules described in the current 125 plan regulations. The same relief is available to employees who fail or have failed to make a salary reduction election for the 2013 fiscal plan year. Employers will have until December 31, 2014 to amend their 125 plans accordingly.

6. **Alternatives to the W-2 Approach to the 9.5%**. Although the W-2 approach is a safe harbor, an employer may also use the rate of pay approach: the employer takes an individual's hourly rate of pay, multiplies it by 130 to get a monthly wage. This approach would work for new employees or for those whose wages increased during the year. It cannot be used if wages are reduced.

   The employer may also use the federal poverty level approach. Under this approach, the employer sets the contribution maximum at 9.5% of the federal poverty line for a single individual.

7. **The Medicaid Issue**. Chief Justice Roberts, in his historic June 28, 2012 ruling on ACA, in addition to ruling on the mandate, also ruled on the rights of states to choose to participate or not participate in the Medicaid expansion. Some states have indicated they will not expand Medicaid coverage which would result in fewer people enrolled in Medicaid making more people eligible for the premium tax credit. Employers in those states need to be cognizant of the risk of additional employees qualifying for the premium tax credit in those states.

8. **Federally Facilitated Exchanges**. The premium tax credit is available only through federally facilitated Exchanges. The law is not clear. Does this mean only those Exchanges established by the states? California has established such an exchange; however only 18 other states have done so. Seven other states are planning multi-state Partnership Exchanges, and 25 states are defaulting to the federal Exchange). Would this mean that employers with employees in other states will NOT be at risk of excise tax penalties for health plans run in states which are not federally facilitated?

9. **The Minimum Value Test and Self-Funded Health Reimbursement Accounts and Health Savings Accounts**. It is unclear whether a health plan's minimum value can include benefits provided by a supplemental Health Reimbursement Account (HRA). Currently, we expect the agencies to allow an employer to use the value of a supplemental reimbursement account. It is more unclear whether employer contributions to an employee's Health Savings Account (HSA) in conjunction with a high deductible health plan (HDHP) can be included in the testing for minimum values. We may have clarity once HHS and IRS publish their respective calculators.

   Unfortunately, stand alone HRAs are less likely to be used to satisfy the minimum essential coverage requirement.

   The Agencies have indicated that the rules promulgated for ESR on December 28, 2012 may be relied upon into 2014. Apparently the Agencies are concentrating on rules for the public Exchanges and do not expect to issue further guidance on ESR in the near term.
