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Affordable Care Act:
Key Issues for Employers in 2014 and Beyond

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It has been almost four years since the Affordable Care Act ("ACA") was signed into law in March of 2010, and nearly two years since the Supreme Court rejected the significant constitutional challenges that were made to the ACA. Since 2010, a number of ministerial health plan mandates have become effective under the ACA. By now, these mandates should have been implemented by an employer's insurer or third party administrator, and include such things as:

- the requirement to extend dependent coverage until a dependent child reaches age 26;
- prohibitions on annual and lifetime limits for essential health benefits;
- alterations to the administrative claims and appeals process and external review requirements; and
- patient protections such as primary care physician rules and coverage of emergency room services.

This summary picks up in 2014, and is designed to provide an executive overview of the most important action items affecting employers and employer group health plans under the ACA that have only recently become effective or will become effective in 2014 and beyond. In this summary, we identify 10 issues that employers and their advisors should generally understand, the most complicated of which is the so-called "Pay or Play" rules that go into effect in 2015. On this issue, we also pose a number of questions that employers and their advisors should be considering in evaluating these requirements. Please note that this is a high-level summary, and does not include all of the details and nuances on the issues discussed. It is intended to help identify issues that should be addressed by employers, not to provide a complete explanation of each topic.

1 - Pay or Play

By far the most important issue for employers to consider under the ACA in 2014 and beyond is the employer "free rider penalty," often referred to as "pay or play." The basic concept is simple: instead of forcing employers to provide group health insurance to employees, the ACA imposes a tax on employers if they don't offer coverage to substantially all of their full-time employees (and their dependents), or if that coverage fails to meet certain conditions. But as

with any tax, the devil is in the details, and every detail is critically important. What follows is a plain English explanation of the most important details.

The pay or play rules will be in effect for large employers beginning on January 1, 2015 (though transitional relief applies to employers with non-calendar year plan years). Large employers for this purpose include employers that have, on average, at least 50 full-time employees on business days during the preceding calendar year (part-time employees are included in this determination, counting each part-time employee's full-time equivalency). Employers within the same controlled group are considered the same employer and must be combined when determining if there are at least 50 full-time employees total. Large employers should begin to look at how they structure their health insurance coverage well in advance of 2015.

The amount of the tax depends both on whether the employer offers coverage to all or substantially all of its full-time employees, as well as the value and affordability of that coverage. Specifically, the ACA imposes one of two potential taxes:

1A. Tax on Employers Not Offering Minimum Essential Coverage ("Headcount Tax" – Likely Very Large)

If an employer does not offer health coverage to all or substantially all of its full-time employees who work at least 30 hours per week (and their dependents), it will be subject to a tax of $2,000 per year for each of its full-time employees. Under the IRS's proposed regulations, the term "substantially all" allows employers to satisfy the rules by offering coverage to at least 95% of the employer's full-time employees (and their dependents). The first 30 full-time employees are not counted for purposes of the tax.

Stated simply, the failure to offer coverage to substantially all full-time employees and their dependents results in a "headcount tax," calculated based on the number of full-time employees (but the first 30 full-time employees are free). The headcount tax amount will be adjusted for inflation after 2015.

1B. Tax on Employers Offering Minimum Essential Coverage That is Unaffordable or Fails to Provide Minimum Value ("Individualized Tax" – Potentially Small)

If the employer offers coverage to all of its full-time employees, but this coverage is either (a) "unaffordable" (i.e., the premium to be paid by the employee is more than 9.5 percent of the employee's W-2 wages); or (b) fails to provide "minimum value" (i.e. covers less than 60% of the total allowed costs of benefits), then the employer's tax is calculated using a different method. In this case, the employer must pay an annualized tax of $3,000 each year (also adjusted for inflation) with respect to each full-time employee who opts out of the employer's group health plan and receives a premium tax credit. The annual penalty is capped at $2,000 times the total number of full-time employees in excess of 30 (also adjusted for inflation).

Due to the fact that this tax is only assessed for individuals who opt out of the employer's plan and are eligible for premium tax assistance, the individualized tax for a particular employer is potentially small. Individuals are only eligible for premium tax assistance if their household income exceeds 400% of the federal poverty level ($45,960 single; $94,200 family of four) or is less than 100% of the federal poverty level ($11,490 single; $23,550 family of four).

1C. Key Decision Points Under Pay or Play

An exhaustive explanation of possible pay or play strategies is beyond the scope of this memo. There is no one-size-fits-all approach. Nonetheless, employers should focus on the following key decision points as soon as possible:

Determine the Methodology for Counting "Full-Time Employees" Now

To effectively gauge risk and apply the rules, the employer must understand which of its employees are full-time employees under the ACA pay or play rules. The answer will be clear for many employees, but is more complicated when dealing with variable hour or seasonal employees. The IRS established safe-harbor methods for counting FTEs by using a "standard measurement period," and a "stability period." The lengths of these periods and their starting and ending dates are set by each employer and may vary between different categories of employees. Employers should begin exploring which methodology they will choose now, because determinations about which employees are full-time employees would optimally be made in advance of the open enrollment period occurring before 2015.

Employer Choice Remains

There is no mandate for employers to provide employee health coverage. Employers will remain free to either offer health coverage for their employees, or not, as well as determine which particular classes of employees are eligible for coverage (subject to nondiscrimination rules). Therefore, the pay or play rules should not be understood as a mandate to sponsor a group health plan. Employers that don't "play" will simply "pay" a tax instead. Depending on the taxes that employers are willing to bear, as well as the cost of insurance, some employers may decide to both play (for one group of employees) and pay (for a different group).

Flexibility With Respect to Part-Time Employees

Part-time employees are not part of the pay or play equation because the tax is only assessed with respect to full-time employees. Employers should be careful to make sure that part-time employees do not exceed 30 hours per week during the relevant measurement period (if they average 30 hours per week or more, they are full-time employees under the ACA regardless of the employer's intent).

Dependent Coverage

The IRS proposed regulations clarify that coverage must only be offered to the employee and the employee's dependent children to satisfy the pay or play rules. Under the proposed regulations, coverage need not be offered to the employee's spouse. Therefore, employers may have some flexibility in how they structure dependent coverage, and spousal coverage in particular, to avoid a tax under pay or play.

If the Plan Isn't Broken, Don't Fix It

If an employer is happy with its current group health arrangement, and offers it to all full-time employees and dependent children, and the plan is sufficient to attract and retain a high quality workforce, it is possible that no changes are necessary at all. The plan may provide minimum value already, and the level of employee premiums may make it "affordable" under the ACA. Or, the number of employees for whom coverage is "unaffordable" may be insignificant and the resulting individualized tax may be immaterial. Minimum value and affordability rules should be examined closely to determine whether the employer's plan already passes muster.

Be Aware of Eligibility Gaps for Employees Working In Excess of 30 Hours

Some employer group health plans permit employees to participate only if they work at least 35 hours per week. Such an eligibility rule will likely result in the "headcount tax" because employees working between 30 and 35 hours per week would not be eligible for coverage. Employers hoping to avoid the headcount tax should consider amending plan eligibility standards (by extending coverage to employees working 30 or more hours per week) to avoid this result.

Get Ready to Comply with Complicated Reporting Requirements

Although not yet finalized, the IRS has issued proposed reporting rules for employers for purposes of determining compliance with the pay or play rules described above. These reporting requirements will be onerous, and employers should strongly consider setting up (or otherwise addressing) reporting processes in advance of 2015.

1D. Additional Questions to Consider

The pay or play rules raise a number of additional questions that should be considered well in advance of 2015, such as the following:

- Does the employer's current health plan provide minimum essential coverage and minimum value? If not, the employer should discuss additional plan options with its broker or insurance carrier.

- Does the employer offer at least one "affordable" option to avoid the individualized tax?
- If the employer chooses to adjust the cost of single coverage to make it "affordable" (i.e., less than 9.5% of employees' W-2 income), will the employer consider charging more for dependent coverage to offset the revenue loss of lower single premium contributions?
- Is the employer treating its union workforce the same or differently with respect to health coverage? Does the employer have to negotiate with its union(s) before making any changes?
- Does the employer have a large part-time, variable hour, or seasonal workforce that does not currently receive health coverage? Will the employer limit hours to ensure they stay under 30 hours per week on average?
- Does the employer use temp agency workers or other independent contractors, and how are they treated by their employer with respect to health coverage?
- What is the potential tax that is likely to apply to the employer, if any, assuming the employer's workforce and coverage stay the same in 2014?
- Can the employer just give more money to employees and send them to a state exchange to purchase their own insurance? Will this be possible from an employee relations perspective?

2 - The Individual Mandate

Employers that choose not to offer health insurance to their employees should also be aware of the individual taxpayer mandate to secure health insurance coverage. While this individual mandate is not a direct action item for employers, it does have the possibility to indirectly affect hiring and retention for the employer's workforce.

Beginning in 2014, all taxpayers will be assessed a "shared responsibility" penalty for any months during which they or their spouse or dependents lack minimum essential coverage. Just like the pay or play tax on employers, taxpayers will have the choice to either secure health insurance coverage for themselves or pay a tax. Employees who are not offered group health insurance coverage by their employers will be faced with this choice (and potential cost) directly.

Access to coverage should not be a problem. Starting in 2014, the ACA creates state health insurance exchanges that will provide varying levels of coverage (with varying costs) in the insurance market to otherwise uninsured individuals. For taxpayers who chose not to secure coverage for themselves (or for their spouse or dependents), they will be assessed a tax that is equal to the greater of a "flat dollar amount" or a "percentage of income amount," as follows:

2A. Flat Dollar Amount

The annual flat dollar amount (phased in over three years) is assessed for each individual, spouse, or dependent who does not have coverage. The amount per individual is set at $95 for 2014; $325 for 2015; and $695 in 2016 and each year thereafter. The amount for individuals age 18 or younger is half of the amount otherwise applicable. Finally, the total amount for any individual taxpayer is capped at three times the annual flat dollar amount per year, regardless of the number of individuals in the taxpayer's household who actually lack coverage during the year.

2B. Percentage of Income Amount

The "percentage of income amount" is determined by first subtracting the taxpayer's exemption (or exemptions for a married taxpayer) and standard deductions from the taxpayer's household income. The resulting income amount is then multiplied by the applicable percentage specified by the ACA. The applicable percentage is phased in over three years, set at 1% for 2014, 2% for 2015, and 2.5% thereafter.

As noted above, the individual mandate has the possibility of affecting hiring and retention goals for employers – primarily because employees who lack coverage will take a financial hit, either from paying for coverage, or for paying the applicable tax.

3 - Automatic Enrollment

Under the ACA, employers with more than 200 full-time employees who offer health coverage will be required to enroll all employees automatically in their plan. While the ACA itself does not provide an effective date for this rule, the DOL later issued an FAQ explaining that employers will not be required to comply until the DOL issues explanatory regulations. It is expected that the DOL will complete this rulemaking in 2014.

In the absence of agency regulations on this provision, we only know what the statute and minimal additional guidance tell us. Automatic enrollment does not require an employer to maintain a group health plan for its employees – it only requires automatic enrollment for large employers that actually offer a plan. Further, automatic enrollment still permits employers to impose a plan waiting period (though that period may be shorter now, as explained in Section 4, below). The process of providing automatic enrollment involves notice and the opportunity for employees to opt out of coverage. The mandate only requires the automatic enrollment of "new full-time employees" and requires the employer to "continue the enrollment of current employees" (presumably, all subject to opt-out rights on a periodic basis, such as through open enrollment).

While the automatic enrollment rules will not likely influence the substantive terms of the employer's health plan, we expect that this issue will affect the cost of the employer's health plan. If full-time employees are automatically enrolled, subject to an opt-out right, it is likely that more employees will ultimately be enrolled in the plan. This issue is likely to affect health costs in general.

4 - Maximum Waiting Periods

Before the ACA, group health plans frequently imposed waiting periods ranging from 30 days to as high as two years. Health plan waiting periods frequently permit employers to maintain a group health plan for their permanent workforce while giving the employer the flexibility to hire temporary workers at a much lower total cost (i.e., without insurance premium costs or, for self-insured plans, the health costs for such workers themselves). In addition, it is common for employers to tie a probationary employment period with the period necessary to gain coverage under the group health plan. For plan years beginning on or after January 1, 2014, waiting periods as condition for eligibility to participate in a group health plan may not exceed 90 days. Therefore, it will be important to make sure that full-time employees will be given the right to enroll in the employer's plan after a period not to exceed 90 days. There are some exceptions to this strict requirement for eligibility rules that require something other than the mere passage of time (for example, a requirement that the employee work a certain number of hours before becoming eligible for health plan coverage).

5 - New Wellness Plan Rules

In plan years that begin on or after January 1, 2014, employers will have the opportunity to provide greater health plan-related incentives or penalties to employees based on their compliance with the employer's wellness plan requirements. In other words, employers can now structure wellness plans to include greater dollar-value incentives (or penalties) to employees who do not participate in or otherwise comply with the particular wellness plan's requirements. There are a number of detailed rules that wellness plans must satisfy. But, a properly-structured wellness plan can now be used by employers to greater advantage in addressing long-term health plan costs. Any employer that wishes to address long-term health plan costs (and in particular any employer that may eventually be liable for the Cadillac plan excise tax discussed below) should strongly consider putting a wellness plan in place or revising an existing wellness plan to take advantage of this new opportunity.

6 - Summary of Benefits & Coverage

Plan sponsors and insurers are now required to provide a concise summary of their health plans (a "Summary of Benefits and Coverage" or "SBC") that accurately describes the benefits and

coverage under the plan in an understandable manner. The SBC serves a different purpose than the current Summary Plan Description ("SPD") already required under ERISA. For one thing, the SBC must be significantly more concise (not more than four double-sided pages).

7 - Dollar Limitation on FSA Contributions

The ACA imposes a $2,500 annual limit on salary reduction contributions to health flexible spending accounts ("FSAs") offered under cafeteria plans. The IRS has clarified that this rule is effective for cafeteria plan years beginning after December 31, 2012. It is important to note that this limitation does not apply to employer contributions to an FSA, but only applies to salary reduction contributions that are elected by the employee. Cafeteria plan documents should be amended to incorporate this new limitation.

8 - Reinsurance Fees

Beginning in 2014, a significant new "reinsurance" fee will apply to all employer group health plans. The fee is expected to be at least $63 per covered life per year, and will apply in each of 2014, 2015, and 2016. The fee will likely be paid by the plan's insurer or third-party administrator, but will in all likelihood be passed on to the employer sponsoring the plan. For a large employer that has tens of thousands of covered lives in its group health plans, the annual fee amount will be in the seven figures. The new fee is being levied by HHS to create a $25 billion reinsurance pool that will be distributed largely to insurance companies to subsidize coverage of high-risk individuals. Importantly, the fee can be built into the plan's total cost so that participants share in the financial responsibility for the fee.

9 - PCORI Fees

For plan years ending after October 1, 2012 and before October 1, 2019 (i.e., for seven full policy or plan years), health insurers and self-insured plan sponsors will be required to pay a fee to fund the Patient-Centered Outcomes Research Institute ("PCORI"). For the first year (i.e., the plan year ending before October 1, 2013), the fee is $1.00 times the average number of covered lives under the policy or plan. For later years, the rate is $2.00, subject to adjustment based on increases in the projected per capita amount of National Health Expenditures. Fees are to be reported and paid once per year, on IRS Form 720.

10 - Cadillac Plan Excise Tax

Beginning in 2018, group health plans with total premium levels above a specified threshold (e.g., $10,200 for individual coverage, $27,500 for family coverage, both subject to adjustment

for inflation) will be subject to a 40% excise tax. This tax is commonly referred to as the "Cadillac plan" tax. The tax will apply to the total dollar amount of health coverage premium costs that exceed the above thresholds for all covered employees of the employer. Obviously, the magnitude of the tax alone makes this a key subject. Employers should consider all available options to ensure that plan costs do not exceed the applicable threshold amounts. This may involve some combination of plan design changes, wellness programs, and other options that can drive down the overall cost of coverage.