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The Employer's Playbook for ACA Compliance: Ten Practical Strategies for 2014

The Affordable Care Act (a/k/a Health Care Reform, or the ACA) is complicated. While there is nothing in the ACA that requires any employer to provide group health care coverage to its employees, the failure to do so can come with a price. The ACA is a game changer – one that requires a different approach to compliance than in the past. As with any complex law, the devil is in the details. Some of those details have been omitted in order to help you focus on the big picture.

I. LOOK AT WHAT YOU ARE DOING NOW

- Is your coverage the same as it was in 2010 and remains "grandfathered" or is it not grandfathered?

The "grandfathered" plan relates to the concept that "if you like the coverage you have today (in 2010), you can keep it," and looks at the coverage you offered on March 23, 2010. If you provided a new program, increased cost-sharing, or modified coverage (within certain parameters), since March 23, 2010, your plan or some of your group health care options may have lost grandfathered status. Your plan's grandfathered status dictates the specific ACA mandated benefits that must be provided. For example, once a plan loses its grandfathered status, it must provide coverage for certain preventive care benefits on a first-dollar basis. However, trying to retain "grandfathered status" may restrict you in shifting more costs to employees.

- How valuable is your coverage (deductibles, co-payments, out-of-pocket maximums)?

If you are now offering a very valuable group health care plan, consider whether you should add a less valuable option – but one that provides "minimum value." A plan provides "minimum value" where 60 percent of the medical costs are paid by the plan and 40 percent of the medical costs are paid by the participant. (The value of the program is unrelated to how much an employee is required to pay as a premium.) A 60/40 program is comparable to the lowest value coverage that will be available on a state or federally-facilitated exchange (marketplace) for 2014. The value of the marketplace plans are described as metal levels (60/40 – bronze, 70/30 – silver, 80/20 – gold, and 90/10 – platinum).

- Is your coverage insured or self-insured?

Depending upon the size of your organization, you might want to consider whether self-insurance might be more cost-effective than a fully-insured program. However, certain compliance obligations increase when you move your group health plan from fully-insured to self-insured.

II. UNDERSTAND WHAT IS CHANGING FOR 2014

Important new "mandates" will apply to all group health care programs in 2014. These include:

- the elimination of any pre-existing condition exclusion, regardless of age;
- the elimination of any annual limitation on benefits; and
- the imposition of a maximum 90-day waiting period.

In addition to new mandates, 2014 is the year of the highly-publicized "individual mandate." Under the individual mandate, if any employee fails to maintain "minimum essential coverage," he or she will, generally, be subject to additional taxes. Minimum essential coverage includes coverage offered under an "eligible employer-sponsored plan." An "eligible employer-sponsored plan" is a group health plan or group health insurance coverage offered by an employer, including both insured and self-insured plans. Based upon guidance to date, "minimum essential coverage" is basically any type of group health care coverage. However, certain health care benefits – like dental or vision, do not constitute "minimum essential coverage."

In 2014, any employee (full-time, part-time, union-represented) can elect to get minimum essential coverage in the marketplace. The marketplace is a website or portal where an individual can shop for health coverage. Both individuals and small employers (less than 50 employees) will be able to obtain minimum essential coverage through the marketplace in 2014.

Also, 2014 is the year that certain employers will be required to provide group health insurance coverage to their full-time employees or pay a penalty if employees get coverage in the marketplace and obtain either premium tax credits or cost-sharing reductions (subsidized coverage).

III. DETERMINE THE POTENTIAL COST OF NON-COMPLIANCE

The employer shared responsibility provision only applies to "applicable large employers." Any employer that has at least 50 full-time and full-time equivalent employees during the preceding year is subject to the "pay or play" provisions for 2014 and is called an "applicable large employer." "Full-time" for ACA purposes means that the employee works, on average, at least 30 hours per week or 130 hours per month. An employer's full-time equivalent employees are determined by taking all of the hours worked during a month by all employees less than 30 hours and divide the total by 120.

For example:

Employer has 40 part-time employees averaging 90 hours a month

Total part-time employee hours in a month: 40 x 90 = 3,600

Full-time equivalent employees: 3,600/120 = 30

While counting your full-time equivalent employees is required to determine whether you are an "applicable large employer," for "play or pay" purposes, coverage only has to be offered to your "full-time" employees, as defined under the ACA. The "assessable payments" (penalties) for non-compliance with the employer shared responsibility requirement are not deductible and are significant. There are two ways an employer can be hit with these penalties.

No Coverage Penalty. The first penalty is more global in scope and can be imposed if you offer no coverage to your full-time employees and their dependents. For example, let's assume you have 200 full-time employees (as defined under the ACA). If you do not offer at least "minimum essential coverage" to substantially all (at least 95 percent, or five employees, if greater, in 2014) of your full-time employees and just one of those employees both obtains health care coverage in the marketplace and assistance in the form of a premium reduction or cost-sharing reduction ("subsidy"), then you are at risk for an assessment based upon all of your full-time employees (minus 30, a "toss away"). Under the example, above, this amounts to a penalty of $340,000 ($2,000 x 200 – 30 (170) = $340,000). Penalties are actually assessed on a monthly basis. In addition to offering coverage to your employees, you also must offer coverage to the dependents of your employees. However, the term "dependent" does not include the employee's spouse. Remember, it is the offer of coverage itself, and not actual coverage that eliminates the risk for an assessable payment.

Penalty if Coverage not Sufficient and/or not Affordable. Let's assume you do offer minimum essential coverage to substantially all of your full-time employees and their dependents. This can, in fact, be fairly bare bones coverage. In order to avoid the second penalty, the coverage you offer must be both "affordable" and offer what is called "minimum value." That penalty is $3,000 per employee annually, but is more targeted and only imposed with respect to those specific employees who both obtain health care coverage in the marketplace and qualify for subsidized coverage. Also, if the second targeted penalty applies, it will never exceed the amount that would have been imposed had the "global" ($2,000 x each full-time employee) penalty applied.

As discussed previously, a plan or program provides "minimum value" if it is designed to pay at least 60 percent of the anticipated medical expenses. A plan or program is "affordable" if self-only coverage for your lowest value plan (whatever that is) only costs 9.5 percent of the employee's household income for the year. It is not the option the employee selects that counts, it is whether there was coverage made available to him that provided minimum value and employee-only coverage under that option was "affordable." Recognizing that household income may not be readily available, there are certain safe harbors you can use to determine affordability.. One such safe harbor is to use the employee's Box 1, W-2 income.

Penalties for Failure to Provide ACA Mandated Benefits. The failure to provide mandated benefits also results in penalties. With certain exceptions, a failure to comply with an ACA mandate can result in an excise tax of $100 per day per employee to which the benefit was denied. No tax will apply if the failure was due to reasonable cause and not to willful neglect, and the failure is corrected during the 30-day period beginning on the date you first know (or by exercising reasonable due diligence would have known) that the failure existed. Correction of the failure would mean you have to put the individual back in the same financial position he or she would have been in had the failure not occurred.

IV. DETERMINE YOUR ORGANIZATION'S BENEFITS CONTROLLED GROUP

In order to evaluate your risk under the ACA's pay or play provisions, you have to understand – Who is the employer? The "employer" is your entire benefits controlled group. The controlled group rules are extremely complex. These rules identify whether two or more corporations and certain other groups of related trades or businesses are treated as if they were one employer under many provisions of the Employee Retirement Income Security Act of 1974, as amended, and the Internal Revenue Code, applicable to employee benefit plans. These include parent-subsidiary groups, brother-sister groups, combined parent-subsidiary and brother-sister groups, and affiliated service groups. The rules for determining your benefits controlled group for purposes of the ACA are the same as for your tax-qualified plans.

If the controlled group, as a whole, has 50 or more full-time and full-time equivalent employees(as defined below), then every member of your controlled group will be an "applicable large employer" under the ACA. While potential liability for the penalties are determined on a controlled group basis (i.e., determining whether you are an "applicable large employer"), the penalties are assessed on each member of the controlled group, separately.

If, after determining whether you have other controlled group members, you determine you are not an applicable large employer, then the ACA employer shared responsibility provision does not apply to you. If you find you are an applicable large employer, but some or all of your controlled group members, standing alone, have less than 50 full-time and full-time equivalent employees, consider breaking the chain of ownership. However, this step requires serious consideration of whether you, as an owner, want to relinquish ownership interests to other individuals or entities just to avoid the ACA pay or play rules, or whether any reorganization makes sense from a tax perspective.

V. DETERMINE WHO WILL BE YOUR ACA FULL-TIME EMPLOYEES

If you are, in fact, an "applicable large employer," and you hire employees that work a variable schedule from week-to-week or month-to-month, how do you know if they are "full-time employees" that must be offered coverage? There is very specific guidance on how you can set up tracking periods – called measurement periods – to determine if and when these types of employees should be considered full-time for ACA purposes. These rules provide for measurement periods (periods of time when you can determine whether an individual has worked on average 30 hours per week or 130 hours per month). In addition, once you determine whether an employee is entitled to group health coverage, there are fixed periods of time during which they must be offered the coverage ("administrative periods") and when coverage must be continued ("stability periods") regardless of the number of hours they work. The logistics of this are extremely complex and are beyond the scope of this article. However, if you intend to utilize these optional measurement, administrative and stability periods, you will need to put tracking systems in place **before July 1, 2013**, if you maintain a calendar-year plan.

In addition to determining your full-time and part-time employees, consider whether you have contingent workers (leased employees and individuals that are classified as independent contractors) that may be considered your own common law employees under the ACA. Be aware that certain strategies involving the utilization of leased employees or other contingent workers may not solve your ACA compliance issues. In fact, some of these strategies may put you at risk for not only pay or play penalties, but other liabilities related to worker misclassification.

VI. REVIEW YOUR COLLECTIVE BARGAINING AGREEMENTS (IF APPLICABLE)

Note that there is no delayed compliance date for "pay or play" for your collectively-bargained employees. You need to review your contracts to see how "full-time employee" is defined, either in the agreement (or in practice), for the purposes of group health care eligibility. If eligibility is based on hours of service, both hours worked and hours paid for time off must be counted. You will also need to review the cost of individual coverage (if you intend the coverage to be affordable) and whether there is a right to obtain dependent coverage. If there are part-time employees or variable hour employees in the bargaining unit, you should consider selecting a measurement period, administrative period and stability period that will apply to those individuals.

Check waiting periods; if coverage is offered to any group of employees (regardless of ACA full-time status), the waiting period cannot be longer than 90 days. However, recognizing that it is a standard practice to require

probationary periods, you can impose a cumulative hour requirement as an eligibility rule, so long as that cumulative hour requirement is not more than 1,200 hours. You would then be permitted to add an additional 90 days before that employee could enroll in your group health plan.

While the cumulative hour requirement is permitted for purposes of the limit on waiting periods, keeping an otherwise full-time employee from enrolling for that period of time would likely result in an assessable payment under the "pay or play" rules. If you prevent an ACA full-time employee from enrolling in your group health plan for three months, this might violate the 90-day waiting period limitation. If you prevent an ACA full-time employee from enrolling in your group health plan for longer than three months because of a cumulative hour eligibility requirement, you might be subject to an assessable payment. These rules are different, but your compliance with them must be coordinated.

Be very careful if you decide to limit hours in order to preclude individuals from reaching full-time status. Depending upon the specific facts and circumstances, such practices may result in a grievance under your contract, claims and/or litigation under ERISA, or constitute a violation of the IRS anti-abuse rules under the employer shared responsibility provisions of the ACA.

If you contribute to multiemployer welfare benefit funds, there has been some relief recently announced for 2014. If any ACA full-time employee covered by a bargaining agreement for which you make contributions to the fund is denied coverage due to the plan's eligibility conditions, you will not be subject to an assessable payment for that individual if he or she gets subsidized marketplace coverage. Even for 2014, you will still need to make sure the fund's coverage provides minimum value and the coverage is affordable. The affordability component is to be determined based upon the compensation and wage information you provide to the fund.

All collectively-bargained plans started out in 2010 being "grandfathered plans." However, cost and coverage changes during the term of the contract may have resulted in a loss of grandfathered status. If the program offered to your union-represented employees is fully-insured, the loss of grandfathered status is reviewed only at the expiration of any collective bargaining agreements ratified before March 23, 2010. This same "pass" does not apply to programs that are self-insured. This may mean that mid-term changes to cost or coverage has resulted in a loss of grandfathered status. The loss of grandfathered status means that different mandates apply, including, but not limited to, first-dollar coverage for preventive care. As noted above, there are penalties for failing to provide a mandated benefit. This is more likely to happen inadvertently in a collectively-bargained plan. This makes it very important to determine whether any program lost its grandfathered status but continued to be administered as if it was still grandfathered.

VII. CONSIDER YOUR OPTIONS

Do not consider play ("offering coverage") or pay ("assessable payments") an either/or proposition. You should not just conclude it is cheaper to pay the penalty. Remember, the health care premiums you pay are deductible while the penalty is not deductible. Depending upon your workforce, it may be better to provide some coverage than none at all. If offering self-only coverage is too much of a financial burden, you can avoid the "global" penalty by offering some type of minimum essential coverage, even if your own contribution is minimal and the coverage is not affordable. By looking at the past history of your employees' group health care elections, you may be able to determine how many individuals generally opt out (which would indicate they may get coverage from a spouse). Based on earnings records, you can estimate how many individuals may qualify for subsidized coverage through the marketplace. By doing some due diligence about the options for coverage, strategies for

cost-shifting, and the demographics of your workforce, you can make an informed decision about how to approach pay or play for 2014.

VIII. KEEP GOOD EMPLOYMENT AND ENROLLMENT RECORDS

As noted above, if someone goes to the marketplace and gets subsidized coverage, you may be required to explain why this individual was either not offered group health care coverage by your organization and/or why this individual was not offered affordable coverage that provided minimum value. This will be part of the "assessable payment" process.

Perhaps your records show that an employee was only part-time and was not required to be offered coverage. You may have, in fact, offered coverage to an individual, but he or she declined. If there was an offer of coverage that was affordable and provided minimum value, the individual is not entitled to receive subsidized coverage through the marketplace. This also means you should not be subject to an assessable payment with respect to this individual. Recordkeeping and substantiation will be essential.

Also, based upon guidance to date, it would appear that if you offer coverage, you must allow each employee an opportunity to decline coverage at least once a year. Therefore, if you have "evergreen" elections, which remain in effect from year-to-year, you may need to move to an annual open enrollment process. It will not be permissible to automatically enroll employees in unaffordable coverage which would preclude them from getting subsidized coverage in the marketplace. Again, having adequate records of "who was offered what" will be critical to defending against the assessment of penalties.

IX. MANAGE YOUR EMPLOYEES' EXPECTATIONS

No later than **October 1, 2013** you will be required to provide a notice to your employees about the ability to obtain health care coverage through an exchange. Sample notices are now available (as of May 8, 2013). Employees who are clearly part-time will want to know whether you will be providing coverage to them or whether they may get hit with their own shared responsibility payment for not maintaining minimum essential coverage. The individual mandate goes into effect in 2014, which will require all of your employees (except those who are eligible for an exemption) to maintain health care coverage or pay an additional tax. Undoubtedly, your employees (both those who are entitled to coverage and those who are not), will be looking to you for guidance.

X. ENLIST OTHERS IN YOUR DECISION-MAKING PROCESS

Any approach to ACA compliance should involve input from various constituencies within your organization. This requires a coordinated and collaborative effort involving individuals with decision-making authority from:

- Finance
- Human Resources
- Benefits
- Legal
- Labor relations (if applicable)

While your outside consultants and brokers are an essential part of the decision-making process, be careful what you discuss with them. Certain strategies employers may contemplate implementing for 2014 are very sensitive in nature and could lead to litigation. These types of conversations should not be held in the presence of anyone outside your organization except your attorneys. Remember, there is no broker/client or consultant/client privilege.

If you have questions or need advice on this topic or other Affordable Care Act matters, contact the author of this article, Sarah Lockwood ("Sally") Church (schurch@saul.com), or the following Saul Ewing employee benefits and executive compensation attorneys: Dan Brandenburg (dbrandenburg@saul.com); Joanne Jacobson (jjacobson@saul.com); Paul Kasicky (pkasicky@saul.com); Joni Landy (jlandy@saul.com and Kevin Wiggins (kwiggins@saul.com), or any Saul Ewing lawyer with whom you regularly work.

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