EXECUTIVE SUMMARY

MAKING THE CALL: PAY OR PLAY

MARCH 21, 2013

Employers must attempt to find the opportunities in health care reform amid ongoing changes in rules and costs, according to speakers and employers participating in the Alliance Learning Circle, “Making the Call: Pay or Play” on March 21 at the Monona Terrace in Madison.

John Barlament, partner with the Employee Benefits Group at Quarles & Brady LLP, and Christopher J. Giese, an actuary at Milliman, offered updates on Affordable Care Act (ACA) regulations as well as advice on breaking the decision-making process into manageable chunks.

Employers responded in small-group discussions by sharing information about the factors influencing their pay-or-play decisions.

‘Moving Parts’

Barlament noted that the pay-or-play section of the ACA appears to be here to stay, although the government is likely to continue to make “tweaks” to some segments, such as the recent repeal of the CLASS Act dealing with long-term care. Court challenges are ongoing, but Barlament expects their short-term impact to be limited.

In the meantime, employers can expect a “tsunami of guidance” on how the ACA will be implemented and enforced.

“There's just a whole lot of moving pieces here,” Barlament said. He cited several recent changes as examples, including:

› The requirement that employers deliver information about insurance exchanges to employees on the federal government's behalf.
› Rules that may make stand-alone health reimbursement accounts (HRAs) illegal beginning in 2014.
› New rules on wellness and the Health Information Portability and Accountability Act (HIPAA).

New Pay or Play Regulations

Barlament cited new rules that impact employers' pay-or-play decision. A sampling includes:

› A delayed effective date for plans with renewal dates other than the end of the calendar year.
› A 5 percent “de minimis” rule that changes the trigger for 4980H(a) penalties ($2,000 per full-time worker minus 30). The original trigger was a single eligible full-time employee who was not offered coverage; it has now changed to failing to offer coverage to more than 5 percent of full-time employees. In this case, a 4980H(a) penalty could still apply if one of the employees not offered coverage accesses an exchange subsidy ($3,000 per worker that gets a subsidy).
› Employers “on the edge” of the 50-employee threshold can look at employment levels over a six-month period in 2013.
› Employers can take advantage of a special transition rule that allows a six month measurement period in 2013 followed by a 12 month stability period in 2014.
› Children must be covered until age 26.
› Spouses can be excluded.
Step One of Seven: Understand General Rules

While more changes lie ahead, Barlament said employers can now use a seven-step process to understand pay-or-play concepts and make an informed decision.

“If you design a plan correctly and you administer it properly, you should know whether you will be hit with a penalty,” Barlament said.

The first step is working to understand the general rules behind ACA regulations. Today, employers of all sizes can refuse to offer health benefit coverage without being subject to a federal tax penalty. Effective Jan. 1, 2014, “large” employers with more than 50 full-time employees or equivalents will pay a tax if a full-time employee receives federally-subsidized coverage from an insurance exchange. A broad definition is used to decide what types of organizations qualify as an employer, including governmental bodies, churches and non-profit organizations.

Large employers face two levels of potential penalties. If an employer fails to offer health benefits that are deemed “minimal essential coverage” and at least one full-time employee receives federally-subsidized coverage from an exchange, the employer faces a “no offer” penalty of $2,000 per full-time employee, minus 30 employees.

If an employer offers benefits that meet the minimum essential coverage standard but do not meet affordability tests and at least one full-time employee obtains federally-subsidized exchange coverage, the employer is charged $3,000 per subsidized full-time employee.

Step Two: Are You A Large Employer?

Barlament said the definition of “large employers” is based on having at least 50 full-time employees during the preceding calendar year. This definition includes all common law employees, part-time employees, seasonal employees or employees in a controlled group. Part-time or seasonal employee hours are converted into full-time equivalents based on Internal Revenue Services (IRS) rules. Independent contractors appear to be excluded.

A full-time employee is defined as an individual who averages 30 or more “hours of service” on a weekly basis. The IRS translates that to 130 hours of service in a calendar month.

“Hours of service” is based on actual hours worked for hourly workers. For other groups, the employer must include hours during which an employee is paid or entitled to payment, including both work hours and vacation or holiday hours. For a college professor, for example, the hours of service include both time spent in face-to-face instruction and hours spent on preparation and grading.

Barlament said “controlled group” rules prevent employers from dividing their employee base into small subsidiary companies to avoid the pay or play rule.

Steps Three and Four: Coverage Issues

Step three of examining pay or play involves determining whether employees will receive subsidized exchange coverage. The ACA establishes exchanges to serve as a marketplace for obtaining insurance benefits. Half of the states have opted not to establish exchanges; in response, the federal government can then step in to create and offer an exchange. The ACA provided federal subsidies that could be used to reduce costs or pay for coverage, but it’s unclear whether those subsidies are available in federal-run exchanges as well as state-run exchanges.
**Steps Three and Four: Coverage Issues, continued:**

Employees qualify for subsidized coverage if their annual income is at least 100 percent of the federal poverty level and not more than 400 percent of the federal poverty level, or $94,200 for a family of four. But employers can avoid the penalty if they offer minimum essential coverage at an affordable price, which represents Barlament’s step four.

The U.S. Department of Health and Human Services (HHS) has broadly defined “minimum essential coverage” to date. Plans that would qualify include a government plan, a grandfathered plan offered in a group market or a plan in a state’s small or large group market. While that list excludes self-funded plans, federal agencies have indicated they will qualify as coverage.

Barlament noted there is no definition of the lowest level of coverage that would still qualify as minimum essential coverage, but he did say that a plan could not offer only HIPAA-excepted benefits, such as a dental or vision plan. The opportunity to sign up for minimum essential coverage must be offered at least once a year.

It is possible for an employer to design a health plan that never triggers a pay or play penalty. “The key is to offer good coverage,” Barlament said. “That is what will prevent a pay-or-play penalty being assessed against you.”

**Avoiding A Penalty**

To avoid the penalty for failing to offer coverage, employers must meet three standards:

1. Offer “minimum essential coverage” under an “eligible employer-sponsored plan” to all full-time employees eligible for subsidized coverage from an insurance exchange.
2. Ensure that the employer’s plan meets “minimum value” standards.
3. Ensure the employee’s share of premium for single coverage under the employer’s lowest cost plan that meets “minimum essential” standards is deemed affordable.

*Source: John Barlament, Quarles & Brady*

**Steps Five and Six: Minimum Value and Affordability**

Offering a plan that meets the ACA’s minimum value requirement is step five on Barlament’s list and can also help employers avert a fine. A plan fails to provide minimum value if it pays for less than 60 percent of the cost of total benefits. Barlament said the IRS is expected to examine typical benefits offered by other employers to set its standards. HHS recently released a minimum value calculator.

In step six, employers should determine whether plan coverage is affordable. The employee's share of the cost of single coverage in the employer's lowest-cost plan should not exceed 9.5 percent of the employee's household income.

Household income is defined as the modified adjusted gross income of the employee and any members of the employee’s family who are required to file an income tax return. Employers are allowed to use an employee's rate of pay or wages reported on the W-2 form to determine household income.

Barlament said some employers may “get lucky” if a full-time employee who would be judged unable to afford a plan gets coverage through a spouse or decides not to purchase coverage as a form of protest. If an employee refuses to use an exchange to get coverage, Barlament said the employer cannot be hit with a penalty.
Step Seven: Determining “Full Time”

The final step is determining how many employees qualify as full-time. In theory, Barlament said an employer could skip this step, but the employer would then need to promptly offer health coverage to every employee or face the federal penalty of $2,000 per year per full-time employee.

An employee is full-time if he or she works an average of 30 hours a week over a “standard measurement period.” Barlament recommends using a term of six or 12 months as the standard measurement period and then checking to learn whether the employee averaged 30 hours a week during that time span.

An employee deemed to be full-time then qualifies for benefits during the following “stability period,” which must last at least six consecutive calendar months. A three-month administrative period can be inserted between the standard measurement period and the stability period.

When employees are hired as new, full-time employees, there is no measurement period and they must enter the plan within three months. Special rules apply to new, variable hour employees to allow time to determine whether the employee meets full-time standards.

“You have to offer coverage within 13 ½ months after you hire the new variable hour employees,” Barlament noted.

For some categories, employers can strategically set the length of the initial measurement periods and administrative periods to help avoid penalties. When dealing with seasonal employees, for example, an employer can use a longer measurement period to avoid full-time designation for an employee who only works a few weeks or months.

Barlament said special rules govern employees who terminate and are then rehired. If the break in employment is 26 weeks or more, prior hours are ignored. But if not, the employer must use special rules to determine when full-time status is reached. Rules also protect teachers’ benefits during the summer break.

A Strategic Approach

Milliman has been working with employers to help them make sense of health care reform. “Now is the time to come up with a strategic plan to be prepared for all that health care reform is bringing to you,” Giese said.

Starting in 2014, all Americans are required to have coverage in a qualified health plan, Giese said. Achieving that requires a timeline with multiple “moving pieces” that are interrelated and evolving.

Many of these moving pieces could impact employer health plan costs. In addition, employers must stay on top of what other employers are doing in their area for competitive reasons in attracting and retaining employees. Giese said employers can use predictive modeling to make an informed decision about how different scenarios impact their costs and their performance.

As insurance exchanges are introduced, employers could see employees leave or join their plans. Employers could suffer from “adverse selection” if healthy employees leave benefit plans to obtain coverage from exchanges while less healthy employees continue to use the employer’s plan. Employers could also see a higher number of employees who now waive coverage joining the plan after individuals begin paying a penalty for failing to obtain health coverage.

Giese said health benefit costs could rise as health reform prompts cost shifting. For example, if health care providers lose income from Medicare and Medicaid or bad debts, they may seek to charge higher rates to employer-based plans. Consumers will also experience cost-shifting in the form of taxes and fees, which were put in place to help pay for ACA costs.

The Moving Pieces

Issues that could affect employer health plan costs include:

1. Benefit mandates
2. In- and out-migration of participants
3. Adverse selection
4. Cost shifting
5. Free rider penalties and Cadillac plan excise tax
6. Additional administrative costs
7. Changes made by other employers
8. Congressional changes to penalties

Source: Milliman
A Strategic Approach, continued:

Some elements of the ACA are already in place, while many more are expected to be implemented from Jan. 1, 2014, when most provisions for employer-based coverage take effect, through 2017. In addition, employers face the 2018 implementation of a “Cadillac plan” tax of 40 percent for benefit plans with costs that exceed $10,200 for single coverage or $27,500 for family coverage.

Making A Plan

By planning ahead, employers can anticipate issues such as the number of employees whose household income falls below 400 percent of the federal poverty level. In Wisconsin, 64 percent of the population had incomes below that level in 2011, which increased to 66 percent in Illinois and Iowa, according to Statehealthfacts.org.

In this environment, Giese said the approach of administering the health plan one year at a time “has to go out the window.” Instead, employers must figure out their penalty exposure for employees with incomes below the 400 percent level who go to the exchange at a penalty of $3,000 per individual.

Out-migration from the health plan could also be caused by employees who obtain health care from Medicaid or other employers, such as young employees who opt to remain as dependents on their parents’ plans. Some employers could realize net savings from this out-migration based on the composition of their workforce. Other employers could end up with in-migration to the plan as auto-enrollment rules take effect.

Giese said employees’ awareness of upcoming changes prompted by the ACA gives employers the opportunity to make other, desirable changes in the health plan now. For example, employers might want to discontinue retiree health benefits.

ACA regulations also allow employers to use higher levels of health plan premiums to motivate employees to embrace wellness. A 30 percent premium differential is allowed for wellness participation, which increases to 50 percent if the wellness program addresses tobacco use.

“There’s a lot of different creative ways that you can set up these plans to tie not just to participation but to achievement as well,” Giese said.

Retaining older workers could become a challenge because they will have access to reasonably priced coverage through exchanges. The cost of insuring an older worker is five to 10 times the cost of insuring a young adult, yet exchanges are only allowed to have a three-to-one premium differential.

It’s essential to examine the workforce for employees between 30 and 40 hours a week who did not qualify for coverage in the past but must be offered the option to join the health plan under the ACA. Giese said the law’s intent was to expand coverage, but some employers are reducing employee hours instead.

“We believe that coming up with a strategic plan (for health benefits) is absolutely critical.”
— Christopher Giese

Milliman’s Key Takeaways

What to do now
› Compliance, compliance, compliance
› Communication, communication, communication
› Calm down, calm down, calm down

What to do by Summer 2013
› Engage the C-suite on ACA issues and its potential impact
› Assess strategically where you want to be by 2018
› Configure 2014 plan offering as phase 1 of a long-term plan
› Develop several scenarios
› Consider whether to wait until mid-October to finalize decision after exchanges are online

What to do in 2014
› Monitor the market: competitors’ decisions, in- and out-migration, etc.
› Keep communicating: employees, C-suite, colleagues, consultants
› Take your time: Follow the “measure twice, cut once” rule and then act
Making A Plan, continued:

Employers will also need to reconsider their plan design and contributions to position the plan for ACA rules and yet remain competitive. If employers ponder terminating their health plan, they must weigh the savings against the impact on their ability to attract and retain employees.

Giese shared the results of Milliman analyses of multiple employers and the potential impact of health reform. He urged employers to thoroughly analyze the potential impact and plan for the future, with an alternate plan in case the employer’s situation or penalty exposure changes. Start this process now by getting executive buy-in and developing a communication plan for employees.

“This is the right time to build a strategic framework,” Giese said.

Employers Weigh In

Employers gathered at the end of The Alliance Learning Circle to discuss the factors influencing their pay or play decisions. Key factors included:

› Remaining competitive in the labor market is a vital, long-term concern.
  » Offering benefits is essential for many employers to attract and retain workers; many employers have already decided to continue to “play” by offering health benefits.
  » If competitors send employees to the exchanges and it enables them to become more competitive, other companies may be forced to follow suit.
  » Employers need to benchmark health plan practices against their competitors.

› The cost of deciding to “pay” instead of “play” could change if penalties rise, which adds to the uncertainty of the outcome if health benefits are discontinued.

› Employers must have a strategy for dealing with employees in positions that are at or near the 30-hour break point where insurance coverage must be offered.
  » Monitoring and reporting is challenging to ensure compliance.
  » If jobs are at or near the 30-hour level, some employers may decide to reduce hours to manage benefit costs.

› Employee communication is a huge chore.
  » Communication strategies are vital.
  » The employer must plan ahead to deliver information about the ACA and benefit plans, as well as insurance exchanges.

› Human resources professionals, including benefit administrators, must be well informed to retain their credibility.
  » Their credibility with employees is impacted by information about changes to benefit plans.
  » Their credibility with the C-suite is impacted as new fees and penalties are announced.

› Onsite clinics are a concern.
  » Many questions remain about how onsite clinics will be addressed by the ACA.
  » Employers who offer onsite clinics strongly want to continue to offer this option.

› The ACA offers an opportunity to use the wellness plan to build a healthy culture at work.

› A long-term benefits strategy is required.
  » Start working on it now and remain prepared as ACA implementation evolves.