Implementing the Patient Protection and Affordable Care Act: The Time Is Now

Employers all across the country should be in full swing as they prepare to implement the tougher parts of the Patient Protection and Affordable Care Act’s (ACA) employer provisions, which are about to come online and take effect in 2014. This article reviews these more challenging requirements and their complications, including how employer calculations over whether to continue to offer coverage might vary by industry characteristics. The author then looks further ahead to the “Cadillac” tax and discusses how this liability may affect every employer’s decision about its health care strategy leading up to 2018.

by Steven E. Wojcik | National Business Group on Health

With the presidential election now a distant memory, employers all across the country should be in full swing as they prepare to implement many of the forthcoming provisions of the Patient Protection and Affordable Care Act (ACA).

Most employers have been conducting their due diligence and complying with the early provisions of ACA. Since the law passed in 2010, employers have done their best to comply with the various provisions as they took effect, including expanding dependent coverage to the age of 26, removing lifetime dollar limits on overall benefits and following government rules for independent review of benefit denials. Now the tougher parts of the employer provisions are about to come online and take effect, particularly beginning in 2014. (See the table.)

For the first time, the government will set some requirements for employer-sponsored coverage. Prior to the health care law, employers’ decisions about offering coverage, benefit levels and employee contributions were purely voluntary, subject to no penalties outside of Massachusetts. While ACA does not call it an employer mandate because employers could choose not to offer coverage and may not pay a penalty if none of their employees qualifies for federally subsidized state exchange coverage, it does fundamentally alter the ability of employers to design health benefits coverage for their employees and, in effect, works as an employer mandate for most employers with at least 50 full-time employees.

Employers are gearing up to assess whether their plans pass the tests to avoid the penalties in the law:

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- The lesser of $3,000 annually for each employee who is not offered coverage that meets the government requirements and also qualifies for federally subsidized

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coverage on the state exchanges, or

• $2,000 annually times all of their full-time employees, with certain exceptions.

Any penalties due will be assessed each month that employers do not offer qualifying coverage to their employees. However, IRS has not specified whether employers would pay assessments quarterly, annually or on some other schedule. Small employers with fewer than 50 full-time equivalent employees are exempt from penalties.

Since this ”pay-or-play” requirement begins in less than a year, employers are well into their planning of benefit offerings for 2014 and have no doubt factored the requirements into their decisions. So, what is required to avoid the penalty? Benefits and human resources (HR) professionals should review both the comprehensiveness and affordability requirements. Failing either one of these could trigger a penalty. The comprehensiveness, or minimum value, test requires that each plan offered to employees must cover at least 60% of the total expected cost of benefits. The government has offered three methods for determining a plan’s minimum value. First, Department of Health and Human Services (HHS) and Internal Revenue Service (IRS) calculators can determine a plan’s value based on benefits offered, cost-sharing features for a core set of benefits and employer contributions for account-based plans. The second method is a safe harbor: If an employer offers at least one plan that does not require an employee to pay more than 9.5% of his or her pay toward coverage, and makes an offer to cover dependent children without respect to affordability, the employer will not be assessed a penalty. The government will not assess a penalty even if for some reason it turns out that the employee qualifies for federal tax credits for exchange coverage. If a penalty applied because the lowest cost plan offered to an employee requires a payroll deduction that is greater than 9.5% of his or her pay, it would be assessed using the same formula above.

The employer penalty would apply to an employer only for full-time employees not offered qualifying coverage. Employers may offer coverage to

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part-time employees but the law does not assess a penalty if they do not offer it. Because the requirement applies only for full-time employees—beyond the first 30 and not including temporary, seasonal or new hires in an eligibility waiting period of not more than 90 days—ACA also defines full-time employee for the purpose of this provision. It is the first time that the federal government has defined full-time employee, one of the lesser known facts about ACA.

The application of penalties only for failure to provide qualified coverage to full-time employees, as defined by the government, presents an added wrinkle or complication for employers with employees who have variable hours and changing schedules. The regulations have created an elaborate method to determine whether an employee is full- or part-time based on how often, how long and how consistently the employee works at least 30 hours or more. The method includes a look-back, or measurement period—a period that the employer can choose between three months and a year to average an employee’s hours and determine whether he or she is full-time or part-time for the sole purpose of determining whether the employer has a need to offer coverage or potentially face penalties.

However, employers still can use existing definitions of part-time and full-time status for other benefits such as vacation and sick pay. Employers can change measurement periods over time and use different measurement periods for different categories of employees but must use the same method for similarly situated employees. Once the employer determines that an employee is full-time or part-time, the employee’s status for the purpose of health coverage remains the same for a “stability period” even if his or her hours change during that time. For example, if an employer determines during a measurement period that an employee met the 30-plus hours work requirement, the employee maintains full-time status for the entire stability period even if his or her hours drop below 30 hours per week. Stability periods must be at least as long as measurement periods but a minimum of six months is required for employees found to be eligible for health coverage.

The method varies slightly for new hires versus current employees and for initial and regular measurement periods, as well, and there are a few other complications detailed in the regulations. Further complicating matters for some employers that impose waiting periods for new hires, the waiting period has to be coordinated with the measurement period and cannot lengthen it. Similarly, if an employer chooses to use an administrative period—a time period to enroll the employee in coverage and process forms, which can be up to three months if employers do not use the maximum measurement period—it must be embedded within the measurement period and cannot be stacked onto it to lengthen the time that the employee would have no coverage from the employer.

The question often is asked whether employers will drop coverage since the penalty for not offering it—$2,000 a year per full-time employee—is well below the average cost of providing coverage, which currently runs between $6,000 and $10,000 for an individual employee. After the passage of ACA, many employers have done the calculations and have asked the question.

Of course, providing coverage has always been voluntary, and employers have offered it for a number of reasons despite the lack of a penalty for dropping coverage before ACA’s passage. The benefits of offering coverage are many, and the costs of not offering coverage go far beyond the direct health care costs.
Of course, providing coverage has always been voluntary, and employers have offered it for a number of reasons despite the lack of a penalty for dropping coverage before ACA’s passage. The benefits of offering coverage are many, and the costs of not offering coverage go far beyond the direct health care costs. As we know, offering competitive health benefits—a benefit highly valued by employees, as the National Business Group on Health’s surveys attest—facilitates attraction and retention of employees, improves employee health and productivity, and helps to manage costs of medical absences, workers’ compensation and disability benefits. Furthermore, there are tax advantages to both employers and employees. Finally, most employers realize that taking away health benefits would require making employees whole by boosting compensation and other benefits. These are many of the reasons why employers currently offer health benefits and are likely to continue offering them in the foreseeable future irrespective of ACA penalties.

Having said this, employers in some industries in certain situations may make a different calculation. They may be industries that operate with very low profit margins. As health care costs continue to rise, they squeeze profit margins further. Employers in industries with low-wage employees that offer health coverage essentially pay a very high percentage of compensation in the form of health benefits. Again, as health care costs continue to climb, the percentage of total compensation allocated for health benefits grows, making it harder for these employers to continue offering coverage. Finally, employers in industries with high turnover, where the relationship between employees and their employers is tenuous, also may choose to drop coverage. Any or all of these factors will affect these employers’ decisions about their health care strategy in future years.

Looking ahead, liability for the excise or Cadillac tax—a 40% tax on plans with values in excess of $10,200 for individual coverage and $27,500 for family coverage—may also affect every employer’s decision about its health care strategy leading up to 2018. Increasing employees’ share of the costs of coverage will not help in this case, since both the employer and employee share of costs will be factored into the value of each plan. To prepare their plans to stay under the thresholds and avoid the tax, many employers have already taken steps and will continue to take steps this year and in years leading up to 2018, including adopting financial incentives for healthy lifestyles, contracting selectively with high-performing hospital and physician networks, increasing price transparency and consumer “shopping” for routine health care services, and moving to account-based high-deductible plans. No doubt, it is a multiyear process and many employers have already begun. The Cadillac tax still is several years away, and two elections will happen before it takes effect. Political pressures may weaken this provision or delay it, but employers cannot be certain of that.

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