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Healthcare Reform 2013 Employer Actions

If you think there are only a few healthcare reform changes in 2013 and that it's OK to sit back & wait for the provisions that take place in 2014, think again! Employers need to make many decisions, create policy changes, and begin new practices now, in preparation for 2014. Changes for 2014 take effect at plan renewal, for organizations already offering a medical plan, or on January 1, 2014, if starting a new plan in 2014.

The three primary Affordable Care Act (ACA) enforcers, Internal Revenue Service (IRS), Department of Health & Human Services (HHS) and Department of Labor (DOL), have laid out many of the regulations and requirements, with more coming throughout 2013. In late December 2012, the IRS released proposed regulations on minimum value, reporting requirements and methods for determining employee status. The need for organizations to stay current on all health care reform details is imperative. Because of the time crunch to have regulations in effect by 2014, traditional comment periods have been shortened and steps skipped. There is a lot of information coming out on Patient Protection and Affordable Care Act (PPACA) so make sure to verify sources of information. Many of the details are still forthcoming or may be subject to change. Continue to read our monthly updates, counsel with ERISA legal advisors, and work closely with your insurance broker, as we all wade through the thousands of details and regulations yet to come.

This article strives to bring attention to important decisions, preparations and actions needed now; ensuring the PPACA (or ACA) will go smoothly— preventing costly fines and mistakes.

Am I a Large Employer?

Large employers are required to offer medical insurance to employees, effective January 1, 2014. You are a large employer if, based on prior year's "look-back period", you averaged 50 or more full-time or full-time equivalent employees. A full-time (FT) employee is one who worked an average of 30 or more hours per week. To calculate the number of full-time equivalent (FTE) employees, divide all hours worked in a month by all PT and other non-FT employees by 120. Average the number of FTE's for each month during your look-back period. For 2013, employers are allowed to use a look-back period of six or 12 months in determining whether or not they are a large employer. Work hours include all paid hours, e.g., vacation, sick, PTO, holiday, or other paid leave.

Actions:

- Determine your look-back period using either six or 12 months, to calculate if you are a large employer (after 2014, a 12-month look-back period must be used).
- Determine whether your company is required to provide medical insurance by calculating FT and FTE employees during your look-back period.
  Calculation: Number of full-time employees + # of hours worked by part-time & seasonal employees per month, divided by 120 = FTE employees for each month in look-back period.
- If you have more than one organization or affiliation, determine if you need to consider employees in all groups under the IRS controlled group rules. If all groups are under the same general management, the rule likely applies— making it so all related employers are considered together in determining if you are a large employer.

Eligibility— Which Employees to Cover?

All full-time employees, those working an average of 30 hours or more, are to be included in medical coverage for large employers. The IRS allows a margin of error as long as at least 95% of full-time employees are covered. Employers are to measure each employee's hours over their defined "measurement period" of three, six, or 12

months, and then treat that employee as full-time (FT) or part-time (PT) for a defined "stability period", which will be the greater of either six months or your measurement period. The waiting period for eligibility is exempt from the look-back measurement period. As a general rule, six months is typically a safe measurement period for most employers to use. Employers may elect an administrative period of up to 90 days between the end of the standard measurement period and the beginning of the stability period, allowing more time for calculation and determination, but cannot be used to extend or shorten the stability period. For example, assuming a measurement period of six months, January 1 through June 30, a 60 day waiting period and 30 day administrative period, the employer would review the PT employee's average hours during the standard measurement period. Any employee averaging 30 or more hours for that period would be labeled as FT and would be offered insurance coverage in accordance with their waiting periods. These employees would now be covered for a minimum time period of six months, the stability period.

For new hires, where it is unclear if they will be FT or PT, the initial measurement period and administrative period combined may not extend beyond the new employee's one year employment anniversary date. At any point where a PT employee's status is clearly changed to FT, they would start the medical plan after the normal waiting period. If a large employer expects an employee to work an average of 30 or more hours per week when hired, they must treat the individual as FT offering coverage in accordance to their waiting period.

Seasonal employees who do not exceed 120 days of employment during the calendar year can be excluded from your large employer calculations. Note: 1099 independent contractors, partners, and 2% shareholders in an S-corporation are not employees.

Actions:

1) Determine your standard measurement period of three, six, or 12 months.
2) Track work hours monitoring eligibility.
3) Conduct calculations, looking at each employee individually, to determine who is FT, hence will be offered coverage under your plan. Start following your participation definitions now or with your next open enrollment.
4) Establish policies and practices for PT employees, making sure work hours are controlled to keep them below 30 hours per work week average, if you plan to exclude them from medical coverage.
5) Make sure all FT employees are offered affordable, minimum essential coverage.
6) Change your definition of FT employment to 30 hours or more in your employee handbooks and in Summary Plan Descriptions and SPD Wrap. Send out revised SPDs and SPD Wrap or Summary of Material Modification (SMM), reflecting changes.

Affordable Coverage

A plan is deemed affordable if the cost of the individual coverage under the lowest cost plan offered does not exceed 9.5% of the employee's reported W-2 annual wages. Other safe harbors may apply where the monthly premium cannot exceed 9.5% of the employee hourly rate, multiplied by 130, or cannot be exceed 9.5% of the most recently published Federal Poverty Level (FPL) as of the first day of the plan.

Actions:

1) Compare the cost for an individual for the lowest plan option to the wages for all covered FT employees, making sure costs do not:
    a. Exceed 9.5% of his W-2 annual wages;
    b. Exceed 9.5% of recently published FPL or
    c. Exceed 9.5% of employee's hourly rate, multiplied by 130, or salary rate for exempt.
2) Set employee contributions at the beginning of the year at 9.5% or less of wages of the lowest paid employee based on his prior year's earnings. Use the most recent FPL as guideline to set contributions for employees.
3) Make any needed adjustments in employee premium costs as soon as possible, but no later than your next open enrollment.

Minimal Essential Coverage

Although the minimum essential coverage is not yet defined, it will likely be determined by reference to the essential health benefits (EHB) mandated for Exchange plans. The EHB includes items and services in at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; and chronic disease management and pediatric services. The only action for employers is to be aware when the final definition comes out, and make sure your medical plan includes these services. Working with good insurance providers and your broker should take care of this requirement.

Minimum Value

Employers are required to provide minimum value by covering at least 60% of the total allowable cost of benefits that are expected to be incurred under the plan. A minimum value calculator will be available from the IRS and Department of Health and Human Services, allowing employers to input plan information such as deductibles and co-pays to make this determination. Employers need to use this tool and others to make sure they provide at least 60% of the total allowable cost of benefits.

Pay or Play?

Large employers who do not offer minimal essential coverage to full-time employees (FTE) face an annual penalty of $2,000 per FTE without coverage. The first 30 employees will not be counted in the penalty calculation. In instances where employees obtain subsidized exchange coverage because the coverage does not meet the requirements of affordable coverage, the employer's penalty increases to $3,000 per FTE. The question for large employers to decide is whether to "pay" the penalties or provide coverage, "play".

Actions:

1) Calculate the potential cost, if you choose to pay the fines instead of offering coverage (that meets requirements of both minimal essential coverage and affordable).
2) Anticipate the potential impact on your ability to attract and retain employees if you do not offer coverage. What is your competition doing? Will employees leave to work for employers who offer coverage? Will employees who stay become disengaged, feeling you don't care about them?
3) If you decide to offer coverage, plan out the best strategy to control costs while meeting employees' coverage needs. Is it best to use self-funding or a fully insured plan? Determine the feasibility of dual options plan design. If you are concerned about affordability and respective penalties, do you consider offering a core plan set at minimum essential benefit (MEB) for affordability calculations and another option with higher benefits? Do you consider funding premiums between 80% - 100% of single premium, to avoid penalties if an employee is required to pay more than 9.5% of family household income and received subsidy? Do you go with a high deductible and HSA? Discuss these strategies with your insurance broker. Use caution in offering split plans where you have a high deductible HSA for one group and a lower deductible plan for others. This can backfire with all healthy people going on the high deductible HSA and those with higher utilization on the lower deductible plan, resulting in increased cost for all.

Waiting Periods

The IRS defined a maximum allowable waiting period of up to 90 days for new employees to be eligible to begin medical insurance. This is a challenge given most insurance providers expect new enrollees to join the first of the month. Unless they change this definition to the first of the month after 90 days, employers are wise to change the waiting period to the first of the month after a 30 or 60 day waiting period at the next open enrollment.

Health Care Exchanges

Exchanges are a one-stop marketplace of health insurance issuers that enable individuals and businesses to choose a quality, affordable health insurance plan. Required in 2014, each state sets the size of the small group market at either 1-50 or 1-100 employees. In 2016, all employers between 1-100 employees can utilize the Exchange. Large employers with more than 100 employees won't use exchanges until 2017. There are not many actions here other than to work with your insurance broker to determine if Exchanges are right for your business or not. Your broker can continue to help you, regardless of whether you elect this route or not.

Wellness Programs

Creating a healthy workforce is a good strategy to control health care cost and benefit from other rewards, such as increased productivity and lower absenteeism. Organizations are allowed to create incentives and premium differences of as much as 20% of an individual insurance cost, encouraging healthy behavior and accountability. This incentive increases to 30% in 2014. Employers should evaluate how to structure wellness programs and whether or not to use premium incentives related to health factors for insurance cost control strategies moving forward. Use caution making sure you do not violate other employment laws such as HIPPA, American's Disability Act, or GINA. In 2014, insurance companies can begin charging as much as 50% more for smokers. Begin efforts to reduce smoking in your organization and to increase premiums for smokers.

Workforce

Considering the many decisions, costs, and hassles in providing coverage for all employees, employers are faced with the decision of whether or not to alter their workforce prior to 2014. Changing your workforce to

include more PT employees, seasonal employees, temporaries, outsourced or independent contractors may reduce your healthcare cost or even take you to a small employer group level of less than 50 FTEs, so you don't have to offer coverage. Use caution getting too creative in changing your workforce to take away employee benefits. Rumor has it, the various enforcers are finding ways to plug holes where employers are striving to get out of responsibilities to provide insurance benefits. It is wise to run strategies that result in the elimination of benefits being offered to employees past a qualified advisor or labor law attorney.

Give consideration to the following factors in making final workforce decisions:

- What kind of talent do you need? Can you find qualified people who are willing to work PT, work as temporaries or be seasonal to keep your hours down?
- How will scheduling be impacted if you reduce FT employees and increase PT workers? Is the hassle worth the savings?
- If you decrease FT workers and increase part-timers or temporary workers, this means more training, more new hire paperwork, and more supervision. How will you deal with these challenges?
- If you use independent contractors, make sure you meet the IRS Rules of determination under three basic categories:
  - Behavioral control (whether there is a right to direct or control how the worker does the work);
  - Financial control (whether there is a right to direct or control the business part of the work);
  - Relationship of the parties (how the business and worker perceive the relationship).
- More workers results in more exposure to employment risks related to discrimination, safety, harassment, and more. How will you control these risks?
- How will you keep employees engaged, motivated and caring about their work, if they are not full-time? How will this impact your work culture, employee morale, productivity, turnover, absenteeism, and retention?

Small Employer Strategies

Depending on the number of employees, average wage of employees, age range, and past health ratings, there are several decisions that may control cost.

Groups under ten in size may want to evaluate whether it is better for them and for their employees to continue offering a group plan. Evaluate your average wage, to determine if employees qualify for subsidies or Medicaid. Is it more cost effective for everyone to drop or continue coverage? What are the tax implications? How does it impact budget, morale, and competition?

Depending on your state, organizations with two to 50, and in some states up to 100 employees, will now be community rated, meaning premium rates will not be based on gender, health status, claims history, medical underwriting, or group size. Instead, rates will be determined by family structure, benefit plan design, geography, age, and tobacco use. Younger workforces with good previous health history will see a larger than normal increase in premiums as the age gap closes and health factors are eliminated, and vice versa for older workforces and those with higher claims. Plan your budgets for 2014 accordingly.

Depending on your group size and current risk ratings, it may be beneficial to consider a strategy of changing your enrollment date to take advantage of potential cost savings. Organizations previously rated higher because of health challenges in their group will now likely benefit from lower rates, hence may want to renew their plan sooner. Conversely, healthy organizations likely to see an increase in cost due to community rating, may want to defer those rates from taking effect for as long as possible. One strategy to consider is renewing the plan in December, 2013, before community ratings apply so the current rates will stay in effect for an extra 11 months. Of course, these strategies are subject to whether or not insurance providers are willing to allow mid-year plan date changes.

Now is the time to prepare for the many changes required when the full provisions of PPACA/ACA start on January 1, 2014. Employers must address the important decisions now, preparing their workforce, budgets, policies and practices to be compliant and ready.

by Ken Spencer, CEO and HR Coach,
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