Employers: Start Planning for Full Health Care Reform Implementation

by Kelly Davis

With key mandates of health care reform set to take effect on January 1, 2014, employers can anticipate an influx of regulatory guidance and a long list of decisions that must be made regarding their employer-sponsored group health plans. Here are some recent developments that employers should be aware of and act on in the coming months.

State declaration of insurance exchange

States had until December 14, 2012, to declare whether they were moving forward with a state-based, federal-based, or partnership insurance exchange. According to the Henry J. Kaiser Family Foundation, approximately 18 states declared a state-based exchange, 25 declared a federal-based exchange, and seven are planning for a partnership exchange.

Center for Medicare and Medicaid Services annual disclosure

Employers that provide prescription drug coverage to Medicare-eligible individuals are now required to complete an annual disclosure to the Center for Medicare and Medicaid Services (CMS) no later than 60 days after the start of a plan year. For calendar year group health plans, the first disclosure is due to CMS on or before March 1, 2013. The form may be completed online.

To complete the CMS disclosure an employer will need the following information:

- The employer's name, address, and federal tax identification number
- The type of coverage offered
- The total number of prescription drug options available to Medicare-eligible individuals
- The creditable coverage status of each option
- The total number of Medicare-eligible individuals covered by each option

For any plan year where there are significant changes (e.g., the termination of prescription drug coverage), the CMS disclosure must be updated within 30 days.

Employer notice of exchange

On January 24, 2013, the Department of Labor (DOL) announced that the March 1, 2013 deadline for the Notice of Exchange to employees has been delayed until regulations and a model notice have been issued. The DOL says it anticipates a late summer or early fall of 2013 timeframe.

The Notice of Exchange requirement is in Section 18B of the *Fair Labor Standards Act* (FLSA), and applies to employers as defined by the FLSA, as "any person acting directly or indirectly in the interest of an employer in relation to an employee."

Employers will be required to provide the notice to all active employees prior to the beginning date of the exchange, and subsequently to any new hires. The notice will inform employees about:

- The existence of the state exchange and a description of the services provided
- Eligibility for a premium tax credit or a cost-sharing reduction if the employer's plan does not meet certain requirements and the employee purchases coverage through the state exchange
- The risk of loss of employer contributions, and that employer contribution coverage may be excludable for federal income tax purposes
- A contact at the state exchange
- Their right to appeal

The employer “pay or play” mandate

In preparation for January 1, 2014, employers subject to the shared responsibility provisions will have to make a choice — whether to pay or play. Their choice will depend, in large part, on whether the cost of providing benefits to their workforce is outweighed by the potential penalties. Of course, there are other considerations if an employer elects to drop its health plan, such as the effect on workplace morale, susceptibility to union organizing, and issues with recruitment and employee retention.

Employers electing to "pay" will not offer their full-time employees the opportunity to enroll in minimum essential coverage under an employer-sponsored group health plan. These employers will be subject to a penalty if just one full-time employee who is eligible for a tax credit or cost-sharing benefit purchases coverage through a state-based insurance exchange. The penalty is $2,000 per employee per year.

Although the statutory text says the penalty will be triggered even if a single full-time employee purchases coverage through an exchange, regulatory agencies have indicated they are unlikely to adopt such a strict reading. It is also likely that a good faith standard will be applied in cases where mistakes and/or miscalculations are made. Should the penalty be triggered, it will be fully applied to all full-time employees after the first 30.

The alternative choice — to "play" — is when an employer elects to provide coverage that is "affordable" and supplies the requisite level of value to full-time employees. The law says a group health plan is considered affordable:

- If the cost does not exceed 9.5 percent of an employee’s W-2 income (under safe harbor regulations)
- If it provides a level of value defined by the IRS and the Department of Health and Human Services
- If the employer pays at least 60 percent of the actuarial value of the plan

An employer choosing to "play" may also end up paying a penalty if the coverage it offers does not conform to the affordability and minimum value requirements. Effective January 1, 2014, employers will be subject to a $3,000-per-year tax:

- If one or more of its employees eligible for a tax credit or cost-sharing benefit purchases coverage through an exchange
- If the employer-sponsored group health plan fails to provide a sufficient amount of coverage or is merely too expensive for the employee

This penalty structure is designed to ensure that employers provide competitive plans to their employees. All of the penalties outlined here are assessed on a monthly basis, and are likely to increase over time.

U.S. Department of Labor examinations of employer group health plans

The DOL has begun auditing employer-sponsored group health plans for compliance with *Affordable Care Act* (ACA) requirements that are already in effect. An insufficient response to a DOL audit request can lead to additional inquiries and even lawsuits. Various penalties may also be imposed by the DOL and/or the IRS for failure to implement certain coverage mandates related to the ACA.

Employers are strongly encouraged to conduct self-audits to ensure compliance with all of the applicable provisions and mandates of the ACA. It is equally important for employers to ensure that their compliance efforts are well documented. Employers should preserve:

- All records relating to the plan administration, design, and maintenance, including contracts with third-party service providers
- All documents distributed to employees that provide notice of the health care reform provisions

Employers should also ensure that all written policies that implement any ACA mandates are easily obtainable for production.

A helpful listing of example documents requested by the DOL from grandfathered and nongrandfathered health plans can be found in a blog post from the law firm of Epstein Becker Green titled Obama Reelected: The Department of Labor Wants to Know if You Are Taking Steps to Comply With Healthcare Reform.

http://www.cliftonlarsonallen.com/Employee-Benefit-Plans/Employers-Group-Health-Plans-Start-Planning-Full-Affordable-Care-Act-Implementation.aspx

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