

PROCESS-DRIVEN ANALYSIS CAN HELP EMPLOYERS UNDERSTAND RESPONSIBILITIES

The health care reform legislation signed into law on March 23, 2010 sets out significant new requirements for individuals, employers and insurers, including the requirement that all employers which are not exempted **must** now “play” and offer a minimum level of employer-provided health benefits or “pay” an excise tax. Compliance with the Act necessarily requires an understanding of the legal requirements which will be further clarified as the Department of Health and Human Services issues its regulatory guidance. Meanwhile, employers are scrambling to: understand the extent to which the Act applies to them; decide whether they will “play-or-pay”, and; determine how to comply with the requirements of the Act and still meet their business purposes for offering health benefits to their employees.

The employer is responsible for understanding and focusing on the pertinent provisions of the legislation, and the pages of regulations being pumped out of the HHS. To better understand the employer’s responsibilities under the act and fashion its response, a process-driven analysis is suggested in the following five steps:

Step One: Put the law in Perspective. While the Act was, and still is, politically controversial, it is now the law. Of the 1200 or so pages of the Act, only the 135 pages of Title I of the Act apply directly to employers. In its efforts to extend health coverage to an additional 35 million Americans, the Act is comprehensive and applies to the three payors of insured health care: the employer, the insurance carriers, and public programs. Certain provisions of the Act suggest at least some bi-partisan involvement. For instance, “small employers” are exempt from the “play-or-pay” provisions. Even large employers with “grandfathered” plans are exempted from certain mandates of the Act for as long as the plan maintains its grandfathered status. Phased-out tax credits are offered to encourage the smallest employers to maintain employer-sponsored health coverage until coverage becomes available under State Insurance Exchanges in 2014. Mandates are phased-in through 2014 when the “play-or-pay” provisions become effective.

Step Two: Determine which provisions of the Act apply to you. The Act applies to both individual policies and employer-sponsored group health plans. Persons or families who are not eligible to participate in an employer-sponsored plan may qualify for cost-shared subsidies if their income is equal to or less-than four times the Federal poverty level and their cost for coverage is at or less-than 9.5% of their annual income.

Small employers are exempt from the Act. Under the Act, a small employer is one, which in the aggregate, has 50 or less full-time and *full-time equivalent employees* and a large employer is one, which in the aggregate, has more-than 50 full-time and *full-time equivalent employees*. The Act provides that a full-time employee is one whose cumulative hours are at least 30-hours per week. For those employees who are not defined as “full-time” under the Act, there is a specific formula for translating the aggregate number of part-time employees into a number of *full-time equivalent employees* an employer has in any one month. The aggregate of all work hours of all part-time employees in a month divided by 120 will yield the number of full-time equivalent employees. The Act includes an exception for seasonal employees if the employer has more-than 50 full time employees for less-than 120 days in a year and of those more-than 50 of those are “seasonal” as defined by the DOL.

“Grandfathered” plans are not subject to certain mandates. A group health plan or policy in effect on March 23, 2010, is grandfathered for as long as it covers at least one participant and does not experience a material change. Recently-issued regulations provide six events which will amount to a material change: eliminating or significantly reducing benefits; raising co-insurance or co-payments; raising deductibles; reducing employer contributions; adding or increasing an annual limit, or; changing insurance carriers. Changes to premiums to comply with the Act or other laws, replacing a third party administrator, changing the plan structure, or changes to a provider network or a prescription drug formulary, all will not amount to a material change.

Step Three: Understand your obligations under the Act. Once an employer is clear as to whether it is a small employer or a large employer, and if a large employer, then whether its plan is a grandfathered plan, the employer is to look to the Act for its respective obligations and elective actions.

While small employers are exempt from the play-or-pay requirements of the Act, the smallest employers, those with less-than 25 full-time equivalent employees, are eligible for a phased-out tax credit beginning in tax year 2010 and ending in tax year 2014.

The Act schedules out the implementation of mandated benefits for large employer-sponsored plans; whether or not they are grandfathered. For plans with a plan year beginning after September 23, 2010 (which is January 1, 2010 for calendar year plans) there can not be any limits on coverage, coverage is to be extended to participants' children through age 26, and eligibility cannot be conditioned on pre-existing conditions. For plan years beginning after September 23, 2012, the employer is to pay a per participant fee of \$1.00, increasing to \$2.00 in 2013 and according to formula thereafter. In 2014 the play-or-pay provisions become effective.

The play-or-pay provisions apply to all large employers. Employers who "play" are required to offer "minimum essential coverage" to its employees and pay for at least 40% of the actuarially-determined participants' cost of coverage. Large employers who don't play in any month will pay an excise tax equal to the number of full-time employees over 30 determined on a controlled group basis multiplied by 1/12th of \$2000. Only employers who have at least one employee receiving a cost-sharing reduction through a State insurance exchange are subject to the excise tax and the tax is calculated on all employees regardless as to how many are receiving benefits under a State insurance exchange.

The following mandates are applicable only to those plans which are not grandfathered: non-discrimination rules which prevent disproportionate benefits from being provided to highly-compensated employees over non-highly compensated employees; implementing an external review process in addition to the internal review process; participant discretion in selecting physicians, pediatricians, and obstetricians/gynecologists, and preventive care must be provided entirely at the employers' expense.

Step Four: Respond strategically. The options available to employers are also determined by the business objectives and benefits philosophies established by each employer. In advance of making the final determinations as to how to respond to the Act, the employer should hone the business objectives for providing health care benefits, define the total benefits strategy including pension or 401(k), paid-time-off, and prerequisites, quantify the return on the employer's health plan dollar and factor in corporate resources, administrative costs and compliance costs and determine if the employer is getting a dollar's worth of benefit for each dollar spent, then compare the return on the health care dollar with the costs for designing and implementing each option and whether the final costs justifies the business purpose for providing the benefits. This exercise should reveal gaps between the design and the costs and the returns. The design and costs can be reconciled to provide a plan that best maximizes the return on the health care dollar.

Step Five: Manage the response to the Act. In this final step it is appropriate to consider one's business forecast and how the ultimate plan design will meet the projected business needs; will an anticipated change in business structure cause the plan to lose its grandfathered status which the success of the original design depended upon? Consult with your service providers and understand their costs, if any, for advice, systems or process changes, and implementation requirements, including communications. Meet with your administrative, management, finance, accounting and legal teams so each may identify their issues which will impact the ultimate business decision. Be mindful of the ERISA fiduciary rules which separate the making of corporate decisions from those to be made solely in the best interests of the participants. And make each formal decision in accordance with the governance structure established for each employer.

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