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Rolling Out The Affordable Care Act

The Editor interviews ***Catherine E. Livingston,*** *Partner in Jones Day's Health Care and Tax Practices in its Washington, DC office.*

Editor: Please describe your background as Health Care Counsel in the IRS Office of Chief Counsel where you had a key role in developing and advising on the Affordable Care Act.

Livingston: I spent ten years as an executive in the IRS Office of Chief Counsel, the last three of which were devoted exclusively to working on the Affordable Care Act. I started working on the law before enactment when the IRS senior leadership needed technical legal advice as they reviewed proposed legislation. From the date of enactment forward, I worked on all of the regulations and other legal guidance necessary to implement the dozens of tax provisions in the law and coordinate them with the provisions administered by Health and Human Services and other federal agencies.

Editor: The Obama administration recently announced that it is postponing three important Affordable Care Act requirements affecting large employers. Please describe them and the effect of their postponement on other aspects of ACA implementation.

Livingston: In early July, the Treasury department announced that it would delay enforcement of three different provisions of the ACA that principally affect large employers in order to allow for more time to work with stakeholders in simplifying procedures. What drove them to this decision was the practical timeline. Two of the delayed provisions involve information-reporting requirements. One of those provisions requires every employer with 50 employees or more to report to the IRS every year on the identity of every employee who worked full-time for one month or more during the year, as well as to provide information on whether that employee was offered health coverage and its costs. The second information-reporting provision required every health insurer and health coverage program, including every self-insured employer, to report to the IRS every year on the identity of every individual covered under the health insurance or health plan. The government knew that it was late in providing the rules necessary to implement the information reporting and therefore wanted to delay enforcement of those rules for the first year. (2014 would have been the first year for which information had to be gathered, with the first reports submitted to the IRS in early 2015.) Once it delayed enforcement of information reporting, the government further acknowledged that it would not be in a position to enforce the so-called play-or- pay employer mandate, the part of the law that penalizes large employers who do not offer coverage that is affordable and provides minimum value to almost all, if not all, of their full-time employees. This delay provides extra time for employers to get ready to comply and more time for insurers to build the systems necessary to do the information reporting. These delays do not otherwise affect the rest of the ACA.

Catherine E. Livingston

There are a few technical details where the connection between the provisions that have been delayed and the provisions that are in effect have yet to be specified. For example, there is a rule for group health plans that limits the waiting period that can be imposed before coverage can start to a maximum of 90 days. There are some open questions about how that waiting period now works, given the delay in enforcement of the employer mandate. We can hope there will be further guidance in the coming months to fill in those missing details.

Editor: What are the penalties for employers for non-compliance in the event that 95 percent of full-time employees are not offered coverage by 2015?

Livingston: Assuming that the play-or-pay employer mandate is in effect and enforced for 2015, the statute provides two different types of penalties. The first is the *no-coverage penalty:* if the employer fails to offer coverage to at least 95 percent of its full-time employees, that employer would have to pay a penalty. Assuming the employer failed to comply for all 12 months of the year, the penalty would be equal to $2,000 times the number of full-time employees that it had for the year, less the first 30. The penalty is actually computed month by month so if the headcount changes month to month, the computation of the penalty would be affected.

The other version of the employer penalty is the *insufficient coverage penalty*. If the employer offers some form of coverage to 95 percent or more of its full-time employees, but that coverage is not affordable or doesn't provide minimum value, or if it doesn't offer coverage to 100 percent of its full-time employees – i.e., if one of the very few full-time employees who is not offered coverage is able to go to an exchange and receives a premium tax credit – then the employer would be subject to a penalty. The insufficient coverage penalty only applies if at least one employee goes to an exchange and gets a premium tax credit. That penalty is then equal to $3,000 for the year times the number of full-time employees who actually get premium tax credits. So

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the insufficient coverage penalty is proportionate to the number of full-time employees who receive government assistance with health premiums through tax credits.

Editor: To play, an employer must offer health coverage that is "minimum essential coverage," is "affordable," and satisfies a "minimum value" requirement to its full-time employees and their dependants. What is meant by these requirements?

Livingston: "Minimum essential coverage" is a new term defined under the ACA as coverage that is sufficient to protect an individual from the penalty that would apply to the individual if he lacked health coverage. Minimum essential coverage comes in several forms: It could be government-sponsored coverage, like coverage through Medicare or through the VA; it could be employer-sponsored coverage of any type that will count as a group health plan and is not excepted benefits (like a vision or dental plan); or, it could be coverage in the individual market, such as the coverage some individuals will purchase through the new state health benefit exchanges.

"Affordability" is a specific test that is applied for purposes of the new premium tax credit, the new subsidy that will be available to help certain people purchase coverage through these exchanges. Individuals cannot get a premium tax credit if their employer provides them with coverage that is affordable. The statute says that the coverage is affordable if the employee's share of the premium for self-only coverage is 9.5 percent of that individual's household income or less. Of course, employers don't know their employees' full household income, so the government has provided some safe harbors that employers can use to get assurance that their coverage is affordable looking only at the wages or the rate of pay that the employers pay to their workers.

The last term is "minimum value." This is a test that is applied to health coverage to see how generous it is in covering the expected medical costs that a typical individual would incur in the course of a year – an actuarial concept. Minimum value for these purposes means that the plan is expected to cover 60 percent or more of the costs that the typical individual would incur. Whether a plan offers minimum value is determined by looking at the deductibles, co-pays, co-insurance, and other terms and conditions that apply under the plan.

Editor: Are there other compliance issues that employers need to address by or before 2014 that have not been postponed?

Livingston: Yes. There is a new requirement under the Fair Labor Standards Act for any employer who is subject to that law to provide all of its current employees with a notice alerting them to the existence of the new exchanges and the health coverage that may be available there no later than October 1, 2013. From that date forward, employers will have to provide an equivalent kind of notice to any new hire within a couple of weeks of that person's being hired. In addition, if an employer is sponsoring its own group health plan, there are some rules with respect to those group health plans that will go into effect January 1, 2014; for example, there is a bar on annual limits with respect to any benefit that would constitute an essential health benefit. Essential health benefits are a new concept that will come into use on January 1. Employers are not required to offer essential health benefits, but any health plan offered on a state exchange must offer essential health benefits. Employers may need to re-check certain details of their health plans to make sure they are in compliance.

Many other requirements went into effect for plan years starting on or after September 23, 2010, so most employers have already come into compliance with many of ACA's insurance reforms, but there are a few that will take effect January 1, 2014.

Editor: What effect is this delay expected to have on enrollment in the state health insurance exchanges?

Livingston: The delay in enforcement of the information reporting and the employer play-or-pay requirement should not have a significant effect on enrollment in the state health exchanges. The one possible place I can see there being an effect would be with respect to employees who are not offered employer coverage or who are offered unaffordable employer coverage, thus leading them to enroll in the exchanges because premium tax credits would become available to them. If the employer play-or-pay requirement were being enforced, employers might be more inclined to offer coverage to those workers or to make the coverage affordable. In the absence of the play-or-pay requirement, employers may not make those decisions, thereby making it possible for their workers to get a subsidy by enrollment in the exchange.

Editor: What impact will the opening of the exchanges have on employers?

Livingston: The impact of the opening of the exchanges on employers is hard to pin down specifically. Other than the notice requirement, employers do not have specific procedures or tasks that they need to do with respect to the exchanges, but they may well find that there are some impacts of the following kind. First, employees are very used to going to their employers to get information about health benefits. They may turn to their employers for information about the exchanges, insurance assistance and financial assistance through the exchanges, and general help understanding the new legal requirement to have health insurance that goes into effect January 1, 2014. Employers and their HR departments may want to prepare for those questions by anticipating them in a way that allows them to have accurate and consistent answers as well as identify questions that the employer is not properly positioned to answer. They may want to identify authoritative sources like the Department of Health and Human Services website (www.healthcare.gov) or the IRS website (www.irs.gov/uac/ Affordable-Care-Act-Tax-Provisions-Home) that might be better sources of information for their workers.

Another possible impact on employers that is hard to predict until the exchanges go into operation are contacts that the exchanges make with the employer as they try to verify information the individuals have put on their application for financial assistance. The exchanges are required to verify what they find on the application, and, under HHS regulations, some of the exchanges may be reaching out to employers to ask whether or not various applicants have been offered or are in fact enrolled in employer health coverage. Until the exchanges are operational, it is hard to know whether they will be successful in making those contacts with the employers and what the nature of those contacts will be.

Editor: In view of the state resistance in some cases, do you expect there will be a

delay in setting up the exchanges?

Livingston: I fully expect the exchanges to begin operation October 1, 2013, as has been repeatedly affirmed by the Department of Health and Human Services and a number of the states. They may not have full functionality on the first day that they are open to the public, but I think that there is great will and determination to make the websites and call centers operational so that they can begin helping the public get access to coverage as of that date.

Editor: What parties are permitted to use the exchanges?

Livingston: Any individual who is legally in the country is able to use the exchanges to enroll in coverage. Financial assistance is a different matter. Whether or not an individual can get financial assistance paying for the coverage he selects through the exchange requires that he satisfy additional eligibility criteria – whether that financial assistance comes through this new premium tax credit or certain cost-sharing reductions that are available, or whether the individual is going to be referred to the Medicaid or CHIP program for assistance obtaining coverage. But enrollment in pure insurance coverage without financial assistance is broadly available to anybody who is in the country legally.

Editor: What penalties are incurred by individuals who refuse to obtain insurance through the exchanges or otherwise?

Livingston: Beginning January 1, 2014, there is a new requirement under the tax code that all individuals either have health coverage, qualify for an exemption, or pay a penalty. Individuals will first have to account for coverage or exemptions or penalties when they file their tax returns in 2015. Individuals whose incomes are low enough that they are not required to file a tax return are exempt from the requirement. The penalty has a floor, a minimum dollar amount that can apply, and also a cap on the maximum amount. The amount of the penalty between the floor and cap depends on family size, income level, and the number of months during the year that people are missing coverage. The maximum amount is based on the national average premium for what is called bronze-level coverage. The cap is intended to ensure that the amount that you pay as a penalty never exceeds what you would otherwise have had to pay to get the minimum level of health coverage under the Act.

Editor: What are the prospects for legislative changes in the ACA? Is it possible that the standard definition of full-time employee will change from 30 hours per week to 40 hours per week?

Livingston: If the time horizon is long enough, the prospects for legislative change are extremely high. It's a very complicated law, and as different stakeholders begin to feel its effects, both intended and unintended, I would fully expect that there will be interest in making changes. In the short term, that is harder to predict, though I can say that there has been bipartisan legislation introduced in the Senate that would make the change in the definition of full-time employee from 30 hours to 40 hours.

Editor: How does the ACA address contingent full-time employees hired through third parties?

Livingston: The statutory language does not directly address that fact pattern, which is very common in a variety of different industries. As we have been talking with our clients and various stakeholders, we have come to see that in manufacturing, there is an increasing use of contracting firms to bring in workers. In the healthcare industry, there are any number of contingent workers whose skills meet various needs or who have a particular profile. It may also be common to use contingent workers in industries where the demand for work is constantly fluctuating or where you might want very skilled workers and the contracting firms may be successful in attracting them or identifying them for you. The responsibilities that the ACA places on employers are placed on *common law* employers. The law doesn't shift those responsibilities over to a third-party contracting firm, just because the firm is the one who is paying the full-time employees or who has identified the employees and put them through the hiring process. So if you are the service recipient firm, you will want to have a clear understanding with the third-party company that has secured the contingent workers as to who is meeting the full set of responsibilities to ensure that all of the workers have been offered health coverage. If the coverage is being offered by the contracting firm rather than by the service recipient firm, there is no current assurance that the federal government will give you credit as the service recipient for having offered that coverage. You may not be protected from a penalty. However, if the arrangement with the contracting firm has explicitly required that health benefits be offered to the contingent worker, then the service recipient firm has a sound argument they can use with the government to help protect themselves from penalties. Similarly, with respect to the information-reporting requirements and FLSA notices and other compliance responsibilities that fall on employers, service recipient firms will want to have a good understanding with the contracting company as to which of the two is meeting the different responsibilities with respect to the workers who are placed with the service recipient.

Editor: I was recently reading an article in *The New York Times* regarding Detroit and the fact that Detroit is delighted to be able to refer retiree health insurance benefits to the exchanges. It seems that many of the cities will be using the insurance exchanges for their retirees. Is that your impression?

Livingston: Certainly retiree health insurance costs have been an increasing concern for employers in both the public and the private sector. Increasing health coverage costs for all workers have been a concern, but retirees, given their age and profile, are a particular source of expense. As a result, I think employers will be looking at all kinds of different creative solutions, and the exchanges may well be part of a strategy for ensuring that retirees have guaranteed access to health benefits, while at the same time structuring that benefit in a way that allows the employers, both public and private, to manage that cost. There are some particular issues that need special consideration, such as the circumstances under which collectively bargained retiree health benefits might be modified. We are looking at all of those different angles as we work with our clients. To say it again, the exchanges will offer new opportunities and new strategies that employers can use to attend to that concern.