

Update for Staffing Firms on the Impact of Health Care Reform

The Health Care Reform changes signed into law by President Obama makes dramatic changes in this country's health care system. Many of these changes impact employers including a new excise tax if they have employees who received government subsidies to help them pay for coverage. While many of the law's provisions don't become effective until 2014, staffing firms across the country are understandably concerned and starting to investigate their options.

At Assurance, our staffing clients have been calling us regularly for advice on dealing with health care reform. Printed here are among the most asked questions, along with our responses.

Does the new law require employers to provide health coverage?

No, but employers with 50 or more full-time employees will pay an excise tax if they have even 1 employee who receives a premium tax credit or a cost sharing reduction through a state exchange. The excise tax will either be \$2,000 or \$3,000 depending the employer's situation.

How do I calculate if I have 50 or more full-time employees?

The new law applies to employers with "an average of at least 50 full-time employees on business days during the preceding calendar year." A full-time employee is an employee working an average of at least 30 hours or more per week in a month. "Full-time equivalent" employees are treated as full-time employees in determining whether an employer has 50 or more employees. Full-time equivalent is determined by dividing the total monthly hours of service of employees who are not full-time employees by 120. An employer will not be considered to have 50 or more employees if its workforce exceeds 50 employees for 120 days or less during the year and the employees more than 50 are "seasonal workers."

What is considered a seasonal worker?

Seasonal workers are defined by the U.S. Secretary of Labor, including workers specified in existing Department of Labor regulations, and retail workers employed exclusively during holiday seasons. Department of Labor regulations define seasonal as "labor performed on a seasonal basis where, ordinarily, the employment pertains to or is of the kind exclusively performed at certain seasons or periods of the year and which, from

its nature, may not be continuous or carried on throughout the year. A worker who moves from one seasonal activity to another, while employed in agriculture or performing agricultural labor, is employed on a seasonal basis even though he may continue to be employed during a major portion of the year." The Department of Labor is expected to issue additional guidance as to the meaning of seasonal.

If staffing firms currently offer full-time staff and temporary employees health plans, what is the impact of the new law?

Group health plans in existence on March 23, 2010 when the law was passed have been "grandfathered" and therefore are not subject to certain of the law's insurance reform provisions. Grandfathered plans can maintain the plan design in place on that date and can increase benefits and make other changes to comply with state and federal rules without forfeiting grandfathered status. Under regulations issued by the U.S. departments of Health and Human Services, Labor, and the Treasury, group health plans will lose their grandfathered status if they:

- Eliminate all or substantially all benefits relating to the diagnosis or treatment of a particular condition
- Increase the percentage of medical costs patients must pay as part of a cost sharing requirement (coinsurance)
- Increase health insurance copayments by more than the greater of \$5 adjusted for medical inflation or a percentage equal to the medical inflation rate plus 15 percentage points
- Increase fixed-price cost-sharing requirements (deductibles) by more than the medical inflation rate plus 15 percentage points
- Reduce contributions to employees' health insurance premiums by more than five percentage points
- Adopt a new annual limit on benefits or lower an existing limit
- Change insurance carriers (self-insured plans may change third-party administrators without losing grandfathered status)

Grandfathered plans will remain subject to many of the insurance reform provisions, including

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those allowing children to remain on their parents' plan until age 26, barring children under 19 from being denied coverage because of pre-existing conditions, limiting waiting periods to 90 days, barring lifetime and restricting annual dollar limits on coverage, prohibiting policy rescissions except for fraud or material misrepresentation, requiring uniform explanation of coverage, and imposing medical loss ratio requirements on insurers.

How does the law affect limited-coverage ('mini-med') plans?

The law provides that effective Sept. 23, 2010, health plans may not impose lifetime limits on the dollar value of benefits. Annual dollar limits may be imposed until Jan. 1, 2014, but only to the extent allowed under regulations to be issued by the Secretary of Health and Human Services. In June, Health and Human Services Secretary Kathleen Sebelius issued regulations providing guidance on how mini-med plans will be addressed. The regulations suggest that most mini-med plans will be allowed to continue in force until 2014. Group health plans will be subject to the following annual dollar limits under the regulations:

- Plan or policy years beginning on or after 9/23/2010, but before 9/23/2011—\$750K
- Plan or policy years beginning on or after 9/23/2011, but before 9/23/2012—\$1.25M
- Plan or policy years beginning on or after 9/23/2012, but before 1/1/2014—\$2M

The regulations state that, with respect to mini-med plans, the government's goal is to ensure that individuals will continue to have access to needed health care services with a minimal impact on premiums. The regulations provide for the secretary to establish a program under which the annual limit restrictions may be waived if they would result in a significant decrease in access to benefits or a significant increase in premiums. Specific guidance regarding the process for applying for a waiver is expected to be issued in the near future. Most mini-med plans are expected to qualify for waivers.

Who determines an employee's eligibility for subsidies?

The Secretary of Health and Human Services is required to establish a program for determining eligibility for a premium assistance credit or cost-sharing reduction. If the Secretary determines that the employer does not offer minimum essential coverage or that the coverage offered is unaffordable or does not provide "minimum value" and the employee meets the income tests, the employee will be allowed to enroll in an exchange-offered health plan and claim a subsidy. In the case of the premium assistance

tax credit, eligibility will be determined in advance of the coverage year on the basis of household income and family size going back two years. For example, if an individual applies for a premium tax credit for 2014, the individual must provide a tax return from 2012 during the 2013 open enrollment period. The U.S. Internal Revenue Service is authorized to disclose to the U.S. Department of Health and Human Services limited tax return information to verify a taxpayer's income based on the most recent return information available.

Individuals must provide the exchange with appropriate documents to prove identity along with information regarding their citizenship or immigration status, income, and family size. The exchange will submit the information to the Secretary of Health and Human Services and relevant portions will also be submitted to the Social Security Administration, the U.S. Department of Homeland Security, and U.S. Department of the Treasury for verification. The results of the verification are then provided to the exchange.

How will an employer know if an employee is eligible for a subsidy?

The Secretary of Health and Human Services is required to notify the exchange of the employee's eligibility and the exchange must notify the employer. The notice to the employer also must include information about the employer's potential excise tax liability and that terminating or discriminating against employees because they received a premium tax credit or cost-sharing reduction is in violation of the Fair Labor Standards Act. An employer is generally not entitled to information about its employees who qualify for a credit, but they may be notified of the name of the employee and whether his or her income is above or below the threshold used to measure the affordability of the employer's health insurance coverage.

There is no single right answer as to how the law will fully apply, as each staffing company's situation and circumstances are unique. For additional answers to these and other questions, you are encouraged to consult with an Assurance employee benefits advisor so you can begin to sort through your options and plan for any necessary implementation or changes necessary for compliance.

To begin the process, contact Assurance's Employee Benefits Practice Leader, Liz Smith:

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