A Blueprint for Employers

HR. Payroll. Benefits.

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The Topline

Employers, take note. The Affordable Care Act (ACA) is affecting every one of you – administratively, financially, and otherwise – more than you realize. In particular, it will influence how you design and make health care benefits available to your employees. You vitally need to understand the implications, especially the financial risks involved. After all, failure to comply with the ACA could spell heavy penalties – possibly stiffer than you suspect – reaching into the millions of dollars, unless you start planning properly right now.

Highlights

- Avoiding the "Catastrophic Tax"
- Avoiding the "Lesser Tax"
- Conducting an Excise Tax Liability Analysis
- Documenting the Offer of Coverage
- Doing Due Diligence on Non-Calendar Year Plans

Our direct experience with our clients shows that employers remain largely unaware of the multiple challenges of the requirements now in place and the potential long-term financial consequences. More serious still, many employers are unprepared to document and report data with sufficient accuracy to avoid or minimize the penalties that can readily be incurred. Make no mistake: this threat is real. And time for planning is running out fast.

That's the primary rationale for this brief – a wake-up call that offers actionable, practical advice. It will spell out how employers can adopt strategies to make well-informed decisions. In the bargain, employers will learn the options available – not only how to do right by their employees and save money, but also achieve full compliance with the law. In short, it's important you understand what the law says, what it means to you, and – the biggest concern of all – what actions you need to take.

FIGURE 1: THE ACA WILL IMPACT

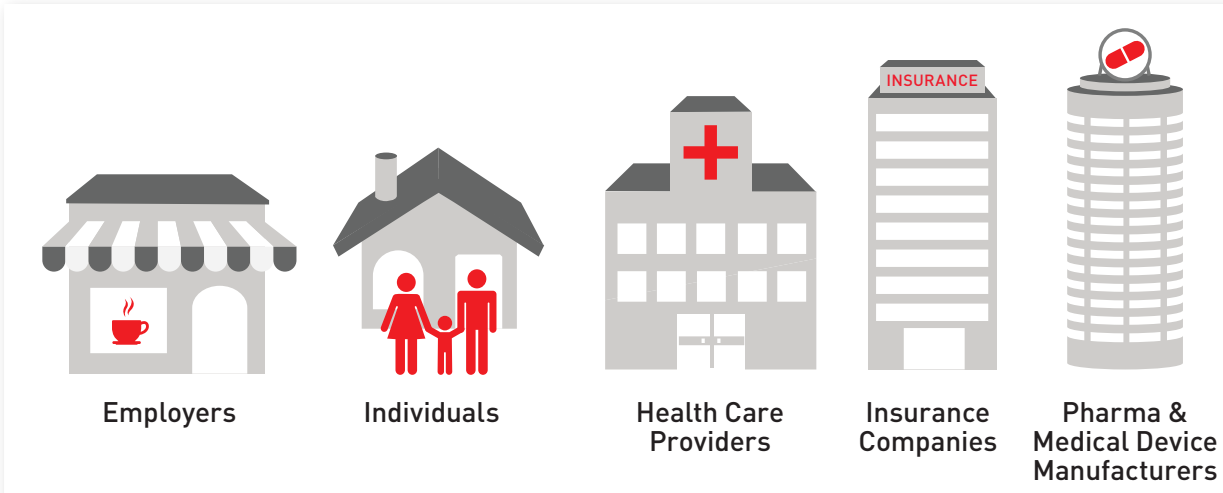
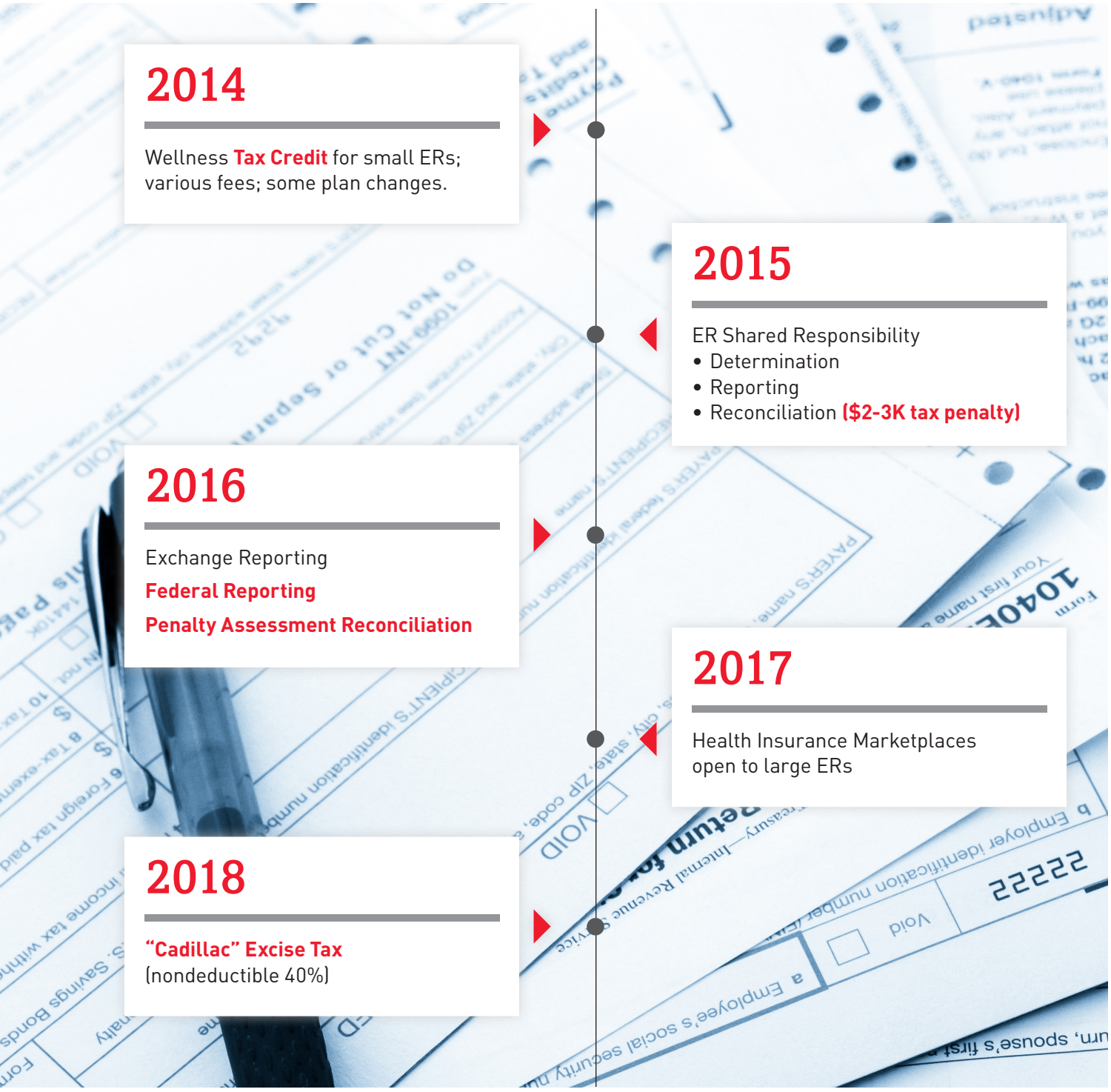


FIGURE 2: ACA IMPLEMENTATION TIMELINE 2014-2018



The Broader Breakdown

When it comes to legislation about benefits, the ACA is unique. Its impact will span widely across organizations. For example: The implications for employers stretch well beyond benefits. A wide range of organizational resources – including Tax, Finance, Risk, IT, Payroll, Time and Absence Management, and Benefits – will require coordination.

Employers will have to make key strategic decisions not only related to benefits, but also – just to name a few — total compensation balance, workforce planning, rates of pay, and penalty costs versus the cost of compliance. Systems that have never shared data will now have to do just that. Such data, related to Payroll, Benefits, HR and Absence Management, will have to be maintained for seven years. That data will be critical in numerous respects: planning and determining the correct strategies to comply with the ACA; complying with the applicable requirements under the ACA to avoid – or at least minimize – nondeductible financial penalties; reporting to the federal government; and reconciling and appealing final penalty assessments made by the federal government.

Systems that have never shared data will now have to do just that. Such data, related to Payroll, Benefits, HR and Absence Management, will have to be maintained for seven years.

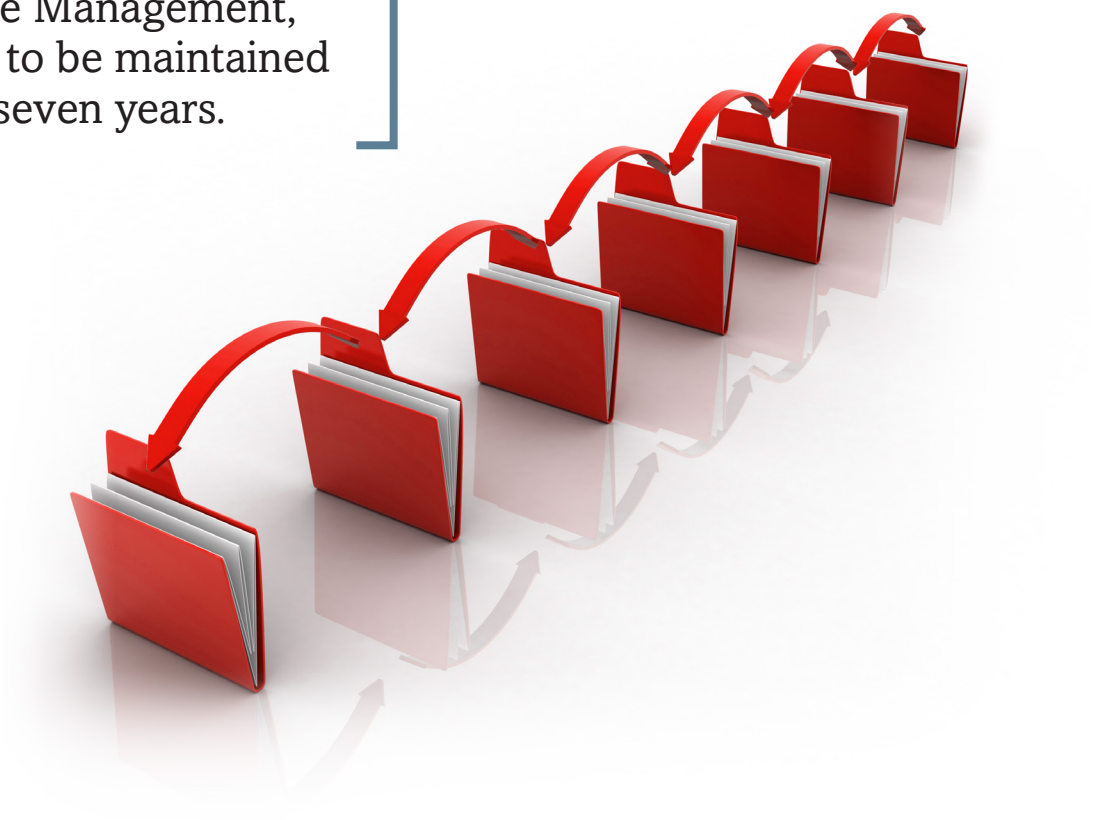


FIGURE 3: ACA – BROAD HUMAN CAPITAL MANAGEMENT IMPACT

For most employers, the two areas within the ACA that will require the greatest focus are the Shared Responsibility/Employer Mandate that takes full effect in 2015 and the 2018 Excise Tax on high-value health coverage. (Employers with fewer than 100 full-time employees and full-time equivalent employees are generally exempt from the Shared Responsibility/Employer Mandate in 2015.) In both cases, employers will have to engage in significant record keeping and reporting in order to demonstrate compliance and avoid penalties.

The "Big" or "Catastrophic" Penalty

The first penalty threshold is sometimes referred to – understandably enough – as "The Big Penalty" or "The Catastrophic Penalty." It requires Applicable Large Employers (ALEs, employers with 50 or more full-time employees and full-time equivalent employees) to take the following step to avoid a penalty: offer a minimum essential coverage (MEC) plan to at least 95% (70% in 2015) of all ACA full-time employees and their dependent children.

If an employer fails to comply with the Shared Responsibility requirements – and if any one of the affected ACA full-time employees goes to the Health Insurance Marketplace and qualifies for a federal subsidy – the employer will incur an annualized nondeductible penalty equal to $2,000 for every ACA full-time employee, even those who are enrolled in coverage. This penalty is assessed monthly, and the employer may exclude the first 30 ACA full-time employees – 80 in 2015 – when calculating the penalty due. Measures can be taken to avoid such penalties.

First, a little additional background. The ACA requires employers with 50 or more full-time employees and full-time equivalent employees to offer coverage to all ACA full-time employees to avoid being subject to a potential penalty. Still, the definition of ACA full-time status applies only to health care benefits. The ACA defines "full-time" as an employee who averages 30 or more hours of service – as opposed to hours worked – during the measurement period. Hours of service encompass all paid hours – including paid vacation and special types of unpaid leave, such as jury duty, the Family & Medical Leave Act (FMLA), and the Uniformed Services Employment and Reemployment Rights Act (USERRA), and must be not be taken into account under the look-back rules.

FIGURE 4: INCOME LEVEL UP TO WHICH A PERSON IS ELIGIBLE FOR SUBSIDY IN A MARKETPLACE

Number of Persons in Family	Federal Poverty Level: 2014 48 Contiguous States	400% of FPL 48 Contiguous States/DC
1	$11,670	$46,680
2	$15,730	$62,920
3	$19,790	$79,160
4	$23,850	$95,400
5	$27,910	$111,640
6	$31,970	$127,880
7	$36,030	$144,120
8	$40,090	$160,360

Source: Federal Register — January 22, 2014.

Consider these three examples.

In Scenarios 1 and 2, the employer must offer minimum essential coverage (MEC) to 95% or more of its ACA full-time population (70% in 2015), thus preventing a penalty. A different penalty could apply in Scenario 2 and will be discussed separately below. These scenarios are based on the 95% coverage threshold that goes into effect in 2016: For 2015, a 70% threshold will apply.

FIGURE 5: MEC PENALTY SCENARIOS OR MEC PENALTY EXAMPLES

	Scenario 1	Scenario 2	Scenario 3
Regular F-T Employees	1,500	1,500	1,500
Variable Hour Employees: Averaging less than 30 hours	500	300	300
Variable Hour Employees: Averaging 30 hours or more	0	200	200
Total ACA F-T Eligible Population	1,500	1,700	1,700
Number Offered Coverage	1,500	1,650	1,500
Percent Offered Coverage	100%	97%	**88%**
Nondeductible Penalty	0	0	**$3,340,000**

Note: Failure to offer coverage to 100% of all ACA Full-Time Employees may result in a penalty under IRC Section 4989H(b) but will be limited to only those individuals who enroll for coverage through the Health Insurance Marketplace and qualify for a federal tax credit.

The penalty under IRC §4980H(a) is triggered in Scenario 3 since less than 95% of ACA F-T EEs were offered coverage.

FIGURE 6: PENALTY CALCULATION

Total Number of ACA F-T Eligibles	–	Less Excludables EEs	=	Number on Which Penalty Is Based
1,700	–	30	=	1,670

1,670	x	$2,000	=	$3,340,000
		Penalty Amount (Annual)		Total Penalty

> If even one of the employees not offered coverage goes to the Health Insurance Marketplace, and qualifies for a federal subsidy/tax credit, a penalty will be triggered...

In the case of Scenario 3, the employer failed to offer coverage to at least 95% of the ACA full-time population (70% in 2015). If even one of the employees not offered coverage goes to the Health Insurance Marketplace, and qualifies for a federal subsidy/tax credit, a penalty will be triggered, based on the entire ACA full-time population minus the first 30 employees beginning in 2016 (80 in 2015).

As it happens, most employers will likely be able to meet the 70% requirement that is in place for 2015. But the 95% requirement, effective in 2016 and beyond, may make it more challenging to determine whether enough employees were offered coverage, unless employers take the crucial step of accurately tracking all hours of service, including special unpaid leaves, in 2014. Failure to meet the 95% offering requirement – and to document such an offering – can result in significant nondeductible penalties, as illustrated above. Failure to account, in particular, for unpaid leaves could result in the employer inadvertently failing to offer coverage to at least 95% of ACA full-time employees, thereby triggering the penalty. These penalties are nondeductible and would be in addition to whatever the employer was actually spending on providing health care for its employees.

The “Individual” or “Lesser” Penalty

The second penalty threshold is sometimes referred to as the “Individual Penalty” or the “Lesser Penalty.” Applicable Large Employers (ALEs) are required to do the following to avoid a penalty:

Offer a health plan with at least a 60% minimum value.

Ensure that this plan is affordable for an employee by using one of the safe harbors described in the regulations. Under these safe harbors, the cost of this plan for “employee only” coverage cannot exceed 9.5% of one of the following:

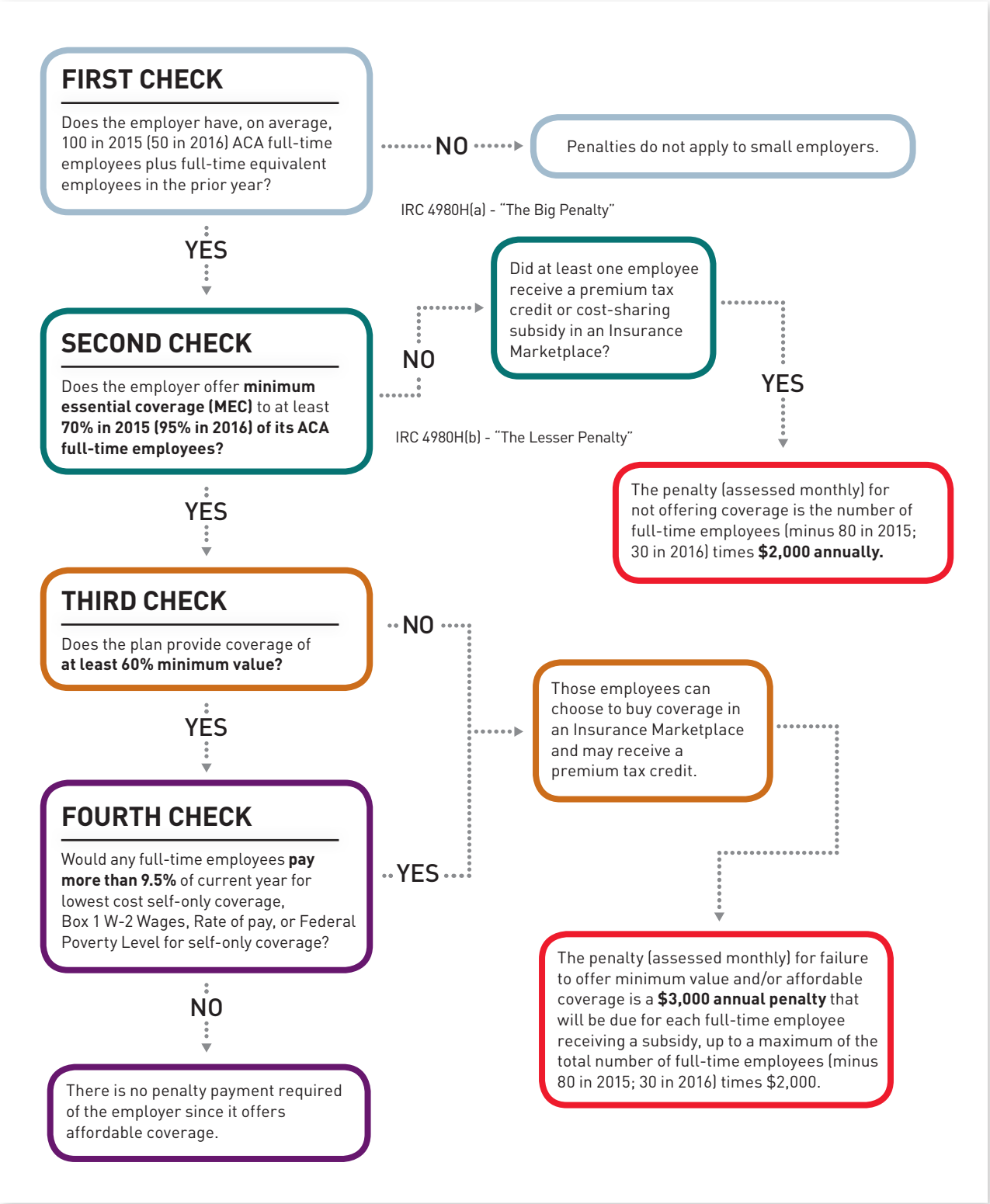
- Current year’s Box-1 W-2 wages;
- The federal poverty level for a single person (can use the federal poverty level in effect six months prior to the beginning of the plan year);
- or an amount equal to the employee’s hourly rate of pay in effect on the first day of the plan year (or lowest monthly rate, if lower) multiplied by 130 hours per month for hourly employees.

If any ACA full-time employee is not offered an affordable plan with at least a 60% minimum value, and the employee goes to the Health Insurance Marketplace and qualifies for a federal subsidy, it will trigger a nondeductible, annualized $3,000 penalty to be assessed monthly.

The total penalty imposed under the “Lesser Penalty” cannot exceed the maximum penalty that could be assessed if the employer failed to meet the requirements under the “Catastrophic Penalty.”

The following flow chart provides a quick reference guide for avoiding penalties under the Shared Responsibility mandate:

FIGURE 7: ACA RESPONSIBILITY — DECISION FLOW



The 2018 Excise Tax

In 1965, health care expenditures were 5.6% of GDP. By 2020, it is expected to be approximately 20% of GDP.[1] Health care costs have grown far more rapidly than the rate of inflation, as measured by the Consumer Price Index (CPI). In fact, every year since 1965, per capita health care spending has increased faster than the rate of inflation, as measured by the CPI![2,3]

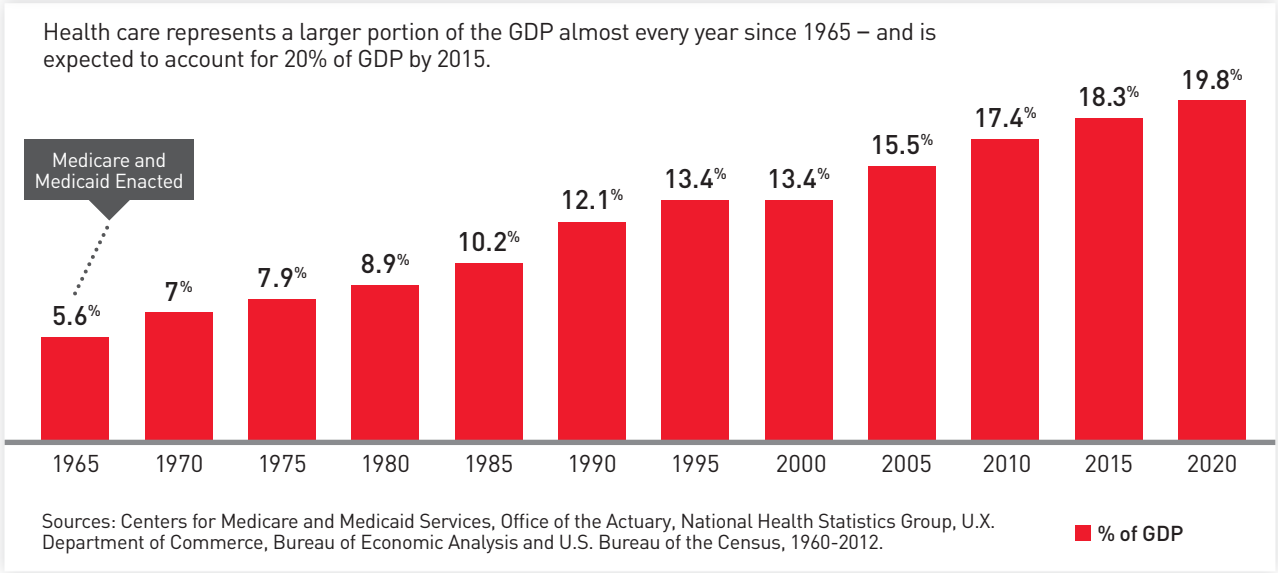
Clearly, nothing tried by either government or employers – HMOs, Flexible Benefits, Restricted Networks – has been effective on a national basis in slowing the rate of growth in health care spending to something approximating general inflation.

Every year since 1965:

- Medical CPI has risen faster than general CPI
- The percentage change in per capita health care expenditures has been higher than the change in medical CPI.

Source: Percent Change in CPI (All Items and Medical Care) - U.S. Dept of labor, Bureau of Labor Statistics

FIGURE 8: HEALTH CARE COSTS CONTINUE A LONG-TERM COST INCREASE FAR IN EXCESS OF INFLATION



Sources: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, U.X. Department of Commerce, Bureau of Economic Analysis and U.S. Bureau of the Census, 1960-2012.

Beginning in 2018, if the cost of health care (including both employer and employee contributions) exceeds $10,200 for individual coverage and/or $27,500 for family coverage, an Excise Tax equal to 40% of the amount in excess of these limits will be imposed and the employer will have to pick up the costs of this Excise Tax. For insured plans, the ET is imposed on the insurance company with the expectation that the cost will be passed along to the employer. For self-insured plans, the Excise Tax is imposed on the plan directly and the employer, as the plan administrator.

Many employers have concluded – mistakenly – that these limits are so high that they should present no problem. But, published research estimates suggest that as many as 60% of all employer plans will cross over these limits as early as 2018, unless these employers make plan design changes prior to that time.[4]

As the following illustrations show – for companies of 2,000 and 8,000 employees, respectively – exceeding these limits even by a small annual amount can result in significant nondeductible penalties.

FIGURE 9: EXAMPLES OF NONDEDUCTIBLE PENALTIES

Example 1	Individual Coverage	Family Coverage	Total
Excise Tax Limit	$10,200	$27,500	-
Cost of Plans	$10,550	$28,225	-
Amount Subject to Excise Tax	$350	$725	-
Number of Employees Enrolled	500	1,500	2,000
Annual Penalty in 2018	$70,000	$435,000	**$505,000**

Example 2	Individual Coverage	Family Coverage	Total
Excise Tax Limit	$10,200	$27,500	-
Cost of Plans	$10,550	$28,225	-
Amount Subject to Excise Tax	$350	$725	-
Number of Employees Enrolled	1,800	6,200	8,000
Annual Penalty in 2018	$252,000	$1,798,000	**$2,050,000**

What employers must do is basic. They should conduct an Excise Tax liability analysis, projecting their costs out to at least 2025, to determine when they are likely to cross over the Excise Tax limits. Then these employers can revisit plan design.

One design gaining popularity is the Consumer-Driven High-Deductible Plan (CDHP). Such a design can better involve employees as informed consumers, while lowering the overall cost of health care, and thus helping to avoid hitting the Excise Tax limits.

These plans put the decision-making and purchasing power directly into the hands of the consumer. According to the Employee Benefit Research Institute's December 2012 issue brief, "Findings from the 2012 EBRI/MGA Consumer Engagement in Health Care Survey,"[5] CDHP enrollees were more likely to use information about their doctors' costs and quality from sources other than the health plan and take advantage of wellness programs that feature health-risk assessments, health-promotion programs and biometric screenings, among other offerings.

As the Rand Corporation found, these approaches are likely to translate directly into health care savings. According to its 2012 report[6], which cites research by Towers Watson, the National Business Group on Health and others, if half of Americans with employer-sponsored insurance switched from a traditional health plan to a CDHP, annual health care costs in the United States would fall by an estimated $57 billion.

Documenting the Offer of Coverage

Employers must offer coverage to their ACA full-time employees and their eligible dependents — and in the event of a dispute or an audit, they must be able to document that they actually made such an offer of coverage. Rolling over an existing election – assuming the chosen plan meets the requirements – now will qualify as proof that an offering of affordable coverage was made.

The following steps are recommended:

THE FIRST STEP in documenting an offering of coverage is an "effective dated" system that shows when an employee was made eligible on the benefits/HR system.

THE NEXT STEP is proof that the employee was notified of his/her option to enroll. This can be achieved via:

- First-Class U.S. Mail that is bar coded and trackable (Certified Mail could be used as an option).
- Electronic distribution of an offering, provided it complies with DOL Electronic Distribution requirements.
- Manual distribution, but only if employees are given a "sign sheet" on which to acknowledge receipt of the offering.

Still, the rollover approach will not address the following groups of ACA full-time employees who:

- Waived coverage,
- Are newly eligible for coverage due to a change in employment status, or
- Are newly hired full-time employees.

Non-Calendar Year Plans

Regulations provide transition relief for non-calendar year plans – those with a plan year that commences on a date other than January 1 each year.

Plans that meet the requirements, outlined below, will not have to comply with the ACA requirements until the beginning of the plan year in 2015. For example, a plan with a June 1 plan year would not have to comply with the 2015 ACA requirements until June 1, 2015.

To qualify for transition relief, a non-calendar year plan must meet the following requirements:

- The plan year must have been legally in effect on or before December 27, 2012. All appropriate ERISA documentation must also have been in place no later than December 27, 2012.
- Since December 27, 2012, the employer has not modified the non-calendar plan's plan year to begin on a later date (for example, the employer has not pushed the beginning of the plan year from June 1 to October 1).
- The employer offers coverage to a sufficient percentage of employees:
  - In general, at least 25% of the employer's total employees are covered under the non-calendar year plan as of any date in the 12 months ending on February 9, 2014 ; or
  - At least one-third of its total employees (or alternately, at least 50% of its full-time employees) were offered coverage under the non-calendar year plan during the most recent open enrollment period ending before February 9, 2014.

If an ALE does not satisfy each of the requirements noted above, it must comply with the Shared Responsibility regulations beginning January 1, 2015.

Reporting and Reconciliation

For ALEs, reporting requirements are substantial and will require data from several systems in order to fully comply, including, at a minimum:

- HRIS – source of data related to employment dates (original date of hire, termination date, re-hire date).
- Payroll – source of data for pay (i.e., Box 1 W-2, Hourly Rate of Pay, etc.) and hours paid (both worked and not worked).
- Absence Management – source of data for hours associated with special unpaid leave.
- Benefits – source of data for employee contributions, MEC certification, minimum 60% actuarial value certification, and documentation of offering of coverage.

This data will be critical for both planning and ACA compliance, and must be stored and maintained for seven years as part of the employer's permanent tax record. This data is subject to audit by the IRS and will be crucial in disputing any incorrect penalty assessments.

Providers of minimum essential coverage (MEC) and of coverage through an employer's group health plan are required to report information that will enable:

- Employees to determine if they were covered by MEC and the months that this coverage was in place, and
- The IRS to verify that the taxpayers were covered by MEC by the employer group health plan and their months of enrollment during a calendar year.

ALEs are required to report information to the IRS about the coverage that they offer to their full-time employees and to furnish related statements to employees. In addition, all employers who sponsor a group health plan must file an additional form with the IRS and provide a copy to those insured by the coverage. To reduce the reporting burden for these employers, the final rules provide for combining reporting on one form. ALEs subject to the employer mandate who are self-insured will complete both halves of the form, while ALEs who are fully insured will complete only the top half – and their insurance provider will report the data required on the bottom half of the form.

This data is subject to audit by the IRS and will be crucial in disputing any incorrect penalty assessments.

In general, ALEs must report employee-specific information on a monthly basis. The final regulations allow an employer to provide a simplified annual statement if the employer provides a "qualifying offer" to any of its full-time employees for all 12 months of the year. Under this simplified option, described in Option 1 below, employers that provide a "qualifying offer" to any of their full-time employees will be allowed an alternative to reporting monthly, employee-specific information about those employees. Option 2 describes a transition reporting method for 2015 under which full reporting will not be required for even those employees who do not receive a qualifying offer for all 12 months. Option 3 describes a method under which the employer is still required to report for all employees, but does not have to report on who their full-time employees are per month.

To qualify for this option, employers have the following three options for meeting the requirements:

Option 1

The employer must certify that it offered to its ACA full-time employees:

- Minimum essential coverage (MEC)
- Coverage that provides minimum value
- A cost to the employee of no more than 9.5% of the mainland federal poverty level (FPL)
- Coverage to the employee, the employee's spouse (if any), and the employee's dependent children (if any)

Option 2

Solely for 2015, the employer may certify that it offered the following to at least 95% of its ACA full-time employees:

- Minimum essential coverage (MEC)
- Coverage that provides minimum value
- An affordable cost to the employee as determined under Option 1 above
- Coverage to the employee, the employee's spouse (if any), and the employee's dependent children (if any)

Option 3

(simplified reporting)

The employer must certify that it offered the following to at least 98% of its ACA full-time employees:

- Minimum essential coverage (MEC)
- Coverage that provides minimum value
- An affordable cost to the employee, as determined under one of the safe harbors provided in the regulations
- Coverage to the employee and the employee's dependent children (if any) – note that under this option, coverage is not required to be offered to the spouse

Even so, in the event of an audit or inquiry from the IRS, an employer using one of the above options to qualify for the simplified reporting approach would nevertheless have to produce detailed records substantiating that such offerings were indeed made.

Conclusion

The ACA imposes a wide range of new administrative requirements on ALEs. While managing through these new rules is complex, careful planning coupled with effective, accurate, and timely data integration will likely result in successful ACA compliance – thereby avoiding potential penalties. Yet our experience suggests that some companies remain surprisingly laid-back. The message to remember above all is simple: You have less time to prepare than you think.

A FEW WORDS ABOUT ADP® AND THE ACA.

ADP is uniquely positioned to understand the compliance requirements associated with the U.S. Patient Protection and Affordable Care Act (commonly referred to as the ACA). The ADP Research Institute® has issued in-depth studies on the impact of Health Care Reform on large employer benefits, revealing, distinct insights derived from actual data versus simply surveyed opinions. One of the nation's largest providers of health benefits administration, ADP administers benefits to 15 million workers and dependents.

For more information, visit **adp.com/health-care-reform** or call **(855) 237-2650.**

Sources

1. Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, U.X. Department of Commerce, Bureau of Economic Analysis and U.S. Bureau of the Census, 1960-2012.
2. Per Capita National Health Expenditures (NHE) - Centers For Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, U.S. Department of Commerce, Bureau of Economic Analysis 2012.
3. Percent Change in CPI (All Items and Medical Care) – U.S. Dept of Labor, Bureau of Labor Statistics, 2014.
4. "Expanding Options for Employers in Next-Generation Private Exchanges," Towers Watson, July 2013.
5. "Findings from the 2012 EBRI/MGA Consumer Engagement in Health Care Survey," http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=5139.
6. "Skin in the Game: How Consumer-Directed Plans Affect the Cost and Use of Health Care," The Rand Corp., 2012, http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9672.pdf.

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ABOUT ADP®

Employers around the world rely on ADP® (NASDAQ: ADP) for cloud-based solutions and services to help manage their most important asset — their people. From human resources and payroll to talent management to benefits administration, ADP brings unmatched depth and expertise in helping clients build a better workforce. A pioneer in Human Capital Management (HCM) and business process outsourcing, ADP serves more than 610,000 clients in 100 countries.

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