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Staffing Industry Compliance with the Employer Shared Responsibility (aka "Pay-or-Play") Provisions of the Affordable Care Act: Five Questions

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Under the **Patient Protection and Affordable Care Act** (the "**Act**"), the federal government, state governments, insurers, employers, and individuals all share responsibility to make affordable health insurance coverage widely available. The rules that apply to employers — referred to as the "employer shared responsibility" rules — build on the existing private employer-based health insurance system. The employer shared responsibility rules apply to "applicable large employers," which include employers with 50 or more full-time and full-time equivalent employees. The vast majority of staffing firms fit this description.

The degree of difficulty in complying with the employer shared responsibility rules differs from industry-to-industry, depending on demographics and workforce characteristics. Industries with large, stable workforces consisting mostly of full-time employees who are provided with robust major medical benefits (e.g., finance, biotechnology, among others) will have little difficulty complying. At the other end of the spectrum are industries that rely on — or, in the case of the staffing industry, provide — large cohorts of variable hour or contingent workers. Owing to historically high rates of turnover, limited assignment tenure, and low take-up rates where health care coverage is offered, staffing firms in particular face daunting challenges as they endeavor to comply with these requirements. (Similar challenges confront the restaurant, hospitality, and retail industries, among others.)

Of course, the staffing industry is not homogeneous. IT and professional staffing firms, for example, routinely offer comprehensive health care coverage to contract workers placed on relatively long assignments. And mid-sized and larger firms that describe themselves as "staffing" firms often provide a suite of services — including permanent placement, temp-to-perm, and payrolling — in addition to the placement of temporary workers on short-term assignments for the purpose of supplementing a client company's core workforce. This advisory focuses on firms in the "general staffing" space, i.e., those whose core (or only) business is assignment of temporary and contract workers. Set out below are five, high-level questions these firms face as they struggle to comply with employer shared responsibility.

1. What are the employer shared responsibility rules, and how do they work?

Commencing in 2014, the Act's employer shared responsibility — or "pay-or-play" — rules generally apply to employers with 50 or more full-time and full-time equivalent employees. These employers are referred to as "applicable large employers." An applicable large employer is subject to a nondeductible excise tax (aka an "assessable payment") in either of two cases:

- **The "no coverage" option.**
  The employer fails to offer to at least 95% of its full-time employees (and their dependents) the opportunity to enroll in group health plan coverage and any full-time employee qualifies for subsidized coverage from a public health insurance exchange; or

- **The "coverage" option.**
  The employer offers to at least 95% of its full-time employees (and their dependents) the opportunity to enroll in group health plan coverage that is either "unaffordable" or fails to provide "minimum value," and one or more full-time employees qualifies for subsidized coverage from a public health insurance exchange.

These rules are set out in new Internal Revenue Code section 4980H.

A full-time employee for this purpose means an employee who works on average 30 or more hours per week. The statute does not distinguish between categories of employees. A temporary employee who works 30 hours per week (or 130 hours per month) is a full-time employee.

Coverage is affordable if the cost to the employee for self-only coverage does not exceed 9.5% of income. Minimum value is an actuarial measure of the plan's generosity, i.e., the plan's share of the cost of benefits must be least 60%. According to the regulators, for a plan to provide minimum value, benefits must include at least catastrophic, major medical coverage with physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits, and laboratory and imaging services. The plan must also contain specified limits on out-of-pocket expenses.

Penalties imposed under the first bullet point above are referred to as "4980H(a) penalties;" and penalties imposed under the second bullet point above are referred to as "4980H(b) penalties." Both are determined monthly, but they are easiest to understand when expressed as annual amounts. The annual 4980H(a) penalty (i.e., the penalty for failing to offer coverage) is determined by multiplying the number of all the employer's full-time employees (excluding the first 30) by $2,000. In contrast, the annual 4980H(b) penalty (i.e., the penalty for offering coverage that is either unaffordable or fails to provide minimum value) is determined by multiplying the number of the employer's full-time employees who qualify for a premium tax credit or cost-sharing reduction by $3,000. But this latter penalty can never exceed the 4980H(a) penalty. Where an employer makes an offer of coverage that is both affordable and provides minimum value, there is no penalty.

2. What are the special challenges that the employer shared responsibly rules present to the staffing industry?

The compliance burdens imposed by the Act's employer shared responsibility rules apply differently from industry-to-industry, sector-to-sector, and even company-to-company. At one end of the

spectrum are the companies described above with large, stable full-time workforces to whom the company provides major medical (and other) benefits. For companies that fit this profile, compliance will be little more than a minor annoyance. Most staffing firms, however, do not fit this profile. Their workforces instead consist of two distinct types of employees: (i) the internal headquarters and field office staffs who recruit and hire the temporary employees and operate the business on a daily basis, and (ii) the employees assigned to perform temporary work for the staffing firms' clients. The latter often consist of lower-wage employees with unusually high rates of turnover.

Because temporary employees have historically shown little interest in health insurance coverage, staffing firms generally have not provided health benefits across-the-board. They are more likely to have "two-tier" arrangements under which the internal staff employees are provided major medical benefits, and the temporary employees are offered no plan or perhaps a limited benefit (i.e., mini-med) plan.[1] The employer shared responsibility rules encourage broad-based offers of at least modestly generous health coverage. But such offers are antithetical to the traditional two-tier staffing industry model. Thus, without other health insurance options, most staffing firms will be subject to an annual penalty of $2,000 multiplied by the number of all full-time employees, including full-time temporary employees, less the first 30.

Even if temporary staffing firms can find a way to make coverage widely available, there is the separate looming concern over the rules governing group health plan nondiscrimination. For self-funded plans, nondiscrimination rules have been in place since 1978, but these rules are little understood and have been sparsely enforced. The Act for the first time directed regulators to prescribe similar rules for fully-insured plans. This latter requirement has been delayed while the regulators prepare implementing regulations. It is unlikely that they will apply before 2015 or perhaps even 2016. Once they do, it's only a matter of time before the IRS and the Treasury Department revisit the application of these rules to self-funded plans. On the plus side, there are exclusions in the rules governing nondiscrimination that make it easier for employers to exclude from the testing calculus of high-turnover employers. If these rules are carried over into fully-insured arrangements (and there is no reason that they should not), then the disruption to current practice should be manageable.

3. How are the temporary workers assigned to clients treated for employer shared responsibility purposes?

For employer shared responsibility purposes, employee status is determined under the "common law" standard. Under the common law standard, an employment relationship exists when the person for whom the services are performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which that result is accomplished. Under this standard, an employment relationship exists if an employee is subject to the will and control of the employer not only as to what shall be done but how it shall be done. It is not necessary that the employer actually direct or control the manner in which the services are performed; it is sufficient if the employer has the right to do so.

Historically and for the most part, temporary employees assigned by staffing firms with client firms have been deemed to be common law employees of the staffing firm. There is no reason to believe this will change, at least with respect to traditional temporary staffing services. Whether this will remain the case for ancillary services, payrolling for example, is less certain.

So long as temporary employees are treated as common law employees of the staffing firm (and not the client), the staffing firm (and not the client) will bear the responsibility for compliance. Staffing

firms and clients should be aware, however, that if the primary purpose of the staffing arrangement is to avoid the employer shared responsibility provisions of the Act, the client may be deemed to be the responsible employer.

4. If I want to offer comprehensive medical benefits to all my full-time employees (including temporary employees), will I be able to find a carrier to underwrite coverage that provides minimum value?

The Act's insurance market reforms require, among other things, that insurers guarantee the availability and renewability of health insurance products in the individual and group markets. As a consequence, staffing firms that want to offer coverage in 2014 and beyond should be able to obtain coverage that provides 60% of minimum value. This rule stands in marked contrast to prior law, under which carriers were free to impose minimum participation requirements, which staffing firms have been unable to satisfy due to historically low rates of participation. Alternatively, larger staffing firms will have the option of self-funding their own minimum value plan, usually with the help of a third-party administrator. Whether fully-insured or self-funded, however, group health plans also must satisfy the Act's other insurance market reforms. For example, prior to the Act many plans imposed annual and lifetime limits as a way to contain aggregate exposure. From and after 2014, this will no longer be possible. The Act also imposes maximum limits on out-of-pocket costs.

The requirement of guaranteed availability means that carriers cannot apply traditional underwriting practices by requiring minimum employee participation and employer contributions. This could result in adverse selection that will increase the cost of health coverage. Final regulations recently issued by the Department of Health and Human Services ("HHS") expressly recognized that the principle of guaranteed availability could increase carriers' adverse selection risks and therefore allows them to limit open enrollment periods in the individual and small group markets to once a year as a way of mitigating that risk. But HHS has declined to extend that provision to the large group market. (We believe carriers should be permitted to impose a similar limit on open enrollment in the large group market.) Despite measures to limit adverse selection, insurance costs could still increase substantially making minimum value coverage impracticable for the staffing and similarly situated industries. Fortunately, the emergence of nonminimum value health plans may provide a cost-effective solution, as discussed below.

5. Can staffing firms satisfy their obligation to offer health coverage (thereby avoiding the no coverage penalty) by offering a group health plan that fails to provide minimum value?

Yes.

Penalties under the "coverage option" explained above (i.e., the 4980H(b) penalty) apply where an employer makes an offer of "minimum essential coverage" under an "eligible employer-sponsored plan." The term "minimum essential coverage" is misleading. It does not refer to the content of the coverage; rather, it applies to the source of the coverage. Sources of minimum essential coverage include Medicare and Medicaid. They also include coverage under an eligible employer-sponsored plan. An "eligible employer-sponsored plan" means a "group health plan" that provides for (any) medical care[2] other than just a HIPAA excepted benefit. (HIPAA excepted benefits include stand-alone vision and dental plans and hospital and fixed indemnity plans, among others.)

A common mistake is to conflate "minimum essential coverage" and "essential health benefits." The

latter consists of 10 broad categories of coverage[3] that must be included in fully-insured products sold in the individual and small group markets as part of an “essential health benefits package.” These rules don’t apply, however, to large group and self-funded plans. Another mistake is to equate minimum essential coverage with “minimum value.” As previously noted, if an employer plan does not provide minimum value, an employee may apply for subsidized coverage through a public exchange, which could trigger a $3,000 employer penalty. But if an employer is unconcerned with meeting the minimum value standard, it need only offer a group plan that covers “medical care” and that complies with the Act’s insurance market reforms. As a consequence, a plan that covers, say, only first dollar preventative care and clinical trials clearly covers medical care and therefore will qualify as an eligible employer-sponsored plan.

Non-minimum value plans of the sort described in the preceding paragraph are beginning to make their way onto the market, although they typically include a wellness component along with some non-coordinated hospital and fixed indemnity features. Such plans must, of course, satisfy the requirements of prior law as well as the Act's insurance market reforms. The advantages are two-fold: first, they are relatively inexpensive, and, second, they do not require underwriting. There is one more, very important advantage: they allow the employer to satisfy the “coverage option” and avoid the no-coverage penalty, which is generally acknowledged as being far more onerous than the coverage penalty. Admittedly, the employer has some residual exposure under the coverage prong (i.e., the 4980H(b) penalty). But the cost of the exposure in many instances will be far less than the cost of providing affordable coverage that provides minimum value.

Some have suggested that the no-minimum value plan approach is somehow abusive and that the regulators will move to bar such plans once they become aware of them. There is no basis for this claim. The ability to offer such plans is a result of conscious policy decisions by Congress, as implemented by the regulators. If plans fail to provide minimum value, low-income employees will be free to obtain subsidized coverage under a plan that provides an essential health benefits package from a public exchange, and the employer will be subject to penalties as a consequence. Moreover, for low-income employees, the cost of subsidized coverage will in most cases be *less* than 9.5% of household income, which is what an “affordable” employer plan would cost. And even if the employee decides to forgo exchange coverage and buys the employer’s nonminimum value product, he or she will not be subject to the individual tax penalty for failing to have minimum essential coverage.

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[1] Limited benefit plans currently operate under waivers issued by the Department of Health and Human Services that expire at the end of the 2013 policy year.

[2] The Public Health Service Act defines “medical care” as amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; it includes amounts paid for transportation primarily for and essential to such care, as well as amounts paid for insurance covering such care.

[3] Essential health benefits include the following: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

Ed Lenz also conrtibuted to this article.

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