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Starting a New Business: What Employers Need to Know About Health Benefits

Author Brandie Gasper // 213-687-6729 // bgasper@lockelord.com

Starting a new business can be very stressful, and with any successful business comes the added stress of hiring and retaining employees. To attract good employees, employers generally need to offer health benefits. Employer-sponsored health care coverage began as a way for employers to attract good workers during World War II when wage and price controls prohibited some employers from raising pay. The practice stuck around even as the wage and price controls went away. Employer-sponsored health care coverage is now so widespread that most employees have come to expect it. Employers that fail to offer coverage may have a difficult time attracting and retaining workers.

Unfortunately, an employer's offer of health care coverage comes replete with a myriad of regulations. While large and established businesses may have human resources personnel or in-house counsel that can navigate the employer through these laws, new business owners need to take the time to gain a basic understanding of the laws that concern health benefits.

This article discusses, via a question and answer format, the two primary laws that impact employer-sponsored health benefits—the Employee Retirement Income Security Act (ERISA) and the Affordable Care Act (ACA)—and what new employers need to know about these laws. Other laws that affect health benefits, including Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability and Accountability Act (HIPAA) and federal benefit mandates, are not discussed in this article.

ERISA

What is ERISA?

ERISA is a federal law that covers employee benefit plans, including retirement benefits and welfare benefits. Examples of welfare benefits include health care coverage, dental coverage, health savings accounts, and other such benefits. Such benefits, when offered by employers, are generally considered to be employer-sponsored welfare benefit plans.

What does ERISA have to do with the ACA?

ERISA was enacted in 1974—if you can imagine, at a time long before Congress ever began debating the ACA. Although the ACA did include some revisions to ERISA, the two laws are very different from each other.

Are all employer-sponsored health benefits subject to ERISA?

ERISA applies to virtually all private sector employers' health benefit plans, no matter the size of the employer. Government and church plans are exempt from ERISA regulation.

As an employer, why should I care about ERISA?

Employers are generally considered the default "plan sponsor" and "plan administrator" of employer-sponsored health plans. ERISA does not require employers to provide health benefits, but once an employer chooses to do so, the employer has certain duties as the plan sponsor and plan administrator. These duties include such things as providing certain plan documents and notifications (such as a Summary Plan Description and a Summary of Material Modification) and filing a Form 5500 with the Department of Labor, when applicable. Failure to satisfy these legal obligations can result in penalties.

What is a Summary Plan Description and a Summary of Material Modification?

A Summary Plan Description is a summary of the terms of the plan offered by the employer. Information that must (or should) be included in the Summary

Plan Description includes the employer identification number, the person designated as the agent for service of legal process for the plan, a description of the employees and dependents eligible for the benefits, whether the plan is an insured or self-insured plan, claims and appeal procedures, plan amendment and termination procedures, and a description of how refunds will be treated. The Summary Plan Description also needs to include certain required statements. An employer must provide new employees that choose to participate in the plan a Summary Plan Description within 90 days of the employee first becoming covered under the plan (or 120 days for new plans) and then at regular intervals thereafter.

When an employer makes material modifications to its offered benefits, the employer needs to provide employees notice of the change via a Summary of Material Modification. Many material modifications occur around open enrollment time. The following are some examples of modifications requiring the issuance of a Summary of Material Modification:

- Changing insurance companies or insurance policies;
- Changing deductible or copayment amounts;
- Changing employer contributions;
- Changing eligibility requirements; and
- Adding or deleting benefits.

An employer must distribute the Summary of Material Modification or an updated Summary Plan Description within 210 days of a material change to the plan, and within 60 days of a material change to the plan that results in a reduction in health plan services or benefits. There is a penalty of up to $110 per day for not delivering a Summary Plan Description or a Summary of Material Modification within 30 days after a participant or beneficiary requests it, and there is also the potential for employer liability, especially if a material reduction has occurred.

Won't the health insurance company or HMO provide the Summary Plan Description and Summary of Material Modification?

Most insurance companies and health maintenance organizations (HMOs) provide a Certificate of Insurance or an Evidence of Coverage, depending on what type of coverage is being provided. While these documents contain many of the terms required to be in a Summary Plan Description, they may not cover all of the required terms. For instance, the employer has some latitude to determine which classes of employees are eligible for the employer-sponsored plan. This information is often not in the Certificate of Insurance or Evidence of Coverage. As a courtesy to their clients, some insurance companies and HMOs do provide additional information an employer can complete and include with the Certificate of Insurance or Evidence of Coverage in order to fully meet the Summary Plan Description requirements.

Do new employers need to file a Form 5500?

Unless an exemption applies, ERISA requires plan administrators (this usually means the employer) to file an "annual report" called a Form 5500 with the Department of Labor. However, small insured plans are exempt from the Form 5500 requirement. Small insured plans are those fully insured plans that cover fewer than 100 participants at the beginning of the plan year. A "participant" includes only employees and former employees covered by the plan; it does not include non-employee dependents.

ACA

Under the ACA, are new employers required to provide health care coverage to their employees?

Employers with fewer than 50 full-time employees are not required to provide health care coverage to their employees. Employers with between 50 and 99 full-time employees are not required to provide health care coverage to employees until 2016, at which point the employer must choose between providing coverage or potentially paying a penalty for failing to do so. Employers with 100 or more full-time employees must provide qualifying coverage or pay a penalty beginning in 2015 if any of their employees obtain government-subsidized coverage through a state or federal Exchange (Marketplace). Because most new businesses are small businesses, this article focuses on how the ACA affects smaller employers.

Determining the number of full-time employees is a little more difficult than meets the eye. A full-time employee includes any employee who worked an average of at least 30 hours per week, as opposed to the more traditionally accepted 40 hour per week requirement. Also, part-time employees are taken into account in calculating the number of full-time employees. For example, an employer that employs 40 full-time employees that worked on average 30 hours per week and 20 part-time employees that worked on average 15 hours per week, will be seen as employing the equivalent of 50 full-time employees. Due to the consideration of part-time employees, the ACA uses the term "full-time equivalents," meaning that, in the preceding example, the employer had 50 full-time equivalents.

Despite the consideration of part-time employees, most new businesses will not begin with 50 full-time equivalent employees. However, employers need to consider related entities, such as parents, subsidiaries, and affiliated entities of the business entity, as the IRS will impose the "control group" rules in determining whether an employer has 50 or more full-time equivalent employees. This means that two commonly-owned affiliated entities, one employing 40 full-time employees, and the other employing 20 full-time employees, would both be required to provide health care coverage to their employees to avoid potential penalties. (However, the penalty for non-compliance would be separately applied to the entities.)

Are new businesses eligible for the ACA small business credit?

Because most new businesses tend to be small businesses, new businesses offering health care coverage should speak with their CPA to determine whether they qualify for the small business tax credit. The small business tax credit credits employers up to 50 percent of the cost of the portion of the premiums paid for by employers. To be eligible for the credit, employers must: (i) cover at least 50 percent of the cost of the health care coverage for employee-only (not family or dependent) coverage, (ii) have fewer than 25 full-time equivalent employees, (iii) pay employees average wages less than $50,000, and (iv) purchase health insurance via the SHOP Exchange—the health care Exchange for small businesses.

What is the Summary of Benefits and Coverage? Does this replace the Summary Plan Description?

The ACA required that health insurers, HMOs and group health plan sponsors (i.e., employers) provide plan participants with a Summary of Benefits and Coverage. The Summary of Benefits and Coverage is an eight-page document with certain required information set forth in a standard format intended to provide plan participants information about their coverage and the ability to more easily compare plans. The Summary of Benefits and Coverage does not replace the Summary Plan Description or the Summary of Material Modification, although is unfortunately named to sound very similar to the other documents.

The good news for insured plans is that health insurers and HMOs prepare the Summary of Benefits and Coverage and usually either provide the participants in the plan the Summary of Benefits and Coverage automatically or work with the employer in distributing the Summary of Benefits and Coverage to the participants in the plan. But an employer should be sure this document is distributed, as the employer may be penalized for willful noncompliance up to $1000 per participant if the participants do not receive a copy of the Summary of Benefits and Coverage.

What else do new employers need to know about the ACA?

Employee benefits tend to get more complicated the larger the business becomes. Large employers are required under the ACA to offer health care coverage to their employees or pay a penalty if employees obtain subsidized coverage through an Exchange. As the employer grows larger, the rules pertaining to health plans become more complex. There are many details large employers need to know to comply with the new requirements, including which employees and dependents must be offered coverage, whether and how much the employer needs to contribute to employee or dependent coverage, whether the employer can offer different benefits to different classes of employees, and so forth. When employers get large enough, many also begin considering creating self-insured health plans, which have many benefits but also carry different responsibilities.

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About the Author

Brandie Gasper is a senior counsel in the Los Angeles office of Locke Lord LLP, where she counsels health plans, insurers and other payors on regulatory, compliance and transactional matters. Ms. Gasper also advises employers on health plan and other welfare benefit matters, including ERISA, Affordable Care Act penalties and reporting requirements, and I.R.C. 105(h) non-discrimination issues. Ms. Gasper frequently presents on the Affordable Care Act, ERISA and other topics pertaining to health care law.