The Impact of the Patient Protection and Affordable Care Act on Human Resource Departments

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Abstract

In 2010, the Patient Protection and Affordable Care Act (PPACA) was passed into law in the United States to ensure that no U.S. citizen would be without healthcare insurance. The PPACA will require major changes to the way that the U.S. government – as well as benefits departments within organizations - implements nationwide healthcare. The changes that will take effect in the upcoming years of 2014-2015 will be some of the largest ever addressed in recent times, especially given the amount of uncertainty about the short- and long-term effects. Hence, the purpose of this paper is to outline and discuss some of the key issues that will be faced in the U.S. with a focus on the impact of the PPACA on human resource departments.

Keywords: healthcare, benefits, human resources

1. Introduction

The issue of healthcare has been in the lime light in the United States (U.S.) since 1930 when President Theodore Roosevelt started to promote national healthcare coverage to address the effects of the Great Depression (Dix, 2013). In 1945, President Harry Truman tried to pass a reform bill that would give everyone access to healthcare, which ended without success. President Lyndon Johnson, in the 1960's, was finally able to amend Social Security by including Medicaid and Medicare. However, it was not until President George W. Bush in 2003 that some progress was made to Medicaid to address coverage of all Americans as well as the completion of work on the Medicare Prescription Drug Improvement and Modernization Act (Dix, 2013).

Most recently, in 2010, President Barack Obama presented the Patient Protection and Affordable Care Act (PPACA, Public Law 111- 148), which was passed to ensure that no U.S. citizen is without healthcare insurance. The PPACA will require major changes to the way that the U.S. government – as well as benefits departments within organizations - implements nationwide healthcare. The changes that will take effect in the upcoming years of 2014-2015 (official effective date of January 1, 2015)[a] will be some of the largest ever addressed in recent times, especially given the amount of uncertainty about the short- and long-term effects. Hence, the purpose of this paper is to outline and discuss some of the key issues that will be faced in the U.S. with a focus on the impact of the PPACA on human resource departments.

2. Overview

Healthcare and human resource (benefits) departments have never been more closely related until the passing of the PPACA. Until recently in the U.S., healthcare has been offered by most organizations to all employees who work full time (which is typically defined as 35-40 hours per week). The organizations would pay a portion of the healthcare costs, and the employees would also pay a portion. Employment-based health insurance covers about 55.1% of employed individuals or 170.1 million people (DeNavas-Walt, Proctor, & Smith, 2012). This type of insurance covers more than half of those employed, but once the PPACA becomes active in 2014-2015, the number of those insured will vastly increase (Miller, 2013c).

In the U.S., a comprehensive benefits package is averaged to be 40% of payroll expenses because health benefits are averaged to be eleven cents for every payroll dollar (Miller, 2013b). So for an employer-sponsored family health care plan, the employer would pay approximately $15,745, and an employee would pay close to $4,316. For coverage of a single employee costing the employer $5,615, the employee would pay around $951 (Miller, 2013b). In years to come, the estimated growth of healthcare spending is expected to rise an average of 5.7% between 2013 through 2021, which is almost 1% higher than the expected annual increase in the gross domestic product (Miller, 2013a). Hence, the price of providing employees with healthcare benefits is continuing to increase, thereby making it that much harder for employers to keep offering this kind of benefit (Miller, 2013b).

Individuals who fall under the poverty line can currently receive assistance from the government through Medicaid. People ages 65 years and older and those who are considered permanently disabled, may qualify to receive Medicare, a federal program to cover health-related services (DeNavas-Walt, et al., 2012). Those covered by government health insurance increased 1% from 2010 from covering 95.5 million to 99.5 million individuals in 2011 (DeNavas-Walt et al., 2012).

According to the 2011 census, the percentage of U.S. citizens without health insurance decreased to 15.7% in 2010 from 16.3% previously, while the number of uninsured people also decreased from 50 million in 2009 to 48.6 million in 2010 (DeNavas-Walt et al., 2012). Seven million children (9.4%) are without healthcare coverage and 13.8% of children who live in poverty are without healthcare (DeNavas-

Walt et al., 2012). This is higher than the rate of all children, indicating that children without insurance are those who live in poverty.

3. Patient Protection and Affordable Care Act

The PPACA was passed by the 111th Congress and signed into law by President Barack Obama in March of 2010 (Dix, 2013). The key provisions are intended to extend healthcare coverage to millions of uninsured Americans by extending dependant coverage to young adults (up to 26 years of age), eliminating denial of coverage due to pre-existing conditions, offering small business tax credit, and prohibiting rescinding health insurance benefits except in the case of fraud (Dix, 2013). The PPACA increases access to health insurance coverage as well as expands federal private health insurance market requirements.

The PPACA required the creation of health insurance exchanges to provide individuals and small organizations access to insurance. There are four tiers or plans of health insurance on the exchange, the "Bronze", "Silver", "Gold", and "Platinum". Each plan has a certain amount of medical costs that will be covered by insurance; "Bronze" covers 60%, "Silver" 70%, "Gold" 80%, and "Platinum" 90%. These plans are available for purchase when an organization chooses not to offer affordable healthcare benefits, and employees are sent to the exchange to decide how much coverage that they wish to purchase. The "Bronze" tier offers the minimum amount of coverage while the "Platinum" tier offers maximum coverage.

One of the largest decisions that an organization will have to make is whether they will "play" or "pay" with regards to the PPACA. Organizations that have more than 50 full-time employees must decide if they will "play", meaning whether they will continue or begin to offer affordable healthcare benefits to their employees who work an average of 30 hours or more per week in a month. Conversely, if an organization decides to "pay", it will incur the penalties for not offering affordable healthcare benefits (Sammer, 2013). The term 'full-time' once meant that an employee worked an average of 35-40 hours a week. Per the PPACA, this has now changed to 30 or more hours worked in an average week.

If employers decide to "pay", the amount of the penalty depends on whether an employer already offers insurance coverage or if they do not (Mulvey, 2013). For employers that already provide health insurance coverage, the coverage must be affordable and adequate to avoid paying a penalty. Health insurance is considered affordable if the employee's contribution to the plan does not exceed 9.5% of the employee's household income for the taxable year (Mulvey, 2013). To help safeguard employers from penalties, the Internal Revenue Service (IRS) allows employers to use their employee's end of the year (W-2) income for the calculation since employers do not have access to their employee's household income. To be considered as providing adequate coverage, a healthcare plan's actuarial value (the share of the total allowed costs that the plan is expected to cover) has to be at 60% (Mulvey, 2013).

Benefit specialists often work closely with employees to assist them in answering their health insurance-related questions when needed, but this position will soon take on a different meaning. Depending on whether an employer wishes to "play" or "pay", an organization's human resource department will have to change to meet the new needs of the company. If an organization chooses to play, these departments will have to keep well documented paperwork of those who are full-time and those who are part-time employees (Sammer, 2013). If the decision is not to "play", but instead to "pay", organizations could be subject to a penalty of $2,000-$3,000 for each full-time employee (Sammer, 2013).

3.1. FTE Calculations and Penalties

The PPACA includes a provision called "shared responsibility" which is a framework to ensure that the government, insurance companies, medical providers, pharmaceutical and medical device companies, employers, as well as individuals work together to hold one another accountable for the reform to succeed

("Health Insurance at a Glance Shared Responsibility", 2010). This provision does not mandate that an employer has to offer health insurance, but the PPACA sets penalties on large organizations if at least one of their full-time employees obtains a premium credit through the newly established exchange that is more affordable than the one being offered by the organization (Miller, 2013a). Organizations are not subject to a penalty if full-time workers are eligible for Medicaid or Children's Health Insurance Program. The PPACA created a two part calculation for determining (1) which organizations are subject to the penalty and (2) which employees will have the penalty be applied. Seasonal and part-time workers are also addressed and added into a full-time equivalent (FTEs) calculation when determining if an organization has fifty full-time equivalent employees for the purposes of receiving a penalty (Dix, 2013).

In order to determine which employees are seasonal, part-time, or full-time, the FTE must be used to determine if an employer is a 'large' company, which is defined as having 50 or more employees including full-time and part-time (Dix, 2013). As noted earlier, full-time is classified as working 30 hours or more per week, but full-time seasonal employees who work under 120 days per year are excluded from calculating full-time employees (Chaikind & Peterson, 2010; see Table 1). Part-time employees, or those who work less than 30 hours per week, are converted into FTEs and are included in calculating whether an organization is 'large' by adding up all of the hours worked by part-time employees during one month and dividing that total by 120 and added to the number of full-time employees. This gives the number of FTE workers (Mulvey, 2013; see Table 2 for calculation example). Seasonal workers must work less than 120 days during a year; this term of seasonal worker is not just applicable to agricultural or retail workers but employees who work less than 1/3rd of a year (Chaikind & Peterson, 2010).

Another type of employee to consider is those who work in a franchise. Franchises can either be owned by a single individual or an entity. Employees in a franchise - whether it is owned by one person or by an entity - must aggregate to determine the number of both full-time equivalent and full-time employees (Chaikind & Peterson, 2010).

A penalty is only applicable to those who are considered full-time, by working thirty hours a week on average. If a large organization offers employees health benefits - but those benefits are deemed "unaffordable" or the benefits do not provide the minimum assistance according to the PPACA - could be penalized $2,000-$3,000 per infraction (Sammer, 2013). The potential for a penalty applies to all common law employers - organizations that offer compensation for their work, including government facilities whether they are federal, state, local, or nonprofit organizations that are exempt from federal taxes, and even Indian Tribal entities (Sammer, 2013).

The total penalty for any large organization is based on the number of its full-time employees. The Secretary of Health and Human Services and the Secretary of Labor collaborated to publish some proposed regulations for employers to use to determine which employees are considered full-time for purposes of the PPACA employer penalty (Mulvey, 2013; see Table 2). These regulations allow an organization to look back up to twelve months to calculate whether a worker is full-time or not. When an employee is considered full-time, there is an administrative period to enroll employees in a health plan. If an organization is charged with a penalty under the PPACA, it only applies for the time period following the administrative period, call the 'stability period'. Organizations are not penalized if an employee enters the exchange and receives a premium credit during that time even if the employee is full-time or not (Mulvey, 2013). This guidance will not penalize organizations and will not make them have to pay a penalty for seasonal workers who do not work 30 hours or more a week over a specified time period such as a 12 month period.

3.2. Taxes

To avoid an excise tax as well as receiving a penalty, organizations are making sure that they keep the total health plan cost below a threshold of $10,200 for an individual and $27,500 for a family (Miller, 2013b). More than a third of organizations have already taken steps to avoid the tax in 2018 (Miller, 2013b). To do this, they are focusing on high-deductible consumer directed health plans by adding a plan or taking steps to increase enrollment in an existing plan, such as expanding wellness programs in an effort to reduce health care spending by improving employees health (Miller, 2013b). These plans cost less but the consumer continuously pays routine health costs by the use of a card that resembles a debit card provided by a bank or insurance plan. If the balance runs out, then the user pays health care bills under a regular deductable while keeping an unused amount to "rollover" to increase future balances for future cost (Coombs, 2013). Large employers that have opted to terminate their healthcare plan (7% of those with 500 or more employees have already done so) are sending their employees to the public health exchanges but would consider sending them to a private health exchange (Miller, 2013b). A private health exchange is different than a public heath exchange in that an employer provides funding and the employee may shop online to choose a medical plan and in some cases other benefits. It also allows businesses to provide a contribution amount to purchase their benefits.

A perk for an employer providing health benefits is that the healthcare coverage will be tax-free to the employee and tax-deductible for the employer. However, if an employer stops offering affordable coverage or offering health benefits at all, under the "shared responsibilities" provision of the PPACA, the organization will have to pay the penalty and will no longer be able to use the tax-deduction (Sammer, 2013). Even if an employer increases employee's compensation to make up for the loss of benefits, the additional compensation will continue to be taxed as regular income would, thus making the increased compensation less valuable than tax-free benefits (Sammer, 2013). Employers must compare the cost of tax-deductable affordable health benefits under the 9.5% "shared responsibility" provision, and the possibility of saving money that way than paying the cost of penalties.

Some organizations have already implemented a plan which will allow them to "grandfather" in the PPACA without having to comply with some of the more expansive reforms (Hamburger & Napoli, 2010). However, a "grandfathered" plan had to be in existence by March 23, 2010 and these plans are not required to implement certain provisions that "non-grandfathered" plans have to, that is, plans placed in effect after March 23, 2010 (Mulvey, Alonso, & Esen, 2013a). "Grandfathered" healthcare plans do not have to have emergency care benefits, nondiscrimination for insured plans under tax code, 100% preventative care coverage, financial and quality data reporting to the government, appeal process rules, and rules on deductible and out-of-pocket maximums (Hamburger & Napoli, 2010). A "grandfathered" plan can lose its status due to certain changes to the plan and if it does not abide by certain regulations. For example, a plan can lose its status if insurance carriers change, eliminate benefits, increase the percentage of cost-sharing, increase a fixed-amount of co-payment and cost-sharing, and decrease the contribution rate by employer (Hamburger & Napoli, 2010). Those organizations that were able to "grandfather" their healthcare plans and keep them in "grandfathered" status, are able to receive tax deductions as well as not having to worry about penalties or a hefty tax (Mulvey, Alonso, & Esen, 2013).

The reform has already begun to be impactful. For example, the largest part of the reform, a 40% tax on high-cost plans, will go into effect in 2018. In an employer sponsored health plan, organizations must keep health benefit plans under $10,200 for a one person family and $27,500 for a family coverage, also known as the "Cadillac plans" to avoid paying the 40% tax (Leonard, 2010; Mulvey, et al., 2013). For instance, if an individual plan is valued at $12,200, it would be above the threshold by $2,000 so the issuer would be taxed at 40% for that $2,000 or $800 for the high-cost plan (Leonard, 2010). The revenue that this

tax will generate is to assist to pay for healthcare reform programs (Leonard, 2010). This tax will raise the federal government revenues by creating a tax on insurance companies that provide high-cost plans and insurers are required to pay the tax (Leonard, 2010). Although, organizations with self-insured healthcare plans would be considered the issuer and be required to pay the threshold value of the excise tax, they are able to pass on the financial burden to employers who can then pass it on to covered employees (Leonard, 2010).

4. Human Resource Implications

Human Resource departments, namely the benefits area, are about to go through one of the largest changes that they have ever gone through and the implications of these changes are still unclear (Sammer, 2013). One of the largest changes - as well as a difficulty that will be faced - will be tracking the work hours of employees who are full-time from those considered to be part-time (See Table 1). Tracking hours and maintaining records will be critical for employers in the event of an audit or to protect an organization against penalties (Miller, 2013b).

The big question of whether an organization decides to either "play" or "pay" or what type of plan is not a simple decision. Many employers are complying with their current benefits and making sure their health plans are meeting the requirements of the PPACA (Sammer, 2013). Organizations do not have to continue to provide health benefits if they choose to instead pay the penalty. Because the future of which action is the 'best' is still unknown, organizations are waiting to see the difficulties and the costs of complying with the "shared responsibility" provision, how state health insurance exchanges will operate, what types of plans will be available at what cost, and the overall impact of these changes on the cost of health benefits (Sammer, 2013). To aid in the decision making, organizations will have the demographics, income levels, and hours worked of all of their employees.

Communication will be very important to help employees understand the changes that may/will occur and the impact of the PPACA. For an organization to continue to have high employee morale and productivity, they must be conscientious of them and their needs. One way that they could possibly do this is by letting all of their employees know what their decisions are going to be, and possibly creating a packet of information regarding exchanges (Watts & Cuthbert, 2011). Human resource professionals should take action to educate their employees so that they have clear understanding and also know who they can go to for assistance. It is important to have a communication strategy in place to explain health benefits, most importantly for those who will be newly eligible to receive health care coverage (Mulvey, et al., 2013). Due to the new definition of a full-time employee, those that were once part-time will now be eligible for healthcare benefits and for some, this is the first time they are able to receive benefits and in most cases will be unfamiliar with benefit offerings and enrollment procedures. (Mulvey, et al., 2013).

5. Discussion

The upcoming changes that organizations, namely the human resource (benefits) departments, will go through are very uncertain but will have a monumental impact in the U.S. Organizations have to decide whether they will "play" or "pay" and address how their decision will affect their employees. Employees are rightly concerned about whether they will still be offered healthcare coverage by their employer, or if they must go to the exchange and choose either the bronze, silver, gold, or platinum plan. There is still uncertainty for organizations of whether they need to supply health benefits, and even the full meaning and implications of the PPACA. There is uncertainty for organizations who do not comply given the penalties as well as taxes on infractions. Fortunately, professional organizations such as the Society for Human Resource Management have provided educational material and are consistently updating their members with

new information regarding the PPACA (Coombs, 2013). The challenge of educating versus being educated will decide whether the changes pertaining to the PPACA will be implemented and successfully put into place.

[a] Note

The PPACA mandate for all organizations with 50 or more employees was originally to be implemented January 1, 2014, but now it is scheduled to go into effect January 1, 2015. The reason it has been postponed is because it had been noted that more time was needed for organizations to make the necessary changes mandated by the law. With more time provided, organizations will be able to full adapt their health coverage and reporting systems while an organization is moving toward making health coverage affordable and accessible for their employees (Miller, 2013c). Even with postponing the provision, premium tax credits available to employees under the PPACA are not affected (Miller, 2013c). Due to the postponement, the "shared responsibility" and "play" or "pay" mandate will not be easily traceable to see which organizations require payments in 2014, so these payments will not be enforced until 2015. In other words, organizations will not face penalties for employees who receive tax credits purchased on government-run exchanges (Miller, 2013c). Provisions that are still mandated for 2014 include a ban on annual dollar limits on essential healthcare benefits, a 90-day limit on eligibility waiting periods, new out-of-pocket limit maximums, the elimination of preexisting conditions exclusions for adults, coverage of clinical trial participant costs, and the employer-provided health care include coverage for recommended preventive care-including contraceptive services for women at no cost-sharing (Miller, 2013c).

6. References

Coombs, J. (2013). Changes to Healthcare in 2013: What HR Professionals Need to Know. *Workplace Visions: A Publication of the Society for Human Resource Management*, (1), 1-4.

Chaikind, H. & Peterson, C. L. (2010). Summary of Potential Employer Penalties Under the Patient Protection and Affordable Care Act (PPACA), *Congressional Research Service*, 7-5700, Retrieved from: http://www.shrm.org/hrdisciplines/benefits/documents/employerpenalties.pdf

DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2012). Income, Poverty, and Health Insurance Coverage in the United States: 2011. Retrieved from U.S. Department of Commerce Census Bureau: http://www.census.gov/prod/2012pubs/p60-243.pdf

Dix, R. L. (2013). Unpacking PPACA: Understanding the Patient Protection and Affordable Care Act. *University of Tennessee Honors Project*, Retrieved from http://trace.tennessee.edu/utk_chanhonoproj/1607

Hamburger, P. M., & Napoli, J. R. (2010). *Health care reform and 'grandfathered' plans*. Retrieved from http://www.proskauer.com/files/News/faa5c918-16a1-4d47-b3a0-09fec2dafe5d/Presentation/NewsAttachment/87f5b3ef-9611-4306-aad2-d6f333b0b516/Health-Care-Reform-and-Grandfathered-Plans.pdf

Health Insurance at a Glance Shared Responsibility. (2010). Retrieved from http://housedocs.house.gov/energycommerce/Shared_Responsibility.pdf

Leonard, B. (2010). *Tax on "Cadillac" health plans could have a major impact*. Retrieved from http://www.shrm.org/Publications/HRNews/Pages/CadillacTaxImpact.aspx

Miller, S. (2013a, April 25). *Managing health care costs*. Retrieved from http://www.shrm.org/templatestools/toolkits/pages/managinghealthcarecosts.aspx

Miller, S. (2013b, June 14). *Employer plans for health care reform evolving*. Retrieved from http://www.shrm.org/hrdisciplines/benefits/Articles/Pages/Employer-Responses-Reform.aspx?homepage=marquee

Miller, S. (2013c, July 3). *Health care law's employer mandate delayed until January 2015*. Retrieved from http://www.shrm.org/hrdisciplines/benefits/articles/pages/mandate-delayed.aspx?homepage=mpc

Mulvey, J. (2013, May 6). *Potential employer penalties under the Patient Protection and Affordable Care Act (PPACA)*. Retrieved from http://www.fas.org/sgp/crs/misc/R41159.pdf

Mulvey, T., Alonso, A., & Esen, E. (2013a, June 16). *Health care reform—challenges and strategies* . Retrieved from www.shrm.org/research/surveyfindings/documents/shrm-health-care-reform-challenges-strategies.pptx

Mulvey, T., Alonso, A., & Esen, E. (2013b, June 16). *SHRM survey findings: Health care reform—impact on health care coverage and costs*. Retrieved from www.shrm.org/research/surveyfindings/documents/shrm-health-care-reform-impact-costs-coverage.pptx

Sammer, J. (2013, February 4). *Making the "play of pay" decision*. Retrieved from http://www.shrm.org/hrdisciplines/benefits/articles/pages/play-pay-decision.aspx

Watts, T. & Cuthbert, J. (2011). Employee communications and health care reform. *Benefits Quarterly* , *27*(1), 18-20.

Table 1.

Determination and Potential Application of Employer Penalty for Categories of Employees

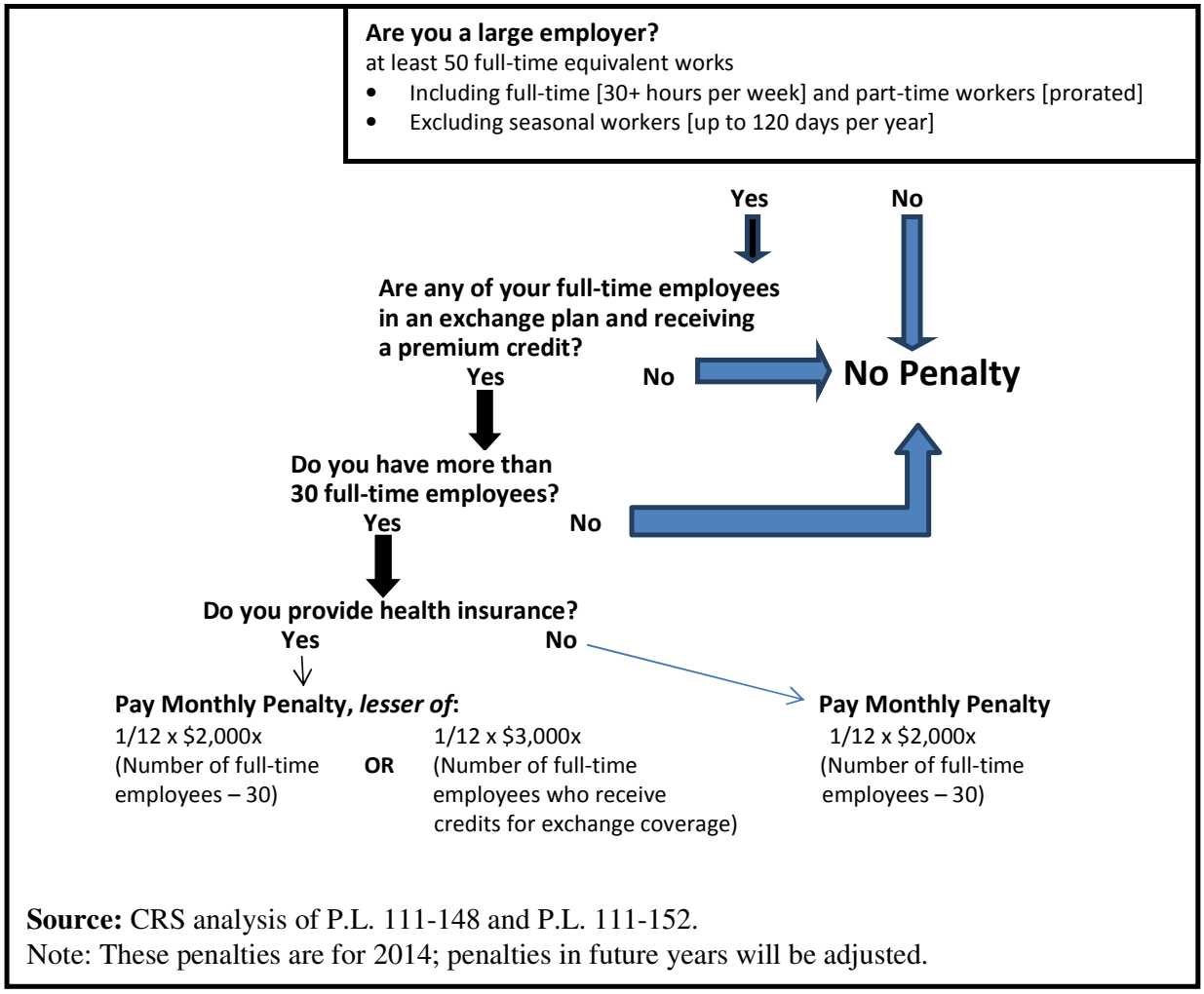
Employee category	**How is this category of employee used to determine "large employer"?**	**Once an employer is determined to be a "large employer", could the employer be subject to a penalty if this type of employee received a premium credit?**
Full-time	Counted as one employee, based on a 30-hour or more work week	Yes
Part-time	Prorated (calculated by taking the hours worked by part-time employees in a month divided by 120)	No
Seasonal	Not counted, for those working up to 120 days a year	Not likely under current "safe-harbor" options
Temporary Agency Employees	Generally counted as an employee of the temporary agency (except for those workers who are independent contractors) [a]	Yes, for those employed by the temporary agency and who are determined to be full-time, on average, for up to 12 months
Franchise Employees	For franchise owners, if they own more than one entity, all employees across the entities must be counted	Yes, for those counted as working for the franchise and who are full-time, on average, for up to 12 months

Source: CRS analysis of P.L. 111-148 and P.L. 111-152

[a.] The controlled group rule applies under 414 (b). (c). (m) or (o) of the IRC and includes employees of partnerships, proprietorships, etc. , which are under common control by one owner or group of owners.

Table 2.

Will an Employer Pay a Penalty?



Source: CRS analysis of P.L. 111-148 and P.L. 111-152.
Note: These penalties are for 2014; penalties in future years will be adjusted.