# Health Care Reform
# And
# Its Effect On Your Company


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# Important Notice

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# Under 50 Employees
# Affordable Care Act (ACA) Economics

This analysis gives you a framework to predict the future. No one really knows exactly how ACA will affect the Small-Group Medical Market in California, but 2014 is a paradigm shift for small business owners. For small employers (under 50 employees) the decisions are a little less complicated because there is no government penalty to consider.

*How Rates Are Currently Determined:* In California, age is the most important factor in determining medical rates. Next is the size of the company. A younger company with 10 plus employees will qualify for a lower RAF (risk adjustment factor), and lower premiums overall. Age-banding also creates a situation where older employees pay more for medical coverage than younger employees.

*Changes In 2014:* Starting January 2014, small groups will pay medical rates based upon being "community-rated." That means two factors are changing. **First**, the RAF disappears. So let's say your RAF is 0.90. Your medical rates could increase (at least) 10% more than the average in 2014. But, if it is higher, then your rates may decrease or be lower than average. **Second**, and more significant, the age-banded gap for what a 60-year-old pays for medical and what a 27-year-old pays at the same company will be cut in half. This could add another 20% to 50% to California rate increases.

*Rate Shock in 2014:* To get all small groups to "community-rated" medical rates, companies that have traditionally paid the lowest rates will see the highest rate increases in 2014. Those companies that have had higher medical usage, or higher RAFs, will see smaller increases or maybe decreases. The youngest/healthiest groups will see the largest rate increases in their medical costs in 2014. Maybe not 116% (as suggested by the WSJ), at least in California, but it could be a shock.

*What We Know:* This only applies to companies with under 50 employees on medical in 2014. Larger companies will not be affected in this manner because they are "large group". Second, this process will expand to companies with less than 100 employees on medical in 2016. Third, medical rates have been increasing an average of 7%-10% over the past several years. Add another 3%-4% for PPACA administrative costs, and an average company might expect to see 10%-14% premium increases in 2014. Someone with a 0.90 RAF might see a 20% to 24% increase or more. (A 45% increase will not be unheard of, but hopefully rare.)

*What You Can Do Now:* California insurance carriers are now offering an early renewal in December 2013. This will allow a small business to kick the can down the road while they consider other options.

*Options You Need To Consider:*

1) Compare the private group insurance coverage you currently have to the Small Health Options Plan (SHOP) through the Covered California Exchange. Cloud, Minturn & Associates will be including SHOP in our market analysis as more details become available.
2) Set up a Medical Reimbursement Plan or Health Reimbursement Arrangement which will allow the employer to set, control and predict health benefit costs.
3) Consider a Professional Employer Organization (PEO) commonly known as employee leasing.
4) Stop offering group health insurance to your employees and direct them to the Covered California Insurance Exchange. There are government subsidies available through exchange for employees that fall below 400% of the Federal Poverty Line. If you choose this option, Cloud, Minturn & Associates will be able to help your employees navigate the exchange and determine if they can receive a government subsidy.

Cloud, Minturn & Associates, as a Risk Management Advisor and Human Resource Administrator, can help you explore these options and make a good financial decision.

Cloud, Minturn & Associates
Presented by Daniel J. Cloud, ChFC, CLU

# Over 50 Employees
# Affordable Care Act (ACA) Economics

This analysis gives you a framework to predict the future. No one really knows exactly how ACA will affect the Large-Group Medical Market in California, but 2014/2015 is a paradigm shift. For large employers (50+ employees) the decisions on how to comply with ACA will be more complicated and require some serious financial and Human Resources considerations.

*How Rates Are Currently Determined:* In California the average age of the group, location and gender of the employees, total size and type of the company are used to help determine health insurance premiums. In addition, claims experience becomes more important as the size of the company increases. These groups have what is known as a composite rate, which is the same rate for Employee, Employee/Spouse, Employee/Child (ren) and Family coverage?

*Changes In 2014:* Starting January 2014, large employers will need to start tracking their size to help determine how they will comply with the large employer mandate taking place January 1, 2015. This will only matter if the employer is down to the 50 employee size.

*Rate In 2014:* At this point it is unclear how ACA will affect premiums in the large group market. Carriers are in the process of developing new plans that will offer options not currently available.

*What We Know:* By 2015 all applicable large employers (50+ full-time equivalent employees) will have to offer health insurance or face an annual $2,000 per employee (minus the first 30 employees) penalty tax. If they do offer coverage, but it does not meet the minimum value standard and/or is unaffordable, they will face an annual shared responsibility penalty of $3,000 for every employee that obtains coverage through the Covered California Exchange and receives a subsidy.

*What You Can Do Now:* If you offer coverage, determine if your base plan meets the minimum value standard and is affordable. As with many large employers offering health insurance to their employees, you may have a company of 75 employees with only 30 on the current medical plan. This is because some of the employees are unwilling to pay their share of the cost. If this is the case find out if your current insurance carrier will offer a special enrollment period in December 2013 for those employees that do not have coverage and their dependents. Conduct a cost analysis to determine your potential expense if additional employees join the plan.

*Options You Need To Consider:*

1) Review self-funding and partial self-funding programs. Insurance carriers are currently creating plans that will fit this option.
2) Set up a Medical Reimbursement Plan or Health Reimbursement Arrangement which will allow the employer to set, control and predict health benefit costs.
3) Consider a Professional Employer Organization (PEO) commonly known as employee leasing.
4) Put employees on part-time status.
5) Stop offering health insurance and pay the penalty. Compare the penalty costs to the cost of compliance.

Cloud, Minturn & Associates, as a Risk Management Advisor and Human Resource Administrator, can help you explore these options and make a good financial decision.

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# Business Responsibilities Under the ACA

The Patient Protection and Affordable Care Act (ACA) has several goals, including increasing access to health insurance coverage, expanding federal private health insurance market requirements, and requiring the creation of health insurance exchanges to provide individuals and small employers with access to qualified health insurance.

For employers, ACA includes a penalty (termed a "shared responsibility" payment) for certain "large" employers who either do not offer health insurance to all of their full-time employees, or who offer health insurance coverage that does not meet certain standards.[1] The ACA sets out two elements for determining penalties. First, which firms are considered to be "large" employers, and thus potentially subject to the penalty, and second, for which employees within a firm the penalty is applied.

Under the legislation as originally enacted, many provisions of the ACA were to be effective January 1, 2014. However, in Notice 2013-45, the IRS announced it would delay enforcing the employer "shared responsibility" payment, as well as certain information reporting requirements, until January 1, 2015.

## Who is a "Large" Employer?

In general terms, the ACA defines a "large" employer as an employer who employed an average of at least 50 full-time equivalent employees (FTEs) on business days during the preceding calendar year. Both full-time and part-time employees are included in this calculation.

- **Full-time employee:** An employee who works on average at least 30 hours per week.
- **Part-time employees:** Part-time employees (less than 30 hours per week) are converted into FTEs. All hours worked by all part-time employees are added up and the total is divided by 120.

> *Example: Assume a firm has 35 full-time employees (30 or more hours per week) and 20 part-time employees, each of whom works 24 hours per week (96 hours per month). The 20 part-time employees equate to 16 full-time equivalents (FTEs), calculated as follows;*
>
> *20 employees x 96 hours = 1920 total hours* *1920 ÷ 120 = 16 **F**ull-**T**ime **E**quivalent**s***
>
> *With 35 full time employees and 16 FTEs, the employer would be considered a "large' employer because there is a total FTE count of 51.*

- **Employee:** The ACA definition of an employee (as contrasted with an "independent contractor") is based on a common law standard under which an employer-employee relationship exists if the employer controls both what and how the work is to be done.
- **Seasonal employees:** Seasonal employees are generally defined as those who work for up to 120 days a year. Full-time seasonal employees who work 120 days per year or less are excluded from the calculation to determine large employer status.
- **Control group rules:** The ACA follows the control group rules of IRC Sec. 414. Thus, if an individual or organization owns all or a substantial part of several other business (for example, a group of fast-food restaurants), all of the business are considered to be one entity. For purposes of the 50-FTE rule, the employees in each business must be aggregated to determine the total.

[1] The discussion here concerns federal law. State or local law may differ.

# Business Responsibilities Under the ACA

- **Temporary agency employees:** For purposes of determining who is a large employer, "temp" (or "leased") employees are generally counted as employees of the temporary agency.

## Who is a "Full-Time" Employee?

The ACA did not specify the time period an employer must use to determine if a worker is a full-time employee. However, IRS Notice 2012-58 describes a safe-harbor method that may be used to determine which employees are considered to be full-time. The safe-harbor method includes several key time periods, which vary, depending on the type of employee.

| | Measurement Period | Administrative Period | Stability Period |
|---|---|---|---|
| Description | A period of time during which an employer measures the average hours an employee worked per week. | At the employer's option, a period of time during which full-time employees are identified and enrolled in a health plan. | During the stability period, the employee is treated as full-time regardless of how many hours are worked. This is also the period in which a penalty payment may be due. |
| On-going employees | From three to 12 months.[1] Uses data from a preceding year. | Up to 90 days. | At least six months, but cannot be shorter in duration than the measurement period. |
| New employees, hired as full-time | Not applicable. | Up to 90 days to enroll. | Not applicable. |
| New variable hour and seasonal employees | From three to 12 months.[2] | Up to 90 days. Measurement period and administrative period cannot exceed 13 months. | Three to 12 months, but cannot be longer than the measurement period. |

## Minimum Essential Health Insurance

If an employer is determined to be a "large" employer, and, in order to avoid a potential penalty, the employer must offer "minimum essential health coverage" to all full-time employees. The health insurance must also be both affordable and provide adequate coverage to employees and their dependents.

- **Minimum Essential Health Coverage:** The ACA lists the types of services that must be included to be considered "minimum essential health coverage", including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including vision and oral care.

[1] For on-going employees, this is referred to as the "standard" measurement period.
[2] For new employees, this is referred to as the "initial" measurement period.

# Business Responsibilities Under the ACA

- **Coverage must be "affordable":** Coverage under an employer-sponsored plan is "affordable" if the employee's required contribution to the plan does not exceed 9.5% of the employee's household income for the taxable year.
- **Affordability "safe-harbors":** As a practical matter, most employers will not know the family's household income. To overcome this, three, alternative "safe-harbor" tests have been proposed. Under the first safe-harbor, the annualized, required contribution must not exceed 9.5% of the employee's earnings from the employer, as shown in Box1 of the employee's W-2 Tax and Wage statement. Under the second safe harbor, the 9.5% affordability test is applied to the employee's hourly rate of pay for a month, multiplied by 130. Finally, if the employee's required contribution is less than 9.5% of the federal poverty level for a single individual, the coverage is treated as affordable. A plan can meet any one of these tests to comply with the affordability requirement.
- **"Adequate" coverage:** For ACA purposes, a plan is considered to provide adequate coverage (also called "minimum value") if the plans actuarial value (i.e. share of the total allowed costs the plan is expected to cover) is at least 60%. Under the ACA, the health insurance plans offered through the health insurance exchanges will generally be available at four "levels" or price points. Each level covers a specified percentage of the actuarial value of the benefits provided by the plan. These levels are: Bronze – 60%; Silver – 70%; Gold – 80%; and Platinum – 90%.
- **Dependent:** Although employers are encouraged to offer health coverage to an employee and all dependents, under proposed regulations, the term "dependent" has a narrow meaning. For ACA purposes, a "dependent" is a child of an employee who has not yet attained age 26. The term does not include a spouse or others (such as parents) that an employee might claim as a dependent on his or her federal income tax return. Thus, in order to meet the letter of the law, an employer must offer health insurance that covers only the employee and his or her children under the age of 26.

## What Triggers the Penalty?

Regardless of whether or not a "large" employer offers health coverage, it will be liable for a penalty only if at least one of its full-time employees obtains coverage through a health insurance exchange and receives a premium assistance tax credit or cost-sharing subsidy.

One part of the ACA calls for the creation of health insurance exchanges. These exchanges are intended to provide an online marketplace where individuals and small businesses can shop for qualified health insurance coverage. Individuals who purchase health insurance through a health insurance exchange may receive help in paying for the coverage in one of two ways:

- **Premium assistance tax credit:** A low-income individual[1] who purchases health insurance through a health insurance exchange may be eligible to receive a refundable "premium assistance" tax credit. The U.S. Treasury pays the premium assistance credit amount directly to the health insurance company, with the individual being responsible for paying any remaining premium.

[1] Generally, someone earning from 100% up to 400% of the federal poverty level (FPL) for the family size involved. For 2013, 100% of the FPL for a family of one is $11,490; for a family of four it is $23,550; for a family of eight it is $39,360.

# Business Responsibilities Under the ACA

- **Cost-sharing subsidy:** An individual may also qualify for a "cost-sharing" subsidy, available through the health insurance exchange. The subsidy reduces the dollar amount of "out-of-pocket" expenses (deductibles or co-payments) that the individual might otherwise pay. This subsidy is generally limited to low-income individuals[1] and is only available for those months when the individual qualifies for a premium assistance tax credit.

## Calculating the Employer Penalty

Assuming that an employer is a "large" employer, and at least one full-time employee has obtained health insurance coverage through a health insurance exchange, with either a premium tax credit or a cost-sharing subsidy, the method used to calculate the employer's "shared responsibility" payment will vary:

- **Large employer not offering health insurance:** For 2014, the monthly penalty assessed to an employer who does not offer health insurance will be equal to the number of full-time[2] employees minus 30 (the penalty is waived for the first 30 employees), multiplied by one-twelfth of $2,000.[3]

> *Example: In 2014, Employer X fails to offer minimum essential health coverage and has 100 full-time employees, 10 of whom receive a premium assistance credit for the year. For each employee over the 30-employee threshold (100 - 30 = 70), the monthly penalty amount for Employer X is $11,667, (70 x ($2,000 ÷ 12)) or (70 x $166.67).*

- **Large employers offering coverage:** Even though an employer may offer health insurance coverage, the coverage may not be "affordable" or it may not be "adequate." In this situation, for 2014, the monthly penalty assessed to an employer for each full-time employee who receives a premium tax credit or cost-sharing subsidy will be one-twelfth of $3,000.[7] However, the monthly penalty will be capped at an amount equal to the total number of full-time employees during the month (regardless of the number of employees receiving a premium tax credit or cost-sharing reduction) in excess of 30, multiplied by one-twelfth of $2,000.

> *Example: In 2014, Employer Z offers health coverage and has 100 full-time employees, 20 of whom receive a premium tax credit or cost-sharing subsidy for the year. For these 20 employees, Employer Z employer owes a penalty of $5,000 per month (20 x ($3,000 ÷ 12)) or (20 x $250). The maximum monthly penalty for is capped at the amount that would have been assessed for a failure to provide coverage, or $11,667 ((100-30) x ($2,000 ÷12)) or (70 x $166.67). Since the calculated penalty of $5,000 for the 20 employees receiving a premium tax credit or cost-sharing subsidy is less than the maximum amount of $11,667, Employer Z will pay the $5,000 monthly penalty.*

[1] Generally, those earning less than 250% of the federal poverty level (FPL), for the family size involved.
[2] Part-time employees are not included in the penalty calculations. Part-time employees are included in determining whether or not an employer is a "large" employer.
[3] The $2,000 and $3,000 amounts apply to 2014. These values are subject to adjustment for inflation in future years. Under IRS Notice 203-45, enforcement of the employer penalty provisions of the ACA has been delayed until January 1, 2015.

# Business Responsibilities Under the ACA

## Other Requirements

Several other requirements must be noted:

- **Information reporting requirements:** Beginning in 2014,[1] "large" employers subject to the employer shared-responsibility requirement must report certain health insurance coverage information to both its full-time employees and to the IRS. An employer who fails to comply with these new reporting requirements will be subject to certain penalties. Additionally, information reporting requirements apply to insurers, self-insuring employers, and certain other providers of minimum essential health coverage.
- **Automatic enrollment:** Those firms with more than 200 full-time employees must automatically enroll new full-time employees in a plan and to continue the enrollment of current employees. Such automatic enrollment plans will be required to include adequate notice and the opportunity for an employee to opt out.

## Seek Professional Guidance

The foregoing is a simplified, high-level summary of a complex piece of legislation. Further, the rules and regulations issued to implement this legislation are subject to change. The guidance of knowledgeable income tax, health insurance, and other financial professionals is highly recommended.

[1] Under IRS Notice 2013-45, enforcement of these information reporting requirements has been delayed until January 1, 2015.

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# Patient Protection and Affordable Care Act

## Timeline

The Patient Protection and Affordable Care Act (PPACA), was signed into law by President Barack Obama on March 23, 2010. A companion package of "fixes" to PPACA, the Health Care and Education Reconciliation Act (HCERA), was signed by the President on March 30, 2010.

Many provisions of the new law are effective in 2010, while others become law during the years 2011 to 2018.[1] The following pages list the legal effective dates for selected provisions of this new legislation. Note that the actual implementation date may not be the same due to the number of steps required to make a particular provision operational.

In many instances, the legislation is applicable to group plans, "for plan years beginning on or after" a particular date. Since many group plans follow a calendar year, a provision that becomes legally effective in one year may not actually be implemented by a group plan until the following calendar year.

### Provisions Effective In 2009

- **January 1, 2009**
  - Expanded exclusion for specified health professionals in certain state student-loan repayment programs.

### Provisions Effective In 2010

- **January 1, 2010**
  - $250 one-time payment for a Medicare beneficiary enrolled in Medicare Part D who reaches the coverage gap of $2,830 for the year (2010 only).
  - Small business tax credit for nonelective employer contributions to purchase employee health insurance.
  - Expanded adoption credit and gross income exclusion for employer-provided adoption assistance programs.
- **March 23, 2010**
  - Exclusion from gross income of health benefits provided by Indian tribal governments.
- **March 30, 2010**
  - Codification of "Economic Substance" doctrine, with associated penalties.
  - Revised definition of "dependent" for purposes of employer-provided health benefits, to include a child (dependent or not) under age 27 at the end of the tax year.
- **June 23, 2010**
  - High-risk insurance pools for individuals with pre-existing conditions.
  - Temporary reinsurance program for employers that provide early retiree health coverage.

[1] The discussion here concerns federal law. State and/or local law may differ.

# Patient Protection and Affordable Care Act

## Timeline

### Provisions Effective in 2010 (continued)

- **July 1, 2010**
  - 10% excise tax on indoor tanning services.
- **September 23, 2010**
  - Extension of health coverage to include adult children up to age 26.
  - No pre-existing condition exclusion for children under age 19.
  - No lifetime limit on the dollar value of essential health benefits.
  - Policies may not be cancelled if policyholder becomes sick.
  - Certain preventive health care coverages are required.

### Provisions Effective In 2011

- **January 1, 2011**
  - Employers required to report the total cost of employer-provided health care on an employee's W-2 form.[1]
  - Increase to 20% of the additional tax on nonqualified distributions from HSAs and Archer MSAs.
  - Distributions from HSAs, Archer MSAs, HRAs, or Health FSAs for over-the counter medicines are considered a "qualified" expense only if prescribed by a physician.
  - Collection of premiums for CLASS Act long-term care program may begin.
  - Simple cafeteria plans may be established by small employers.
  - Annual fees levied on branded prescription drug manufacturers and importers.

### Provisions Effective in 2012

- **January 1, 2012**
  - Additional information reporting by a business of payments of $600 or more to a single payee, for property or services.

### Provisions Effective In 2013

- **January 1, 2013**
  - 0.9% additional Hospital Insurance (Medicare) tax on high-income taxpayers.
  - 3.8% unearned income Medicare contribution.
  - Threshold for itemized deduction of unreimbursed medical expenses generally increased to 10%.
  - $2,500 reimbursement limitation on Health FSAs under cafeteria plans.
  - Business deduction for federal subsidies for retiree prescription drug plans repealed.
  - 2.3% excise tax on the sale of certain medical devices.

[1] This requirement applies to tax years beginning in 2011. For most employees, this information will first be shown on the W-2 for calendar 2011, issued at the beginning of 2012.

# Patient Protection and Affordable Care Act

## Timeline

### Provisions Effective In 2014

- **January 1, 2014**
  - Minimum essential health coverage required for most U.S. citizens and lawful resident aliens, with monetary penalties for non-compliance.
  - No pre-existing condition exclusion for adults.
  - States required to establish American Health Benefit Exchanges (AHBE) and Small Business Health Options Program (SHOP) Exchanges.
  - Refundable premium tax credit for eligible individuals who purchase health insurance through an AHBE.
  - Cost-sharing subsidies become available to qualified individuals who purchase health insurance through an AHBE.
  - Free Choice vouchers available to qualifying employees to purchase health coverage.
  - Expanded Medicaid coverage, to include certain groups with household incomes up to 133% of the federal poverty level.
  - Shared responsibility for employers. Certain employers are required to offer health insurance coverage to employees, with non-deductible excise tax penalty for non-compliance.
  - Annual fees levied on health insurance providers.

### Provisions Effective In 2018

- **January 1, 2018**
  - 40% excise tax on high-cost ("Cadillac") health plans.