The Affordable Care Act: FAQs for Employers

For the first time in history, beginning in 2014, there will be a federal requirement to offer prescribed health coverage or potentially pay a penalty.

In 2014, certain employers will be required to:

1. Offer all full-time employees "affordable" coverage; or
2. Potentially pay a penalty if any full-time employee is provided with "unaffordable" coverage and receives a tax credit to purchase coverage in the exchange.

Definitions

Which employers are required to offer coverage?
"Small employers" do not have to offer coverage. "Applicable large employers" are required to provide coverage to their full-time employees.

Am I a small employer or an applicable large employer?
A "small employer" has fewer than 50 full-time-equivalent (FTE) employees, on average over the course of a month. An "applicable large employer" has 50 or more FTE employees, on average over the course of a month.

How is a full-time-equivalent (FTE) employee determined?
Add the total number of hours worked by your part-time employees in a month, and then divide that number by 120. Add that number to the total number of full-time employees.

How is a full-time employee defined?
A full-time employee is an employee who works at least 30 hours per week, averaged over the course of a month.

To whom must I offer health care coverage?
"Applicable large employers" must offer the mandated coverage to all full-time employees.

Coverage

What type of coverage do I have to offer?

The type of coverage that you must provide will depend on whether you (as an employer) will be purchasing coverage for your employees in the small group market, the large group market, or self-insuring.

The choice to self-insure or offer your employees fully-insured coverage is up to you but there are a number of additional important issues to consider as you make this decision. If you choose to offer your employees coverage through a fully-insured plan, whether you purchase coverage in the small group or the large group market will be dictated by the number of people you will be covering.

Will I purchase coverage in the small group market or the large group market?

Generally, if you have fewer than 100 employees (using the definition for full-time equivalents) you will be purchasing coverage in the small group market.

What are the different coverage requirements?

If you are purchasing coverage in the large group market or if you are self-insuring, you must offer "affordable coverage" that provides "minimum value." If you are purchasing coverage in the small group market, your coverage must be "affordable", provide "minimum value," and cover the "essential health benefits package."

How does the law define "affordable" coverage that provides "minimum value"?

Employer sponsored coverage is "affordable" if the employee's share of the premium for self-only (individual) coverage does not exceed 9.5% of the employee's household income. Employers may rely on the employee's W-2 statements to calculate affordability in lieu of household income, which few employers know.

A plan meets the "minimum value" requirement if it has an actuarial value of 60%, meaning that the health plan pays for 60% of the costs of services that the plan covers.

Essential Health Benefits Package

What is the "essential health benefits package?"
Future regulations will specify details, but under the law as it stands now, plans that have to offer the essential health benefits package must: (1) cover the essential health benefits, (2) meet the new limitations on cost sharing, and (3) satisfy the new actuarial value requirements.

What are the essential health benefits that my plan must include?
Generally, the essential health benefits include items and services contained within ten broad categories:

- 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
- Pediatric services, including oral and vision care

The Affordable Care Act sets forth that the EHBs should be equal in scope to benefits offered by a "typical employer plan." The rule proposes that states select a benchmark plan, either (1) the largest plan by enrollment in any of the three largest products in the state's small group market; (2) any of the largest three state employee health benefit plans options by enrollment; (3) any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or (4) the largest insured commercial HMO in the state.

All plans that cover EHB must offer benefits that are substantially equal to the benefits offered by the benchmark plan. If a benchmark plan is missing any of the 10 statutory categories of benefits, the states or HHS must supplement the benchmark plan in that category.

Who must offer the "essential health benefits package?"

In addition to satisfying the "affordability test" and the "minimum value" test, plans offered in the small group market must cover the essential health benefits package. Plans in the large group market do not have to cover the essential health benefits package; however, if they do cover a benefit that is defined as an essential health benefit, plans in the large group markets may not impose any annual or lifetime dollar limits on that benefit.

Are state mandate benefits covered as part of the "essential health benefits package?"

For 2014 and 2015, it will depend on which of the possible four benchmark plans a state selects. If the state chooses a benchmark plan that is subject to state mandates for plan years 2014 and 2015, those mandates will be part of the essential health benefits package for that period. If a state selects a benchmark plan that is not subject to state mandates, the state will be required to cover the costs of its mandates outside the essential health benefit benchmark package.

If my state passes new benefit mandates now, will they go into effect for 2014 and 2015?

No. The state-mandated benefits must be enacted by December 31, 2011, and covered by the selected benchmark plan to be incorporated into the essential health benefits package for 2014 or 2015.

Penalties

What happens if I fail to meet the reform law requirements?
Simply failing to offer the mandated coverage to full-time employees does not necessarily mean an employer will have to pay a penalty. Whether you will be penalized and at what cost will depend on:
1. Whether you are an "applicable large employer;"
2. Whether you offer minimum essential coverage to all full-time employees;
3. How many full-time employees receive a premium tax credit and use it to purchase coverage in the exchange.

Which employees are eligible for a premium tax credit?
In order to be eligible for a premium tax credit, a full-time employee must have a household income between 100-400% of federal poverty level (FPL), depending on family status. If all full-time employees have household incomes above 400% of federal poverty line, an employer will not be penalized, regardless of whether coverage is offered or not.

How will the amount of the penalty be determined?

The penalty will be determined by the following:

- If an employer offers coverage but it is deemed "unaffordable" and at least one FT employee obtains a tax credit in the Exchange
  PENALTY= $3,000 per FT employee that receives tax credit
- If an employer doesn't offer coverage and an employee receives a tax credit in the Exchange
  PENALTY= $2,000 per FT employee (after first 30 employees)

How will I be assessed the penalty and how do I pay it?
Future regulations will specify penalty assessments. Beyond the employer mandate penalty, additional reporting requirements as to the coverage that is offered will also increase the costs and administrative burdens on employers.

When do these penalties go into effect?
The penalties will go into effect January 1, 2014.