Employers Association of New Jersey

30 W. Mount Pleasant Ave., Suite 201, Livingston, NJ 07039

www.eanj.org

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An Overview of the Affordable Care Act: What Employers Need to Know

The primary purpose of the Affordable Care Act (ACA) is to move the United States toward more universal healthcare coverage. Five key actions help achieve this goal:

1. **Preserve current employer-provided coverage.**
2. **Implement a coverage mandate that penalizes individuals who can afford health insurance but don't have it.**
3. **Subsidize coverage for those who can't afford health insurance.**
4. **Create a new Exchange marketplace for individuals and small businesses.**
5. **Expand state Medicaid programs for our poorest citizens.**

The federal government anticipates that the ACA will cut the number of uninsured in half over the next five years, primarily by expanding Medicaid and creating Exchanges. It does not expect that there will be any drop in employer-provided coverage—and uses several mechanisms to ensure that coverage remains in place For small employers, the ACA provides incentives—such as tax credits—to encourage retaining health insurance for employees. For large employers, however, the government is using a stick rather than a carrot to keep current programs in place.

Starting in 2014, large employers will be assessed penalties for not offering minimum essential coverage to full-time employees and their dependents, as well as for offering coverage that is either not affordable or does not provide minimum value. These penalties only kick in if a full-time employee buys federally-subsidized coverage through an Exchange. (Only individuals with incomes between 100% and 400% of the federal poverty line who are not eligible for Medicaid can benefit from premium tax credits or cost-sharing reductions for coverage purchased through Exchanges.)

The "shared responsibility requirement" for employers introduces a whole new vocabulary of terms. What does it mean by large employers, penalties, full-time employees, dependents, minimum essential coverage, affordability, and minimum value? In this article we'll take a look at each of these terms and what they mean for your plans, responsibilities and options.

What Are the Penalties?

The penalty for not offering coverage to at least 95% of all full-time employees (FTEs) is 1/12 of $2,000 per month for each full-time employee minus the first 30 FTEs. The monthly penalty for offering coverage that's not affordable or does not provide minimum value is 1/12 of $3,000 for each FTE who obtains subsidized coverage through an Exchange. Employers will receive certification when an employee has benefited from a premium tax credit and have the chance to respond before the IRS demands payment.

Who Is a Large Employer?

A large employer is defined as any business with an average of 50 or more FTEs and FTE equivalents during the prior 12-month calendar year. This definition applies to all types of employers, including non-profit and governmental entities. Related businesses with common ownership are treated as a single entity when determining if they fit the "large employer" criteria. This ensures employers can't avoid penalties by dividing themselves up into smaller organizations.

How Can You Calculate Your Number of FTEs and FTE Equivalents?

FTEs are employees averaging 30 or more hours per week each month during the prior calendar year. (Paid time off is included in hours of service.) FTE equivalents equal the total monthly hours of employees with less than 30 hours of service a

week, divided by 12. To calculate your total, add your FTEs and FTE equivalents for each month of the prior calendar year and divide by 12.

There is important guidance to keep in mind for specific scenarios:

- Leased employees are excluded.
- Employees working outside the US are excluded.
- Employers can use days- or weeks-worked equivalencies for employees not paid hourly.
- Special rules apply to educational organizations and seasonal workers.

Under a transitional rule for 2014 only, employers may use any six consecutive months during 2013 (rather than the full 12-month period) to assess their large-employer status. This rule gives businesses the time and opportunity to plan.

To avoid the monthly penalty, employers must offer minimum essential coverage to at least 95% of FTEs and their dependents. (Dependents are defined as employees' children younger than 26. For 2014, employers will not be penalized if they don't offer dependent coverage, as long as they are working toward satisfying the dependent requirement).

It's important to note that the number of FTEs is calculated differently when determining coverage obligations than when determining large-employer status. FTEs are counted each month as those who averaged at least 30 hours per week during that month. This approach, however, creates a timing dilemma when it comes to coverage. Employers need to know at the start of the month which employees must be offered coverage—yet they may not have that information for a particular employee until they calculate hours of service at the end of the month.

To solve the dilemma, the regulations provide an optional "look-back" measurement period of 3–12 months—followed by a stability period—for continuing employees. Employees averaging 30 hours per week during the measurement period can continue to be considered full time during a subsequent "stability period." (The stability period can be either 6 months or the length of the measurement period—whichever is longer.) Employees averaging less than 30 hours a week during the measurement period can continue to be classified as part time during the stability period. In addition, employers may have an administrative

period of up to 90 days between the end of the measurement period and the beginning of the stability period.

There are special rules in place for new employees (who weren't on board during the look-back period)…seasonable or variable-hour employees…and employees who leave, return or have other status changes. There are not special rules, however, for temporary employees—those working full-time for a specified short period. Employers do, however, have the option to exclude employees from coverage for up to three months after their initial employment.

What Is Minimum Essential Coverage?

Which types of plans fulfill the minimum essential coverage requirements? In general, eligible employer-sponsored plans—such as group health insurance and self-insured plans—qualify as providing minimal essential coverage. Individual health insurance coverage (including coverage through Exchanges)… government plans (Medicare, Medicaid, CHIP, TRICARE, veterans' healthcare)…and plans added by proposed regulations (such as college and university self-insured plan) also qualify. Limited coverage plans, however, do not meet the minimal essential coverage obligation. These include disability, workers' compensation, dental- or vision-only plans, long-term care insurance, disease-specific insurance, fixed indemnity insurance and supplemental coverage (such as Medicare supplements).

How Is Affordability Determined?

Under the ACA, employers are not only obligated to offer health coverage to at least 95% of their FTEs, they are required to ensure that coverage is affordable—or they may incur penalties. Coverage is considered affordable if the FTE's contribution to the lowest-cost, employee-only coverage is no more than 9.5% of the FTE's household income. There are three simple methods employers can use to make sure they are hitting the 9.5% or below mark:

- W-2 wages (Box 1);
- Rate of base pay;
- Federal Poverty Line (Below the poverty line, employees are eligible for Medicaid.)

Although affordability is determined by the cost of employee-only coverage, the ACA deems that dependents of that employee also have been offered affordable

coverage. Therefore, dependents are ineligible for premium tax credits and cost-sharing reductions through Exchanges—a move that could leave some families without affordable health coverage. (Those who fall into this gap would not face a penalty nor would those who would have been eligible for Medicaid if their states had participated in the ACA's Medicaid expansion.)

What Is Minimum Value?

While affordability is based on the employee's share of coverage costs, minimum value is based on the employee's share of medical expense costs, such as co-pays, coinsurance and deductibles. Under the ACA, coverage provides minimum value if, on an actuarial basis, the plan pays at least 60% of the total allowed cost of benefits. The IRS and HHS will provide a calculator, which will make it easy to determine, whether the plan meets the minimal value requirement.

What Are Your Recordkeeping, Reporting and Employee Notice Requirements?

Employers will be required to keep records substantiating their number of FTEs; the healthcare coverage they maintain, along with how it's offered and to whom; employee cost-sharing requirements; and other key information. In addition, they will need to report the individual coverage they provide—both to the government and to employees—either on W-2 forms or on a separate form that's sent with the W-2.

Employers also are required to notify employees that state Exchanges are available, explain what Exchanges do and provide contact information. This notice must also explain that, if the employer does not offer affordable coverage that provides minimum value, the employee may be eligible for tax credits, if he or she purchases individual coverage through an Exchange. Finally, the notice must inform employees that, if they buy coverage through an Exchange, they may lose employer pretax contributions to coverage costs.

The notices originally were scheduled to be distributed to all current employees by March 1, 2013. That date has been postponed, however, to late summer or early fall, pending further government guidance.

What Actions Should You Take Now to Be Ready for 2014?

There are seven critical actions you can take now to be sure you are prepared for 2014:

- **Decide whether to provide coverage.** Several factors go into this decision, including employee relations, the cost of covering versus not covering, and the complexity of administering all the new coverage rules. It's important to remember, however, that employers who do not provide coverage still will face significant administrative complexity. Because penalties are based on a monthly number of FTEs, employers will need a process for determining and reporting that information. In fact, the least administratively burdensome approach is to cover all employees and their dependents, including part-time employees.
- **Determine if you are a large employer.** For many employers, this will be self-evident. Employers that are close to the 50 FTE and FTE equivalent cutoff, however, will need to select a 6-month or longer period for performing their calculations. They may be able to pick a particular period in 2013 that would get a good testing result—and allow them to avoid large-employer status in 2014.
- **Identify which full-time employees must be offered coverage.** Again, this requires a measurement period of six months or longer—but it can end no earlier than October 3 for a calendar-year plan. We anticipate that most employers will continue to have annual enrollments for their healthcare plans and adopt a look-back method, allowing them to determine their FTEs for an entire plan year.
- **Make sure coverage is offered to the required 95% of FTEs**. Employers not following this step could end up both paying for coverage and paying a penalty for not hitting the 95% level.
- **Confirm that the offered coverage meets affordability requirements.** Select how to measure affordability and test it against required employee contribution limits.
- **Consider whether your organization meets the requirements for transition relief, if your plan follows a fiscal year.** Employers with fiscal-year plans have the opportunity to defer compliance until the plan year.
- **Assess whether to change cafeteria plan elections.** For plan years beginning in 2013, employers may amend cafeteria plans, allowing

employees to change their elections relating to premiums for employer-provided coverage

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