

FARM LEGAL SERIES

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The Affordable Care Act—What You Need to Know

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INTRODUCTION

With the passage of the Affordable Care Act (“ACA”), employers are faced with numerous issues to consider in order to ensure they comply with its requirements. The purpose of this fact sheet is to outline those requirements in order to provide assistance in making those assessments. The flow chart at the end of this fact sheet should also provide assistance in navigating these often complex requirements.

THE EMPLOYER MANDATE IN A NUTSHELL

The general premise of the mandate is rather simple: employers need to provide group health coverage to their full-time employees come 2015, or pay the ACA penalty for failing to do so. Of course, as with everything else in this law, the devil is in the details.

First, certain employers are exempt from the mandate. Employers with fewer than 50 full-time employees are not required to comply with the mandate. In 2015, employers with fewer than 100 full-time employees get a pass—they don’t have to comply until 2016.

Second, the ACA specifies which employees are considered full-time for purposes of the mandate. Generally, employees working 30 or more hours per week must be considered full-time. This is a departure from the historical position that generally permitted employers to determine the number of hours required to be considered full-time.

Third, employers are now required to offer group health coverage to all full-time employees. Prior to the ACA, to the extent an employer could satisfy either non-discrimination or underwriting considerations, the employer was free to determine workforce coverage on its own.

Fourth, the group health coverage must satisfy two different standards to be considered conforming “affordable” coverage under the ACA. Both the percentage of benefits the plan pays (as compared to a participant’s out of pocket cost), and the amount the employee is required to pay for premiums must satisfy specific standards.

Finally, the ACA imposes penalties on employers for failure to comply. If an employee goes to a state or federal exchange and purchases coverage using a government subsidy, the employer may be subject to one of two penalties: (i) the penalty for a failure to offer coverage, or (ii) the penalty for a failure to offer affordable coverage. The remainder of this article will discuss the employer mandate provisions in more detail.

WHO IS SUBJECT TO THE MANDATE?

Employers with 50 or more full-time employees are required to comply under the ACA. An “employer” is determined on a controlled-group basis. This means all employees of related entities must be aggregated to determine whether the 50 employee threshold has been met. Entities can be related directly through an ownership

chain, such as a parent company with one or more subsidiaries. Common ownership of multiple entities by small groups can also create a controlled group.

A parent subsidiary controlled group exists when one corporate entity owns at least 80% of another. For example, consider a company with multiple divisions. It is very common for an umbrella or shell organization to own several operating units, each devoted to different aspects of the business. As long as the shell owns at least 80% of each operating unit, the entire group is considered a single employer for purposes of the ACA.

Entities can also be related through a brother-sister controlled group. In this analysis, if five or fewer persons own at least 80% of each entity, and at least 50% of the ownership is identical, the entities will be a controlled group and considered a single employer. For example, if three friends each own one-third of three different companies, this test would be satisfied. The three friends fit as “five or fewer”; together they own 100% of each of the entities, and 100% of the ownership is identical. Obviously, depending on the number of owners and the ownership percentages, companies may or may not be related enough to be required to include all employees in this determination. For that reason, it is important to consult experienced benefits counsel in making this determination.

To make things even more confusing, there are family attribution rules that require certain family members’ ownership to include that of other family members. For example, an individual is considered to own any interest that his or her spouse and, in some cases, child or parent owns. This sometimes makes it difficult for family owned businesses to stay separate enough to avoid the requirements.

Control of nonprofit entities is determined by the ability to control their boards of directors. If 80% or more of the directors of the nonprofit organization are employees of another entity, or are appointed and removed by another entity, that other entity and the nonprofit are in the same controlled group.

Once the entities that must be considered a single employer have been determined, the next step is to count full-time employees. Only employers with 50 or more full-time employees are required to comply with the mandate. For this purpose, an employee working 30 or more hours per week is considered full-time. For organizations that hire part-time employees, a full-time equivalency calculation is used. The employer must first add together all the monthly hours of all part-time employees, then divide that number by 120. The resulting number is the employer’s full-time equivalency, which is added to the population of employees working 30 or more hours per week. If the result is 50 or greater, the employer is subject to the mandate.

There is a special exception that may help employers with seasonal employees. If the employer had more than 50 employees for 120 days (4 months) or less, and all employees in excess of 50 are seasonal, the employer is exempt from the mandate.

Employers must use the previous year’s employment data to determine whether the 50 employee threshold is met.

WHICH EMPLOYEES MUST BE COVERED?

Full-time employees and their dependents must be covered to avoid the risk of penalties.

The question of who is considered full-time is more complex. An employee who works on average 30 hours per week (130 hours per month) is considered to be full-time for purposes of the ACA. All employees that

employers currently categorize as full-time are likely to meet this standard. However, it is possible that a significant number of employees currently categorized as part-time meet this standard as well. The rules take three kinds of situations into account: (i) ongoing or new employees who are expected to work 30 hours per week or more, (ii) ongoing employees whose hours are variable, and (iii) new employees whose hours are variable. Equivalencies may be used for employees whose hours are not tracked—8 hours for one day, 40 hours for one week. However, these equivalencies must not be less than the actual number of hours worked. For example, if an employee works three days a week, but is paid on salary and hours are not tracked, the employer could credit 8 hours for each day worked. This would result in a total of 24 hours counted per week. However, if that employee is working three 12-hour shifts, the actual number of hours must be credited.

For purposes of the ACA, dependents are the employee's children under the age of 26. Note that spouses are not dependents for this purpose. Therefore, to comply with the mandate, the employer must offer coverage to the employee and his or her children. The employer is certainly allowed to offer coverage to the employee's spouse, but this is not required. The employer does not have to pay for coverage for the dependents. There are affordability requirements for the employee's coverage (see the next section of this article), but not for the dependent coverage. Hence, the employer could pay for the employee's coverage only, and let the employee enroll any children in the plan at his or her own expense.

There are additional rules governing how leaves of absence may be taken into account in measuring hours. If an employee terminates and is rehired 13 weeks or more after the termination, he or she can be

considered a new employee for purposes of the measurement periods. If the break in service is shorter, the employer may be able to count the employee as new, depending on how long the first period of employment was.

WHAT KIND OF COVERAGE MUST BE OFFERED?

To avoid penalties, the coverage offered to the employee and his/her dependents must be of "minimum value," and must be "affordable." A plan's coverage meets minimum value if the plan's share of the total allowed costs of benefits provided under the plan is at least 60% of those costs. In other words, at least 60% of covered expenses must be paid by the plan. The employee's out of pocket expenses, such as copays and deductibles (but not including premiums), must not be greater than 40% of covered benefits. The minimum value calculation is an actuarial calculation, and is not related to how much of the premium will be paid by the employer. A minimum value online calculator is available online through the Centers for Medicare and Medicaid Services (<http://cciio.cms.gov/resources/regulations/index.html#pm>). Most employers will be aided by their brokers and insurers in making this determination. Currently, many if not most employer plans provide a much more robust coverage rate—often in the 75% to 85% range.

The affordability of the plan is determined in relationship to each employee's financial situation. The ACA calls for the determination to be based on household income, but of course employers cannot know what that is. The regulations have provided three safe harbors. The one which is most commonly referred to is the W-2 safe harbor. If the employee portion of the premium is not greater than 9.5% of the employee's W-2 income, the coverage is affordable. The second safe harbor is based

on the rate of pay. If the monthly employee portion of the premium doesn't cost more than 9.5% of the employee's hourly rate, multiplied by 130 hours per month, the coverage is affordable. Finally, a third safe harbor is based on the federal poverty line. If the employee's cost is not greater than 9.5% of the federal poverty line for a single individual, the coverage is affordable. For all of the safe harbors, the calculation is based on employee-only coverage that meets minimum value requirements. If the employer has more than one plan available, the least expensive coverage is used for the calculation.

WHAT ARE THE PENALTIES FOR NON-COMPLIANCE?

The ACA provides two separate penalties for non-compliance with the mandate. The penalties are not cumulative; they would end up being assessed on an "either/or" basis. The penalty for failing to provide affordable coverage to full-time employees will be capped at the amount the penalty would have been for failure to provide coverage at all. This is an important point, as it shows the intent of the regulators to incentivize employers to provide coverage. An employer who tries to comply by offering coverage and falls short with regard to the affordability requirement will not find itself in a position of being worse off, penalty-wise, than if it had not tried at all to comply with the mandate.

Both penalties are only triggered when an employee obtains subsidized coverage through an exchange. If no employee goes to the exchange to obtain coverage, or if an employee that goes to the exchange is not eligible and therefore does not receive a subsidy, then no penalty will be triggered. It always takes an employee getting coverage and subsidy from an exchange for an

employer to be in a potential penalty situation.

PENALTY FOR FAILURE TO OFFER COVERAGE

The first penalty is an annual \$2,000 per employee. It has earned the nickname "the hammer," because calculation uses an employer's entire full-time employee count as the starting point for assessment even if only one employee goes to an exchange and obtains coverage and a subsidy.

The hammer penalty applies when an employer does not offer group health coverage to its full-time employees. The rule is that coverage needs to be offered to all full-time employees, and the definition of full-time is those that work 30 or more hours a week, under the calculation description above. The original guidance did not provide any exception for error - technically, missing a single employee who fit the full-time standard would have put the employer at risk for the penalty. Fortunately, the newer guidance offered a substantial compliance measurement. An employer that offers coverage to at least 95% of its full-time employees can avoid this penalty. For the 2015 calendar year only, an easier standard of 70% compliance applies.

In calculating the penalty, the regulations allow the first 30 full-time employees not to be counted. Thus an employer subject to this penalty will be assessed an amount according to the following formula: $\$2,000(n-30)$, where n is the number of full time employees. In 2015 only, the first 80 full-time employees will not be counted. The penalties in all years will be calculated on a month-by-month basis.

PENALTY FOR FAILURE TO OFFER AFFORDABLE COVERAGE

The second penalty can apply when an employer offers coverage, but that coverage is not considered “affordable” under the ACA. An employee who goes to an exchange and applies for subsidized coverage will have to demonstrate that the employer-provided group health plan was not affordable. If the employer plan is found not to be affordable, the employer will be subject to a \$3,000 penalty for that employee. Unlike the hammer penalty, this one is only assessed for each employee who actually obtains subsidized exchange coverage. Like the hammer penalty, this one will be calculated on a month-by-month basis.

Plan Coverage Analysis

The affordability measurement has two main components as described in more detail above: first, the plan’s coverage of expenses must be at least 60% of the cost of those expenses. This is the “minimum value” requirement. This measurement may offer employers a planning opportunity when reviewing how best to comply while reducing costs.

Employee Cost Analysis

The second affordability measurement, also described in more detail above, is the cost to the employee for premiums. This cost cannot exceed 9.5% of the employee’s household income. Employers generally do not know an employee’s household income, and employers have good reason to continue in this lack of knowledge. There are significant employment and employee relations problems with trying to obtain an employee’s household income information. Thus, it is recommended to use one of the safe harbors described above. This creates a smaller number in most cases than would result in

using the household income. However, the administrative ease and predictability will make it an obvious choice to use in assessing compliance.

The premium affordability analysis applies on an individual employee basis. This means that the maximum permissible premium amount in terms of dollars will be less for lower paid employees than for more highly compensated employees. Currently, the vast majority of employer provided plans utilize a standardized employee contribution amount or percentage. This new ACA measurement may provide employers with a planning opportunity to redesign the methodology for determining employee premium contributions.

Obtaining a Subsidy on the Exchange

Under the first premise of penalty assessment, an employer will not be subject to either penalty unless an employee goes to an exchange and obtains subsidized coverage. Subsidized coverage will only be available for individuals who satisfy the income requirements for a subsidy. The subsidy will be available on a sliding scale basis for employees who have a household income between 100% and 400% of the current year’s Federal Poverty Level. In states that expand Medicaid (such as Minnesota), employees with household income below 138% of the Federal Poverty Level will be eligible for Medicaid. Employees eligible for Medicaid do not get subsidies on the exchange, because they get Medicaid coverage. Employees with incomes that exceed 400% of the Federal Poverty Level will not be eligible for a subsidy at all.

The Federal Poverty Level depends on household size. In 2014, it is at \$11,670 for a single person (\$46,680 for 400% of the Federal Poverty Level), and \$23,850 for a family of four (\$95,400 for 400%). Employers

conducting a risk analysis for ACA penalties can use 2014 Federal Poverty Levels to evaluate the likelihood that their employees will be eligible for an exchange subsidy.

The ACA provides a mechanism for employers to respond to exchange decisions

to give an employee a subsidy—for example by demonstrating that coverage was offered and refused, or that coverage is affordable for a particular employee. The rules for that process have not yet been fully developed.

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