Frequently Asked Questions about the Health Care Law

House Committee on Small Business
May, 2013

1. **Aren't small businesses exempt from the health care law?**

   Employers who have fewer than 50 full-time equivalent (FTE) employees are not subject to the employer mandate. However, all employers are required to do certain things, such as provide employees information about the exchanges and how to access them. Note: The regulation on how employers are supposed to notify employees about the exchanges has been indefinitely delayed.

   The employer mandate covers firms that employed an average of at least 50 FTEs in the prior calendar year. According to the Department of the Treasury's proposed rule, businesses should look at the prior calendar year to determine if they meet the threshold of 50 FTEs for the following year, based on monthly averages. An employer calculates the number of full-time workers by counting each employee that worked an average of 30 hour per week that year. Second, employees who were part-time employees in the prior year are calculated by: 1) determining the number hours worked by all part-time employees who were not employed on average at least 30 hours per week; and 2) dividing the total hours by 120 to get an average FTE for a given month. This average FTE is added to the number of full-time employees to get the total number of FTEs.

   If the number is 50 or higher, the employer is potentially subject to the employer mandate. If the number is under 50, he is not. Employers subject to the employer mandate (i.e., those with 50 or more FTEs) who do not offer coverage to full-time employees and whose employees access coverage on an exchange and receive a premium credit are subject to a penalty of $2,000 per full-time employee annually. Employers may exclude the first 30 full-time employees.

2. **Is it true that the first 30 full-time employees are exempted under the penalty (Ex: For a company of 100 full-time employees who did not offer health insurance, the penalty would be for 70 full-time workers, for a total of $140,000?**

   Yes, that is correct.

3. **Can employers offer a high deductible plan? What is the highest deductible permitted?**

   Yes, employers may offer a high deductible plan. The plan must be considered "adequate." Under the health care law, a plan is considered to provide adequate coverage if the plan's actuarial value (i.e., share of the total allowed costs that the plan is expected to cover) is at least 60%. According to a preliminary analysis done by the Actuarial Research Corporation for the Congressional Research Service, the majority of employer-sponsored plans would meet the actuarial value requirements in the health care law. Also, all high-deductible plans currently offered by employers today would meet the 60% actuarial value requirement.

4. **Is there a minimum plan offered under the law, and if so, what is it?**

An employer must offer full-time employees coverage that does not exceed 9.5% of their household income. If the employer does not, and a full-time employee uses a premium tax credit to access coverage on the exchange, the employer is subject to an annual penalty of $3,000 per full-time employee doing so. See further explanation of "affordability" in answer to number 5 below.

5. How will an employer know if a plan is "affordable" for full-time employees?

An employer probably won't know the employee's household income. The Internal Revenue Service (IRS) issued a notice stating that employers may use an employee's W-2 wages as an affordability test instead of their household income. Employers may rely on this guidance at least through the end of 2014. A health plan's individual coverage would be considered affordable for an employee if their premium contribution for self-only coverage does not exceed 9.5% of their W-2 wages.

6. **Is it true that in year 1, companies are only required to offer employees coverage, and that coverage for dependents isn't required until Year 2?**

Employers with 50 or more FTEs who do provide health insurance coverage to avoid a potential penalty must offer coverage to employees and their dependents. According to the IRS' proposed regulation, the term "dependent" means the child of an employee who has not reached the age of 26, but does not include an employee's spouse.

7. Will a "mini-med" plan satisfy the employer mandate? Are the HHS-issued waivers for these plans still effective?

Mini-med plans are unlikely to satisfy the employer mandate in 2014. Current HHS waivers for these plans are effective through the end of 2013. By way of background, in September 2010, some companies requested a temporary waiver from the Medical Loss Ratio (MLR) requirements of the health care law for employees with minimum coverage (or "mini-med") insurance plans. Employers were concerned that higher costs of these plans meant they might not meet the new MLR requirement that 85% of premiums be spent on health benefits, so some received waivers. The majority of waivers were extended through 2013, but HHS has said that once the exchanges open and other coverage is available, waivers are unlikely to be extended.

8. How will an employer determine if his full-time + part-time employees trigger the employer mandate?

The employer mandate applies to businesses with an average of 50 or more full-time FTE employees during the preceding calendar year. To determine the number of FTEs, the IRS has proposed counting all employees who work an average of 30 hours per week as full-time employees. To determine average FTEs per month, an employer should add the number of hours part-time employees worked and divide by 120 (hours). Add both numbers together for the total number of FTEs.

If an employer offers coverage and the total number of FTEs is 50 or higher, the employer may be subject to a penalty if one of their full-time workers uses a premium credit to a premium tax credit to access coverage on the exchange. If the number of FTEs is below 50, the employer is not considered to be a large employer and is not potentially subject to a penalty.

9. What is the penalty that an employer must pay if he is subject to the mandate and fails to offer insurance?

If an employer is subject to the employer mandate (i.e., those with 50 or more FTEs), fails to offer coverage to their full-time employees and at least one full-time employee is eligible for a premium tax credit and purchases

insurance on an exchange, the employer would be subject to an annual penalty of $2,000 per full-time employee, minus the first 30 full-time employees.

For example, an employer with 50 full-time employees who does not offer coverage and who has at least one employee who uses a premium tax credit to purchase coverage on the exchange would face an annual penalty of $40,000. [50 total full-time employees – 30 full-time employees excluded from the calculation = 20; 20 x $2,000 penalty = $40,000.] Note: Although the statute specifies the penalty calculation, or assessed, federal agencies have not yet issued regulatory guidance on how the penalty would be calculated or assessed.

10. What are the minimum standards the policy offered to employees must meet? What are the penalties?

Employers offering coverage in the individual and small group market must offer coverage that: 1) is affordable; 2) provides minimum value; and 3) (for small employers only) covers the essential health benefits package.

Minimum value is at least 60% actuarial value, according to the IRS/HHS minimum value calculator that will be available on HHS' website. Employers will be able to submit information about their coverage, such as deductibles and co-pays, into the calculator to determine whether the plan provides minimum value by covering at least 60% of the total allowed cost of benefits that are expected to be incurred under the plan. For essential health benefits, beginning in 2014, insurers must cover 10 broad categories of care, including emergency services, maternity care, hospital and doctors' services, mental health and substance abuse care and prescription drugs. Limits on annual out-of-pocket costs for consumers will apply to all policies. Those limits are: $6,250 for a single policyholder and $12,500 for a family based on this year's rate.

11. If an employee is not offered insurance, or refuses it and purchases insurance on the exchange with a premium tax credit, what is the employer penalty? Does the penalty go to the IRS, and how is it assessed?

The employer penalty for not offering insurance is $2,000 per full-time employee, minus the first 30. There will be no penalty if employers offer coverage to at least 95% of their full-time employees and their dependents up to age 26. If an employer offers insurance that does not meet the minimum value or affordability requirements, the penalty may be the lesser of $2,000 per full-time employee minus the first 30, or $3,000 per number of full-time employees receiving a tax credit. Penalties will be assessed by the IRS on tax returns.

12. Under the individual mandate, if a person does not purchase insurance, or sufficient insurance, what is the dollar amount penalty? Will it be $95 the first year? Does it increase each year on a sliding scale?

The individual mandate requires individuals to obtain minimum essential coverage for themselves (and their dependents) beginning in 2014 or pay a penalty. The penalty is the greater of:

- For 2014, $95 per uninsured person or 1% of household income over the filing threshold;
- For 2015, $325 per uninsured person or 2% of household income over the filing threshold; and
- For 2016 and beyond, $695 per uninsured person or 2.5% of household income over the filing threshold.

There is a family cap of 300% of the flat dollar amount listed above, and the overall penalty is capped at the national average premium of a bronze level plan purchases through an exchange. For individuals under 18 years of age, the applicable per person penalty is one-half of the amounts listed above. Beginning in 2017, the penalties will be increased by the cost-of-living adjustment. Individuals under the age of 30 may purchase catastrophic plans to meet the individual mandate. Employers may not offer catastrophic plans to meet minimum essential coverage requirements. The requirement for individuals to obtain minimum essential coverage can be satisfied by participating in an employer-sponsored plan, purchasing individual policies, obtaining coverage under a state insurance exchange, or gaining coverage through Medicare, Medicaid or other

governmental programs. There are several exceptions to the individual mandate; members of Indian tribes, illegal aliens, etc., are exempt.

13. When will the employee premiums for policies under the employer mandate be available -- in 2014 or at some point in the future? Are they determined by the insurance companies, by statute or regulation?

While the rate filings to each state are generally submitted by insurance carriers in the spring, the actual premium that a given employer group will pay for health insurance is subject to negotiation between each employer and each carrier. The announcement of the premium for an employer group is based on the plan year. Since not all plan years are the same (for example, some employer plan years do not follow the calendar year), when premiums are announced for a given employer will vary. For employers that already provide health insurance, premiums for 2014 will likely be made during the normal enrollment period.

Under the health care law, insurance carriers that sell insurance to small groups 1) must accept every applicant for health insurance, as long as the applicant agrees to the terms and conditions of the insurance offer; 2) must provide coverage for preexisting health conditions; 3) are prohibited from basing insurance premiums on health status; and 4) must abide by other insurance market reforms.

14. Can premiums for employees vary based on factors such as their employees' age, weight, health status, whether they smoke, etc.?

While the health status of an individual employee currently may not be used to increase premiums for just that employee, most states currently allow companies selling health insurance to small groups to use health status, age, gender and tobacco use to determine the premiums for the whole group. In 2014, the health care law prohibits insurers from basing small group premiums on health status and gender. Insurers may vary premiums among small groups based on age and tobacco use, with some limitations, so long as such variation is not prohibited under state law. These rating restrictions would not apply of the small group self-insures.

Currently, employers are allowed to reward employees who participate in wellness activities, so long as these activities are non-discriminatory. The health care law increases the amount employers may reward participating employees, so long as the rewards meet the existing non-discrimination standards.

15. What about attempts to avoid the employer mandate?

The IRS, in its January 2, 2013 employer mandate proposed rule, noted that it anticipates the final rule will address practices that employers may contemplate to avoid the application of the mandate. For example, the proposed rule describes an arrangement where a company uses a temporary staffing agency to employ the company's employees for part of each week, which results in neither the company nor the staffing agency appearing to employ the employees on a full-time basis.