Article from

The ACA@5

August 2015
Issue 1

ACA Impact on Employers—The Road Ahead and the Road Behind

By Sujaritha Tansen and Brian Stentz

As actuarial consultants who collaborate with many types of employers, insurance companies and regulators, we are actively abreast of the Patient Protection and Affordable Care Act's (ACA's) impact on the health insurance market. Of the many dimensions of the ACA, we will explore the ACA's impact on employers, which, as of now, is an ever-evolving landscape where material changes are still to take place. Per the fact sheet[1] released by the IRS in February 2014, approximately 96 percent of employers are small businesses that are exempt from the employer mandate provisions of the ACA. Mid-size and large-size employers constitute 2 percent each of all U.S. employers and are subject to phased-in employer mandate provisions of the ACA. These 4 percent account for a major portion of the insureds in the United States. Per the report[2] issued by the U.S. Census Bureau, over 169 million buy employment-based health insurance. According to Congressional Research Service,[3] 72.4 percent of all employees work for firms that are large enough to be potentially subject to the penalty, but only 2.4 percent of employees work in firms that do not already offer health insurance. Considering the scope and range of new requirements, it is imperative that employers have strategies in place that help them navigate the new landscape.

The government's delay of the employer mandate until 2015 gave employers additional time to consider various strategies such as eliminating employee medical coverage, providing unsubsidized medical coverage, subsidizing employee coverage only, limiting spousal coverage, and using private health exchanges (PHEs). As 2015 unfolds and the employer mandate takes effect, employers are now facing the reality of having to involve legal counsel, IT personnel and human resources in meeting the compliance and reporting requirements of the ACA.

SCOPE

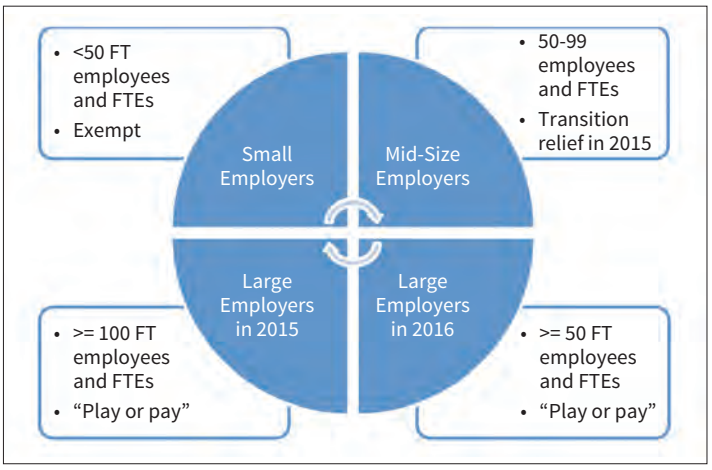
This paper presents an overview of three key W's (who, what, when) of the ACA's impact on employers and does not delve into the "why" aspect. Considering that ACA regulations are well over 1,000 pages, the information presented here is by no means exhaustive, but is meant to provide a bird's eye view of the impact on employers. We will be focusing more on the prospective impact on employers and less on changes that have already taken effect. We will not be making predictions about the future of employer-sponsored health coverage, possible erosion, or clean-cut exit from offering coverage, as it is too early in the game to comment on the future with any degree of certainty.

We will employ the following definitions shown in Figure 1 to help clarify the impact on small, mid-size and large employers.

In this parlance, an employee is a full-time (FT) employee for a calendar month if he or she averages at least 30 hours of service per week. For the purposes of determining FT employee status, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week. Full-time equivalence (FTE) is applicable if the business employs part-time employees. It is computed by dividing hours worked in a month by all part-time employees by 120. We direct the reader to the final regulations[4] for details on the two measurement methods (monthly measurement versus look-back measurement) for determining whether an employee has sufficient hours of service to be an FT employee.

Figure 1

Employer Size and ACA Impact



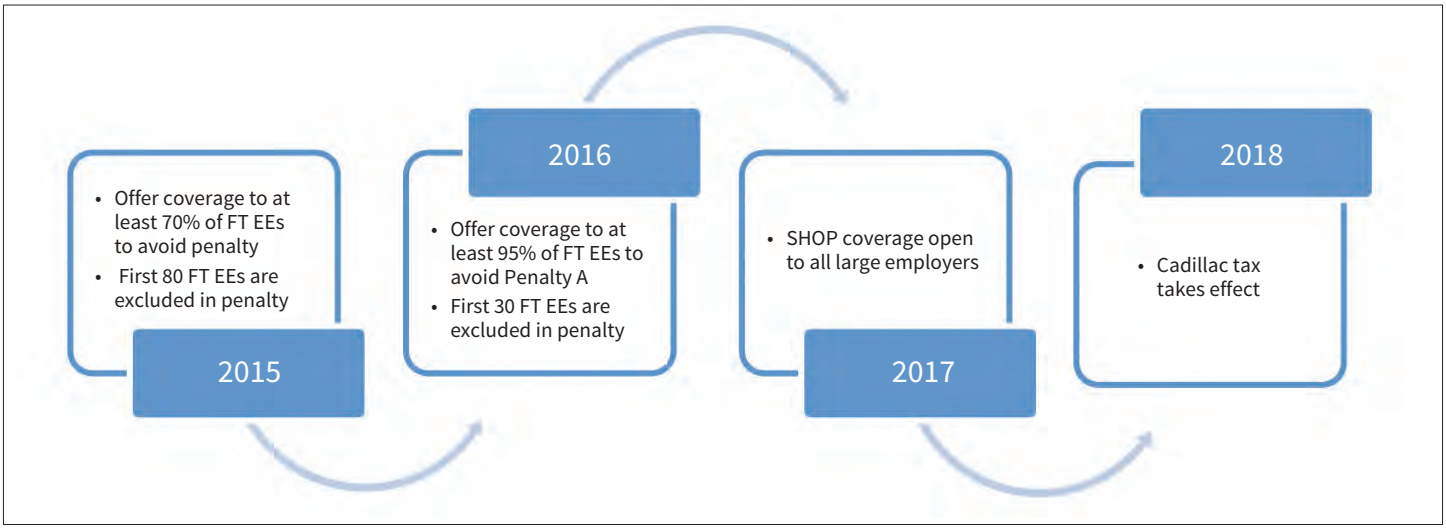
LARGE EMPLOYER PERSPECTIVE—BRIEF HISTORY OF TIME AND WHAT LIES AHEAD

On Feb. 12, 2014, the IRS published the final regulations pertaining to "Shared Responsibility for Employers Regarding Health Care Coverage," which provided guidance to employers that are subject to the "play or pay" provisions of the ACA.

The employer mandate was originally intended to take effect in 2014 when the federal or state marketplaces became operational. Subsequently, the mandate was delayed until 2015 or 2016, depending on employer size. Even with the delay, employers needed to be abreast of the new requirements, including IRS reporting forms, to ensure that the company has

CONTINUED ON PAGE 44

Figure 2
Employer Impact—A Timeline



an efficient infrastructure to collect and submit the needed data for the following year. A snapshot of the large employer impact by timeline is presented in Figure 2.

WHO?

Intending to allow a gradual phase-in and to better assist employers subject to the employer mandate, the "play or pay" provisions apply only to larger firms with 100 or more FTE employees starting in 2015 and employers with 50 or more FTE employees starting in 2016.

WHAT AND WHEN?

As part of the gradual phase-in, the employer mandate provisions in 2015 are less stringent than in later years. Transitional relief was allowed in 2015 to mid-size employers as long as they do not restructure their workforce and they continue to maintain or enhance previously offered coverage beginning Feb. 9, 2014 and ending on Dec. 31, 2015. Large employers, however, are subject to employer mandate provisions in 2015.

The Employer Shared Responsibility Payment (informally known as the employer mandate fee or penalty) is a per employee per month fee, applicable to large employers under the scenarios listed below. As demonstrated below, large employers do get some transitional relief in 2015 by the way of a lesser penalty relative to 2016. In this context, we present the definitions of the two most-cited provisions:

Minimum Value: A health plan meets the minimum value (MV) standard if it is designed to pay at least 60 percent of the total cost of medical services for a standard population (i.e., the employee pays via deductibles, coinsurance, copayments and other out-of-pocket amounts no more than 40 percent of the total value of benefits under this plan). The U.S. Department of Health and Human Services (HHS) regulations allow an employer to meet the MV requirement by applying the MV calculator provided by HHS or a safe harbor established by HHS and the IRS. For nonstandard plans, MV can be established through an actuarial certification. In November 2014, the IRS clarified that an employer plan cannot be considered to meet the MV standard unless it provides substantial coverage for inpatient hospital and physician services, thus eliminating the lure to offer potentially unattractive benefit packages just to avoid the employer penalty.

Affordable Coverage: If the employees' share of the premium costs more than 9.5 percent of their annual household income, the coverage is considered not affordable. Since an employer may not be aware of its employees' aggregate household income, employers can use one or more of three affordability safe harbors defined in the final regulation. Employers should now have strategies in place to track affordability of coverage and the safe harbor method that best suits them.

- Employee's W-2 wages: Affordability is based on whether an employee's premium contribution for the lowest-cost, self-only MV coverage does not exceed 9.5 percent of the employee's W-2 Box 1 wages for that calendar year.
- Rate of pay: Affordability is based on the monthly wage of hourly employees (hourly rate of pay for each hourly employee multiplied by 130 hours per month) or the monthly salary of salaried employees.
- Federal poverty line (FPL): Coverage is affordable if the employee's premium contribution does not exceed 9.5 percent of the FPL for a single individual.

It is important to note that the affordability provision only applies to employee coverage, not

for dependent coverage. Each of the safe harbor methods has pros and cons that employers need to assess so they can make decisions that best fit their organization. For instance, employers need to wait until the end of the year to compute affordability based on W-2, while the rate of pay computation can be made at the beginning of the plan year. The W-2 method might be more suited for employers with a relatively stable workforce constituting mostly FT employees whose wages are not likely to fluctuate significantly. The rate of pay safe harbor requires multiplying the hourly rate by 130 hours per month regardless of the number of hours actually worked by the employee, whereas the actual wage is used in the W-2 method. The FPL safe harbor is the easiest from a computational standpoint. Based on the 2014 FPL of $11,670 for an individual, the maximum employee contribution would be $92.38. This method typically provides the lowest threshold amount for most employers.

Table 1a

Penalty A

2015 Penalty per Month	2016 Penalty per Month
$2,084 / 12 * (# of FTs – 80)	$2,084 / 12 * (# of FTs – 30) with indexed penalty amounts for 2016

It is important that employers understand and proactively plan for compliance with affordability provisions. We are presenting below the employer penalty under three different scenarios.

Scenario 1—Employer does not offer health insurance to at least 70 percent/95 percent of its employees

If the employer does not offer health insurance coverage to at least 70 percent (95 percent in 2016) of its FT workers and their dependent children, and if at least one FT employee receives a premium tax credit or cost-sharing subsidy in the marketplace, then the employer is subject to a penalty as shown in Table 1a.

Transitional relief is provided in 2015 by:

- Decreasing the coverage requirements to 70 percent (instead of 95 percent in 2016) of the FT workforce; and
- Subtracting 80 FT employees for 2015 instead of 30 FT employees in the penalty computation.

It is important to note that the actual penalty is calculated based on the count of FT employees, but the employer size is determined by taking into consideration FTEs as well.

Assuming the penalty amount of $2,084 will be the same in 2016, an employer with 200 average employees under this scenario will pay an annual penalty of $250,080 in 2015 and $354,280 in 2016.

Scenario 2—Employer offers health insurance to at least 70 percent/95 percent of its employees, but does not meet MV standards

This scenario is the case when an employer offers health insurance coverage to at least 70 percent (95 percent in 2016) of its FT workers and their dependent children, but does not offer MV coverage. Employees and their dependents can opt to buy coverage in the individual marketplace and can apply for premium tax credit and cost-sharing subsidies. If at least one FT employee receives a premium tax credit or a cost-sharing subsidy in the marketplace, then the employer is subject to the minimum of Penalty B and Penalty A (defined above).

In most cases, Penalty B will be less than Penalty A as it is paid only on those employees who receive a premium tax credit or a cost-sharing subsidy.

Table 1b

Penalty B

2015 Penalty per Month	2016 Penalty per Month
$3,126/ 12 * (# of FT employees receiving a premium tax credit or cost-sharing subsidy)	Similar to 2015, but penalty amount will be indexed by increase in health insurance premium

Scenario 3—Employer offers at least MV health insurance to at least 70 percent/95 percent of its employees, but not affordable coverage

This scenario is the case when the employer offers MV health insurance coverage to at least 70 percent (95 percent in 2016) of its FT workers and their dependent children, but the coverage is not "affordable" (as defined earlier) for its FT employees. If at least one FT employee receives a premium tax credit or cost-sharing subsidy in the federal or state marketplace, then the employer is subject to the minimum of Penalty B and Penalty A (defined in Tables 1a and 1b.)

SMALL EMPLOYER PERSPECTIVE

While not subject to shared responsibility provisions like large employers, the ACA did have an impact on small employers. Small employers with fewer than 50 employees could simply choose not to provide insurance at all and rely on their employees to purchase their own coverage in the individual marketplace.

Some mid-size employers have reduced the size of their workforce to fewer than 50 employees and/or converted their FT positions to part time to give themselves additional flexibility in determining their health care benefit packages or to reduce their potential penalties for failing to provide health coverage. Regardless of whether small group employers choose to either maintain the health coverage they offered prior to the passage of ACA or choose to provide their employees coverage in the post-ACA marketplace, they need to have a thorough understanding of their

CONTINUED ON PAGE 46

options. For example, insurance purchased after 2014 must comply fully with ACA-mandated provisions such as guaranteed issue, essential health benefits and revised rating rules. The enactment of the ACA has also provided incentives to encourage small employers to begin and/or continue offering health coverage to their employees. These incentives include tax credits and the creation of the Small Business Health Options Program (SHOP) for the small group market.

Tax Credit Incentives

One provision of the ACA is designed to incentivize certain qualifying small employers to offer health insurance coverage to their employees. These tax incentives are available if an employer:

1. Has fewer than 25 FTE employees;
2. Pays an average annual wage below $50,000;
3. Pays at least half of the cost of its employees' health insurance; and
4. Purchases coverage on the SHOP exchange as of 2014.

For years 2010 to 2013, the maximum credit was 35 percent of premiums paid by small employers for insurance coverage (25 percent max credit for small tax-exempt employers). This percentage varied on a sliding scale depending on the number of employees and the average annual wage.

For years 2014 and later, the maximum tax credit increases from 35 percent to 50 percent for qualifying small employers (from 25 percent to 35 percent for qualifying tax-exempt employers) and is available for two consecutive years.

Since the primary goal of ACA reform was to increase insurance coverage to the uninsured, these tax incentives were included to encourage small employers with a low-income workforce to provide health insurance coverage. According to GAO report,[5] fewer small employers claimed the tax credit in tax year 2010 than were estimated to be eligible. Of the estimated 1.4 million to 4 million eligible small employers, only 170,300 employers claimed the tax credit, totaling $468 million in 2010. The GAO report noted that small business representatives and tax preparer groups indicated that the credit was not large enough to incentivize employers to begin offering health insurance, and complex rules coupled with the time needed to calculate the credit often deterred claims. As per HHS,[6] more than $1.5 billion in credits have been provided to small businesses since the tax credit first became available in 2010. It is important for small businesses to understand this incentive is available when deciding on their employee health benefit packages.

Grandfathered and Grandmothered Group Health Plans

The ACA allowed small businesses the opportunity to continue offering grandfathered plans. Plans are grandfathered if they were purchased before March 23, 2010 and did not make major changes to the plan design and coverage (e.g., cutting benefits, increasing cost sharing significantly, etc.). Maintaining a grandfathered plan allowed a small employer to avoid some ACA requirements (e.g., covering essential health benefits, not requiring coverage of preventive services without cost sharing, etc.).

In addition, there are grandmothered or transitional plans that are not grandfathered but were effective prior to Jan. 1, 2014. In late 2013, HHS announced a transitional relief program wherein states and health insurers could allow such non-ACA-compliant individual and small group policies to renew at the end of 2013. These plans do have to comply with some of the provisions of ACA (e.g., no annual limits on coverage, mandatory preventive care coverage without cost sharing, coverage for dependents until age 26). In March 2014, HHS extended transitional relief, allowing these grandmothered plans to renew up to Oct. 1, 2016 in states that allowed them.

Even though employers and individuals have been given transitional relief via grandfathered and grandmothered alternatives, it is expected that the majority of health coverage will eventually be fully compliant with the ACA. It's important for employers to fully understand the impact these reforms will have on the plans they currently offer as well as be cognizant of what will be available once the transitional periods end.

Small Business Health Options Program (SHOP)

One of the primary impacts the ACA has had on small employers is the creation of SHOP exchanges—online marketplaces for small employers with fewer than 50 FT employees. Starting for plan year 2016, the SHOP exchanges will be opened to employers with 100 or fewer FT employees. Starting in 2017, states have the option to allow employers with more than 100 employees to buy large group coverage through SHOP.

The main purpose of these SHOP exchanges is to give small employers a convenient way of reviewing multiple plan options offered by different insurance companies. An additional goal was to reduce costs by pooling similar risks in the development of the rates as well as to reduce administrative costs. It is too early to tell if SHOP exchanges will impact the small employer market significantly, but employers should realize that this marketplace is available to them.

CADILLAC TAX—THE TAX AHEAD!

Another provision of the ACA that has yet to take effect is an excise tax on high-cost employer-sponsored health coverage. This upcoming tax, commonly referred to as the "Cadillac tax," is scheduled to begin in 2018 and will potentially affect employers of all sizes who offer health coverage to their employees.

The stated purpose of this new tax is to generate $80 billion in new tax revenue to assist the federal government in covering the costs of health care reform.

Another purpose is to slow down rising medical cost trends the insurance industry has faced for many years by encouraging employers to reduce rich "low-cost-sharing" plan designs and to reduce utilization of health care services.

The Cadillac tax is a 40 percent tax on the total value of the medical benefits in excess of an annual dollar limit set by the ACA. The amount used in determining the tax is the total costs of the medical benefits for both current and former employees regardless of whether the costs are paid by the employer or the employee. This also includes FSA & HSA contributions.

The annual limits are currently set at $10,200 for self-only coverage and $27,500 for family coverage and are subject to certain adjustments. The adjustments account for health inflation, age and gender characteristics of participants, and the presence of qualified retirees and high-risk professionals. A brief description of the adjustments included in Section 4980I is below:

- **Health cost adjustment:** There is a one-time "catchup" adjustment to the annual dollar limits set in 2010 in the event the cost of health insurance increases more than originally expected. If the cost for providing coverage per employee in 2018 under the Blue Cross/Blue Shield (BCBS) standard benefit option for Federal Employees Health Benefits Plan (FEHBP) increases by more than 55 percent compared to 2010, then the excess is the adjustment amount. For 2019, the annual limit is tied to the consumer price index (CPI) plus 1 percent. For 2020 and beyond, the annual limit is tied to CPI alone.
- **Age and gender:** There is an adjustment to compensate employers that have high-cost coverage that is a result of the demographic profile of their employees. This adjustment is also calculated using the BCBS standard benefit option. It is based on the difference between the premium of the FEHBP standard option priced for the age and gender mix of the employer compared to the premium if nationwide averages were used for age and gender characteristics.
- **Retirees and high-risk professions:** There is an adjustment to allow for higher limits if employers have high-cost coverage that is a result of covering qualified retirees or as a result of covering high-risk professions (e.g., law enforcement, fire professionals, mining, etc.). The adjustment allows for the dollar limit to be increased by $1,650 for self-only and $3,450 for other coverage.

To illustrate, a simple scenario to demonstrate the potential tax liability facing a small employer in 2018 is included in Table 2. This example is for an employer with 40 employees and has only employee only or family coverage. We have assumed a 6 percent trend assumption starting in 2014 and that none of the potential adjustments described above were required.

Table 2

Small Employer with 40 Employees

Tier	EE Count	2014 Annual Premium	Assumed Annual Trend	2018 Annual Premium	Annual Limit	Amount Subject to Tax per EE	Excise Tax Rate	2018 Estimated Tax
EE Only	15	$10,000	6.0%	$12,625	$10,200	$2,425	40%	$14,549
Family	25	$27,500	6.0%	$34,718	$27,500	$7,218	40%	$72,181
							Estimated Total Tax	$86,730

Even though it's commonly assumed this tax will affect only rich plan designs, it's easy to see how this could ultimately affect even less rich plans due to medical inflation that has been rising faster than the CPI (which the annual limits are tied to). It is important that employers of all sizes understand and proactively plan for this potentially new tax provision.

PRIVATE EXCHANGE MARKET

An alternative that some employers are utilizing is the so-called "private exchanges." These exchanges are unrelated to the publicly funded marketplaces promulgated by the ACA. These private exchanges do not provide premium subsidies or standardized coverage tiers. The Kaiser Family Foundation's September 2014 report[7] estimates enrollment of 2.5 million subscribers in the private exchanges in 2014. Kaiser's 2014 Employer Health Benefit Survey estimated market penetration of private exchanges to be approximately 2 percent of large employers. Kaiser's report estimates that 20 to 33 percent of employers will adopt a private exchange approach over the next three to five years. Given that the value proposition of private exchanges includes the flexibility to design benefit tiers specific to employer segments and freeing the employer from administrative burdens associated with annual enrollment and ongoing tasks, we assess that private exchanges are very likely to have increasing enrollment in the years ahead.

CONTINUED ON PAGE 48

ANNUAL REPORTING REQUIREMENTS—TRANSITIONAL RELIEF AND WHAT LIES AHEAD

The enactment of the ACA increased many employers' annual reporting responsibilities, particularly to the IRS. Some of these reporting requirements have already been implemented. The ACA requires employers to report the aggregate cost of employer-sponsored group health plan coverage on their employees' W-2 forms. Beginning in 2012, the IRS made this reporting requirement mandatory for large employers. There are other reporting requirements that have already taken effect. We would like to draw focus primarily on new requirements for 2015.

Code Sections 6055 and 6056

Starting in February 2016, all applicable large employers (ALEs) are required to report to the IRS significant health coverage information based on calendar year 2015.

The ACA requires ALEs to file information returns with the IRS and also provide statements to their FT employees about the health coverage the employer offered or to show the employer did not offer coverage. Similar to the delay in the employer shared responsibility mandate, the implementation of the temporary transitional relief period postponed the enforcement of most reporting provisions until 2016. While information reporting was voluntary for calendar year 2014, we assess that it is unlikely that many employers were ready to file the IRS forms in February 2015 as the final forms and instructions were made available only recently.

To prepare for 2016, ALEs need to have processes in place to track 2015 information monthly. This includes whether FT employees and their dependents were offered minimum essential coverage that meets the MV requirements and affordability requirements. It is important for employers to review the IRS forms 1094-B, 1095-B, 1094-C and 1095-C and to ensure that they are on track for information reporting on all forms applicable to them. It is very possible that there will be additional revisions and clarifications to the published IRS form instructions. ALEs should keep abreast of these requirements in order to be able submit these forms that are due by February 28 (if filing on paper) or March 31 (if filing electronically) of the year following the calendar year.

The reported information will be used by the IRS to determine if a premium tax credit is available to the employees as well as to determine the penalty if the employer does not provide minimum essential coverage.

Employers who fail to file timely, correct information returns to either the IRS or the employee are subject to significant penalties. We refer the readers to section 6055 of the IRS code for further guidance on the information reporting requirements, applicable filing methods and possible penalties for compliance failures.

CONCLUSIONS

The ACA's impact on employers will vary based on the size and structure of the employers' workforce. There is no one-size-fits-all solution that best fits all employers in their efforts to comply with ACA. With the employer mandate taking effect in 2015 for large employers, the impact on large employers will gain traction in the forthcoming months. While additional provisions of the ACA, such as the Cadillac tax, will take effect in 2018, it remains to be seen how benefit plans offered by employers will be transformed in the years ahead. Additionally, in light of new reporting requirements, it is imperative that employers are proactive in developing a compliance strategy for what lies ahead. ■

ENDNOTES

1. *http://www.treasury.gov/press-center/press-releases/Documents/Fact%20Sheet%20021014.pdf*
2. "Health Insurance Coverage in the United States: 2013," September 2014, *http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf.*
3. "The Affordable Care Act and Small Business: Economic Issues," Jan. 15, 2015.
4. *http://www.gpo.gov/fdsys/pkg/FR-2014-02-12/pdf/2014-03082.pdf.*
5. "Small Employer Health Tax Credit—Factors Contributing to Low Use and Complexity," May 2012, *http://www.gao.gov/assets/600/590832.pdf.*
6. "An Update on the Small Business Health Options Program: Is It Working for Small Businesses?" Sept. 18, 2014, *http://www.hhs.gov/asl/testify/2014/09/t20140918a.html.*
7. "Examining Private Exchanges in the Employer-Sponsored Insurance Market," *http://files.kff.org/attachment/examining-private-exchanges-in-the-employer-sponsored-insurance-market-report.*

Sujaritha Tansen, ASA, MAAA, is an associate actuary at Lewis & Ellis in Allen, Texas. She can be reached at *rtansen@lewisellis.com.*

Brian Stentz, ASA, MAAA, is an assistant vice president at Lewis & Ellis in Allen, Texas. He can be reached at *bstentz@lewisellis.com.*