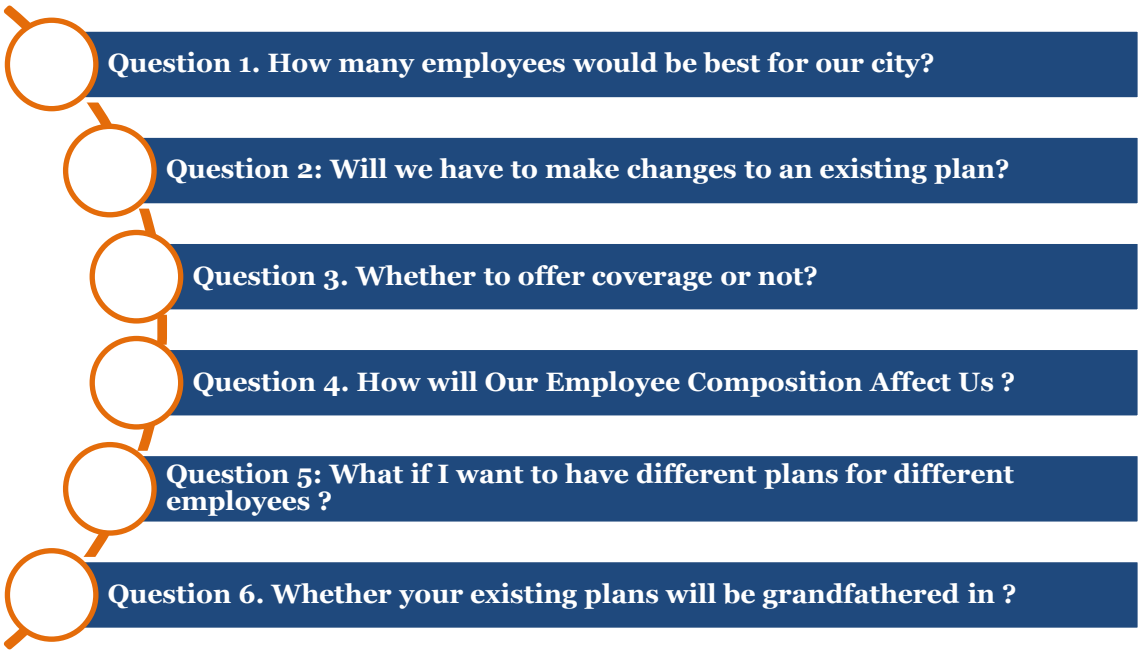
Health Reform Road Map for Cities and Villages

By Josh Brown, Esq.

Municipal officials should currently be discussing how to comply with the Patient Protection and Affordable Care Act (ACA). The Internal Revenue Service (IRS) has specifically noted that it applies to government entities and that there are no governmental plan exemptions. I strongly suggest getting to know this bill—fines could range in the tens of thousands of dollars and there is a possibility that officials could be personally liable for non-compliance. This essay will only discuss the sections of the ACA that effect employers, particularly municipalities. To put it mildly, this law will require substantial and expensive planning. This article will give you an unbiased heads-up about several issues you are likely to face.

To begin with, I have identified 6 questions below that I think you should be researching currently:



This essay is not intended to be a thorough discussion of the ACA. Rather, it is intended to be a road map of some issues you should study before you approach your lawyers, insurance agents, and accountants about fiscal planning. In the end, I have included a list of references at the end for more in-depth analysis.

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This is a working paper, available at www.omlohio.org . To help improve this paper, we need your input. Please send your feedback and questions to jbrown@omlohio.org .

Question 1. How many employees would be best for our city?

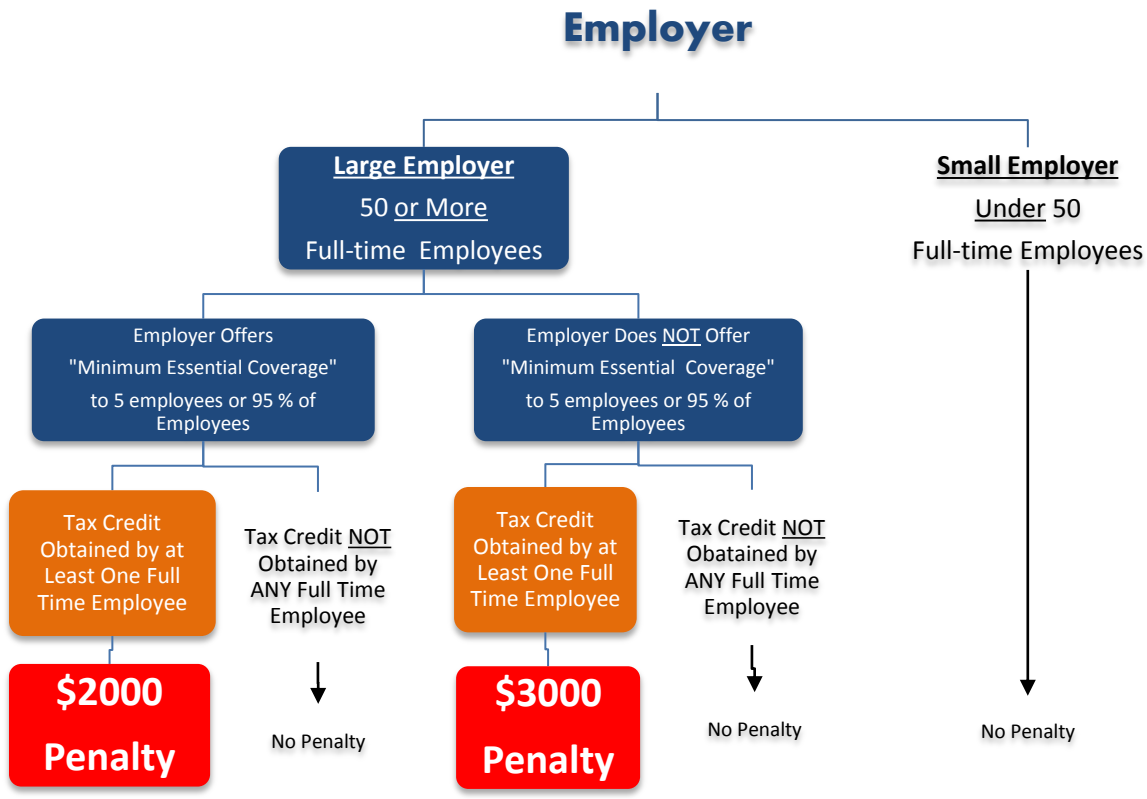
Under the ACA, only "large employers" are subject to penalties for non-compliance. A "large employer" is one whose workforce exceeds 50 full-time employees for 120 days or more during the calendar year. "Small employers" are those that fall under that mark. Employers are not required to provide coverage to part-time employees. Seasonal workers are not counted in this total until they work 120 days. I define these terms later in this essay.

Note: *These employee counts are under the IRS rules. Do not confuse this count with HHS's employee counting rules for purposes of the health exchanges, discussed below.*

If any employer does not provide sufficient coverage, their employees will be eligible to obtain a "health care premium tax credit" to use to get their own insurance on the exchanges, which I discuss below.

- ➔ Small employers will never have to pay any penalty.
- ➔ For large employers, the penalties kick in when any employee obtains the premium tax credit (whether the employer provides coverage or not). See **Figure 1** for illustration.

Figure 1



It appears that the penalty is not based on eligibility for the tax credit, but whether the employee actually *obtained* it or not. The tax credit may be obtainable by an employee for any one of four reasons:

Reason 1: the employer did not offer coverage to that employee;
Reason 2: the offered plan did not provide "minimum essential coverage;"
Reason 3: the offered plan did not provide "minimum value;"
Reason 4: the offered coverage was "unaffordable" to the employee.

Expanding on the first reason, the penalty for not offering coverage at all is discussed below under Question 3. On the second and third reasons, the coverage requirements to meet "minimum value" and "minimum essential coverage" are discussed below under Question 2. As for the fourth reason, under the ACA, employer-sponsored coverage is "unaffordable" if the employee's share of the premium exceeds 9.5% of the employee's total household income.

There are two currently unresolved problems regarding the fourth reason (determining unaffordability). First, employers have no way of knowing their employee's household income—although, this may be resolved because the IRS has indicated that employers could simply use an employee's W-2 form instead. However, W2 income cannot always be known until the end of the current plan year—so the IRS also has proposed allowing employers to base income on the employee's rate of pay or by simply substituting the federal poverty line for the employee's pay.

Second, it is not clear whether the 9.5% threshold applies to individual health plans or family plans—which is a big difference because a family plan averages three to four times the premium cost. The federal Health and Human Services Department (HHS) and the IRS have offered currently pending rules that would define unaffordable coverage as a health insurance plan where premium costs exceed 9.5% of individual coverage only—not family coverage. For more details, see: http://www.irs.gov/pub/irs-drop/n-12-58.pdf .

Here are a few other issues to look out for in the area of employment levels:

- Be careful of trying to move below the 50 employee threshold—the final regulation will include an "anti-abuse" rule to prohibit some evasive efforts. However, expect some flexibility to minimize or avoid penalties in the rules that will come out over time.
- Also, understand that this essay does not consider other, non-legal factors, such as employee and public relations.
- There is no indication that members of the municipality's legislative body or executive staff are excluded from the count. If you are close to the employee threshold, consider cutting council meetings short to keep those members part-time.

Counting Employees

Section 1. Who is Considered Full-Time?

Under the IRS employee-counting rules created under the ACA, employee counts are required on a monthly basis. Under these counts, 30 hours a week or 130 hours a month is considered full-time—and must be calculated on a "reasonable and consistent basis."

Also be aware that the definition of "full-time employees" (FTE) includes a formula that determines when the hours of part-time or seasonal workers create "full-time equivalent employees" (FTEE's) and will count toward your full-time total. How this basically works is this: take your part-time employees, and add their hours for the month in question. Then divide that number by 120—the result is your FTE total for that month. IRS issues guidance on the rules that govern this formula
(see page 9 of this document for details: http://www.irs.gov/pub/irs-drop/n-11-36.pdf).

For your first employee count, the regulations provide a transitional plan. You may use the any consecutive 6 month period of 2013 for your first

employee counts, to establish whether you are an applicable large employer for 2014.

Section 2. Should Employees of Various Divisions be Included?

Currently, the answer to the question of this section is that we do not know yet. When counting employees, under the ACA, employers must count all employees that fall under a single "control group." Many employers exercise some type of control over several entities such as jointly-controlled agencies, non-profit partners, special commissions, water and sewer districts, or joint economic districts. However, employers are not sure which entities' are considered part of the control group, for purposes of counting employees. The IRS is aware of this issue and should eventually issue regulations to clarify it.

The general rule is that all employers under a single "control group" will be considered a single employer, for purposes of counting employees. However, even though the IRS will look at every entity within the control group as a single employer, the IRS will levy penalties on a "company-by-company" basis. What does company-by-company mean for a public employer? As a public entity, you may be confused, because this is private sector language. This is part of the problem—in the case of municipalities, the IRS will have to adopt private sector laws to public sector institutions. The IRS says that their rules on this will be "consistent with longstanding standards," arising from statutes many private sector employers will be familiar with: 26 USC § 414 and § 1563(a).

So how will the IRS adopt these standards to public employers? I do not know, but here is what I do know. The term "control group" is misleading (something that is common in the realm of administrative regulations). The IRS and Treasury rules really focus on common ownership, rather than the exercise of control. Sometimes a person or entity will own an organization, but not exercise much (if any) control over it. For example, institutions may have a parent-subsidiary relationship, a brother/sister relationship, or ownership may be governed by a complicated array of stock-types. Either way, the government thus decided to concentrate on ownership in applying these standards.

I plan to do a full update on this subject. Until then, the IRS explains control groups here: http://www.irs.gov/pub/irs-tege/epchd704.pdf .

Section 3. Counting Hours

Again, 30 hours a week or 130 hours a month is full-time. Keep in mind that the counting of part-time employees is used both for 1) determining if the employer is a "large" employer, and 2) to determine if the part-time employee will qualify for health insurance.

Hours worked outside the U.S. do not count. However, all hours of paid leave do count. All hours worked under the "controlled group" do count—regardless of whether those hours are in different "businesses" (control groups are explained in preceding section).

This 30/130 hour standard is relatively flexible for various employee scenarios. There are three hours-counting methods available for non-hourly employees, which include flexibility provisions and abuse protections:

Methods:

1. actual hours worked;
2. days worked (where at least an hour of work during a day counts as 8 hours toward the total); and
3. weeks worked (where at least an hour of work during a week counts 40 hours toward the total).

Flexibility Provisions: You may create classifications of employees, and use different methods of counting hours for each class, as long as your classifications are reasonably and consistently applied. You can change those classifications and methods each calendar year. One example of a situation where you may see this arise is where an employee's hours are subject to safety-related limits (such as an airplane pilot).

Again, you are looking for: 1) reasonableness and 2) consistency. It is "reasonable" that your classifications used for counting hours for a pilot

may be different from those of a clerk because pilots are frequently grounded due to safety concerns. The problem arises here when your classifications or applications of them are arbitrary or a pretext for avoiding the law's requirements. For example, you probably could not classify female clerks from male clerks, and count their hours differently under the theory that female clerks spend more time handling personal emergencies. This would be an unreasonable application of a classification and would be especially troublesome if the classification changed the application of the ACA or other laws toward your institution.

Your application of this designation is "consistent" as long as all clerks and all pilots are designated similarly. The designations of different employees do not have to be consistent with each other, only among each designation. For example, what is defined as a safety exception for a pilot has to be applied to all pilots, but not necessarily the clerk.

Abuse Protections: Your calculations must generally reflect paid hours actually worked and cannot be used to understate an employee's hours worked, for the purpose of moving that employee below the 30 hour threshold. In other words, if an employee works 30 or more hours a week, these methods must result in the employee being considered full-time.
Note: *You do not have to apply the 30 hour-a-week standard to other employee benefits. For example, you can continue to apply different definitions of "full-time" for purposes of eligibility to participate in your employee benefit plans, including group health plans.*

*Section 4: Administration of Employee Counting (See **Figure 2** for illustration)*

Employers will have up to a 90-day "administrative period" (AP) to determine whether part-time, variable-hour, or seasonal employees are full-time employees. In addition to the 90 days, if you get into a time crunch, the guidance also grants employers a "safe harbor" provision—which is an extended "look back period," of between 3 and 12 months, where you can determine who is full-time without being subject to a penalty. For details, see: http://www.irs.gov/pub/irs-drop/n-12-58.pdf .

To administer your safe harbor, you may, but are not required to, use a framework that incorporates: 1) a standard measurement period or initial measurement period (SMP or IMP), 2) an administrative period (AP), and 3) a stability period (SP). **Figure 2** helps illustrate these terms.

This framework involving three periods of time is often described more complicatedly than it needs to be. Basically it works like this:

- During the SMP or IMP the employee works, thereby establishing a work schedule that the employer can look at.
- Then during the AP, the employer has time to make a determination as to whether the employee is full or part-time, notify and enroll them if they are eligible for the plan, answer questions, and collect materials.
- Once that determination is made the SP is the period that follows, where (generally speaking) that employee's status stays the same.

Your job as an employer will be to decide how long each of these three periods will be, within the rules. There can be no gaps between the periods. The rules are designed so that you can use a yearly basis or some other basis, such as a payroll period.

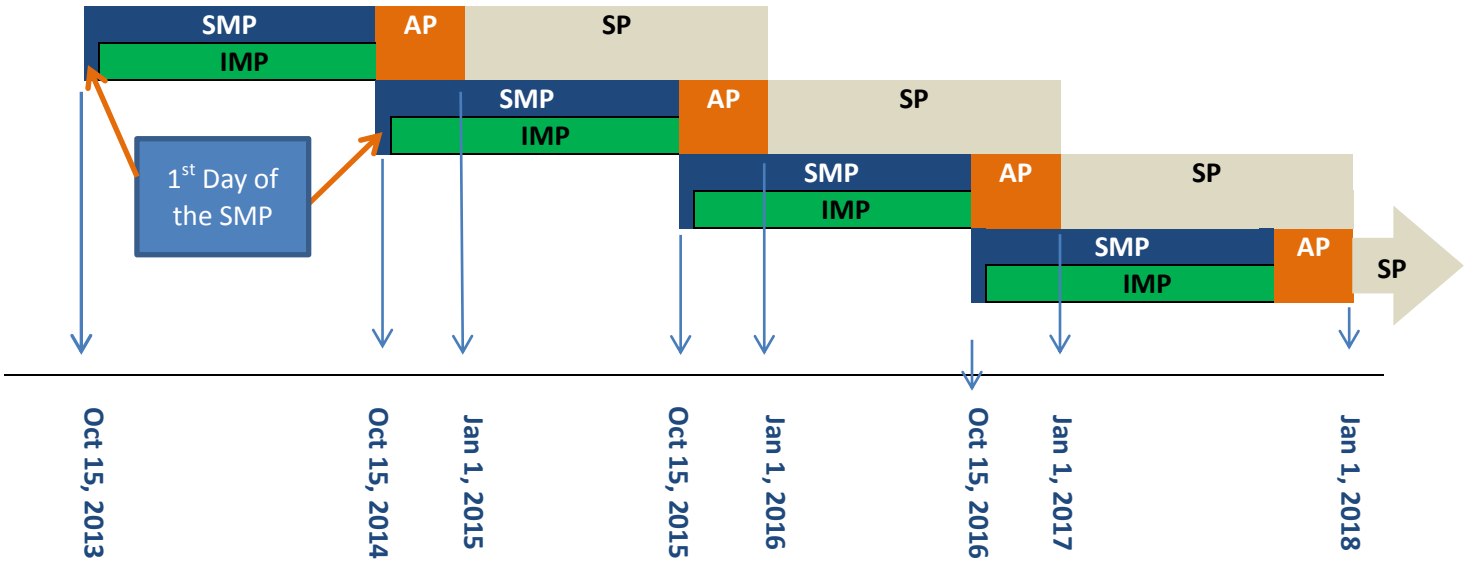
As you begin to understand these rules, you will see that—if you want to be on a calendar-year scheme like the one in **Figure 2**—you have to begin that plan in 2013, before the regulations kick in. The regulations provide for a one-time-only measurement period to begin the cycle, but only for that first cycle. That unique measurement period must be 6-12 months and begin after July 1, 2013 and end between October 31, 2013 and January 1, 2014.

For certain types of employees, the SMP and SP lengths you choose may vary with different starting dates between these groups of employees: collective bargaining / non-collective bargaining employees, hourly / salaried employees, employees in different bargaining units, and employees in different states. The specific rules governing these periods vary, depending on whether you are looking at ongoing employees,

new employees, or variable hour / seasonal employees.

Figure 2

Look-Back Process Sample Timeline:



SMP
1. Standard Measurement Period

- Must be 3 - 12 consecutive months
- Applies to ongoing employees
- During this time, the employee is working and thereby establishing his full or part-time employment status

IMP
Initial Measurement Period

- For new employees (i.e., not employed on the first day of the SMP)
- For variable hour and seasonal employees

AP
2. Administrative Period

- Permitted for up to 3 months
- During this time the employer determines which employees worked full-time during the SMP, notifies and enrolls them if they are eligible for the plan for the next SP, answers questions, and collects materials.

SP
3. Stability Period

For a Full-Time Employee (as established during the SMP)

- For this employee, the SP must be at least the longer of 6 months or the length of the SMP

For a Non-Full-Time Employee (as established during the SMP)

- For this employee, the SP cannot exceed the length of the SMP

During this time, the employee's status must be the same as it was during the SMP as long as he remains employed, regardless of hours worked during this period.

On page 7 of the IRS rules (see http://www.irs.gov/pub/irs-drop/n-12-58.pdf**) the IRS uses an example to illustrate how the rules work. Figure 3 above is based on that IRS example. In this example, the employer is seeking to base his system on a calendar year. To do this, he chooses to: 1) set his first Standard Measurement Period (SMP) from October 15 (2013) to October 14 (2014), 2) set his first Administrative Period (AP) from October 15 (2014) to Dec 31 (2014), and 3) set his first Stability Period from January 1 (2015) to December 31 (2015). These dates will remain the same every year. Only an ongoing employee who works full-time during the SMP is offered coverage during the SP that is associated with that SMP.**

Ongoing Employees

An ongoing employee is one that has been employed for longer than one complete Standard Measurement Period (SMP). Their treatment depends on whether they were working at least 30 hours per week during the SMP:

- ➔ If yes, then they must be offered coverage during the subsequent Stability Period.
- ➔ If no, then you have an option as to whether to provide coverage during the subsequent Stability Period.

New Employees

A new employee is someone who was not working for the employer on the first day of the SMP. At first, this employee will initially go into an "Initial Measurement Period," (IMP) and later integrate into the SMP on the next cycle.

For this new employee, first ask if the person is reasonably expected to work 30 hours a week. To determine this, look at factors such as the person who previously held that job and at other employees in comparable positions.

- ➔ If yes, then the government will require you to offer coverage within 3 months or pay a penalty. Seasonal employees are in a different category altogether.
- ➔ If not, then look at whether the person is seasonal or variable hour (see below).

Variable Hour and Seasonal Employees

Variable Hour Employees can include situations where an employee's hours are expected to change, but they are not seasonal or temporary. Seasonal employees are those who perform at certain seasons of the year, and are not continuous in nature (the IRS is respecting "good faith" determinations of this through at least 2014). "Temporary" includes those employed for a particular piece of work, usually of short duration. Neither definition includes supervisory employees. For details, see: Labor Regulations Section 500.20(s)(1).

For these types of employees, you have a choice to use different IMP timelines which will run concurrently with those of other types of employees. If you use this different timeline, you will not be subject to penalties during that employee's IMP or AP.

Here's how it works. You should already have a system in place for ongoing employees. Concurrent to it, for variable hour, seasonal, and temporary employees, you will administer the program by selecting an IMP of 3 – 12 months and an AP of up to 3 months. The IMP must begin after the first hour worked. Combined, the two periods must be shorter than 14 months (13 plus a fraction of a month). The employee's first stability period (SP) comes at the end of these time periods.

- ➔ If the employee works full-time during the IMP, then they must be treated as full-time during the SP or at least 6 months.
- ➔ If the employee does not work full-time during the IMP, then they do not have to be treated as full-time during the SP or for at least 6 months.

Recall that I said your two systems will run "concurrently." As you track the employee's hours during the IMP, you must also track his hours during the SMP system that applies to ongoing employees. Variable and seasonal employees may become ongoing employees if they are considered full-time during the SMP—meaning they would then have to be treated as full-time during the company's SP for ongoing employees. However, even if they are not full-time during the company's SMP, they could still be considered full-time for hours worked during their unique IMP.

Question 2: Will we have to make changes to an existing plan?

You will want to do a side-by-side comparison with your plan and the ACA's requirements. Understanding this will be particularly important with large group and self-insured plans because they are the most likely to need adjustments.

Requirements on group health plans:

- Cannot exclude coverage for preexisting conditions of children under 19 years old.
- Cannot rescind coverage when an individual files a claim, unless there is fraud or intentional misrepresentation.
- must pay for preventive health services, without applying the employee's deductible.
- Must offer "minimum essential coverage" (discussed in more detail below).
- Must cover dependents up to the age of 26, unless the plan is grandfathered and the dependents are not eligible for their own employer plan (Ohio already requires coverage for dependents up to the age of 28). A "dependent" is only defined as a "child" up to the age of 26. Factors such as financial dependency, residency, student status, employment, or marital status are not considered. Spouses are not mentioned in the definition, so presumably, they cannot be dependents under the ACA.
    - The regulations provide a transitional plan for implementing dependent coverage for those who do not have it. If the employer takes steps during its plan year beginning in 2014 to offer coverage to dependents, then it will not have to pay penalties, solely because it failed to offer coverage for dependents during that first plan year. This only applies to that first plan year.

Minimum Essential Coverage

This phrase is currently undefined as it relates to the employer mandate and the rules are currently being written. However, it is defined in terms of the individual mandate in another section of law.

Note: be sure to distinguish between "minimum essential coverage" and "essential health benefits package," which is only applicable to certain health plans.

If a large employer does not offer this minimum essential coverage to its full-time employees (and their dependents) the employer will be subject to a monthly penalty if any full-time employee receives a tax credit to get coverage on an HIX or SHOP. See **Question 3** for more about the HIX.

According to HHS, 98% of existing plans are sufficient. State and Federal laws (such as HIPAA) already include much of the provisions in the ACA, so large group plans are probably already largely in compliance. In fact, the ACA actually defines essential benefits as being those covered under the typical employer plan. As of this writing, we know that minimum essential coverage includes the following: TRICARE, Medicaid, Medicare Part A and B, COBRA, Refugee medical assistance supported by the Administration for Children and Families, AmeriCorps Coverage, and CHIP.

Employers can apply to the Treasury Department to have their plans recognized as minimum essential coverage. Although the Department has designated employer-sponsored plans as eligible, employment-*based* coverage is not recognized as minimum essential coverage. Specialized coverage, such as dental, workers compensation, or vision care, will not be considered sufficient to meet the standard.

When making changes to existing plans…

- Recall that issues related to grandfathering of plans and nondiscrimination are discussed herein.
- Material coverage changes will require the employer to give 60-day notice.

- Beyond this notice, the ACA also requires implementation of an appeals review process, in case any employee wants to challenge the changes that you make. This process basically expands the existing IRS claims procedure, increases the internal review rules, and adds a non-judicial external review step.

Minimum Value

Be sure to distinguish between "minimum essential coverage" and "minimum value" (I have seen this mistake before, even in professional literature). Both are required to avoid a penalty. To comply with minimum value, the actuarial value of benefits must be at least 60% of a state-by-state benchmark (that does not exist yet). The IRS website promises that "a minimum value calculator will be made available by the IRS and HHS." Few details have been provided, although the IRS says it will "work like an actuarial value calculator."

Cost-Sharing Limitations*:* For coverage in the individual and small group market (see figure 2 above), the ACA imposes caps on deductibles and annual out-of-pocket costs. These caps will be adjusted every year (the 2014 caps are set and the long-term rules are currently being formulated).

To help mitigate the impact of these caps, I suggest using a "flexible spending account" (FSA). The ACA allows the caps to be increased if there is money "readily available," for reimbursement, and FSA's are allowed for this purpose.

Question 3. Whether to offer coverage or not?

The issue then becomes whether it makes sense to offer health insurance. This is a highly politically charged debate—but I will simply offer the mathematical analysis the best I can. Generally, I anticipate that employers might compare the costs of offering health coverage to the costs of paying penalties.

The Cost of Health Insurance

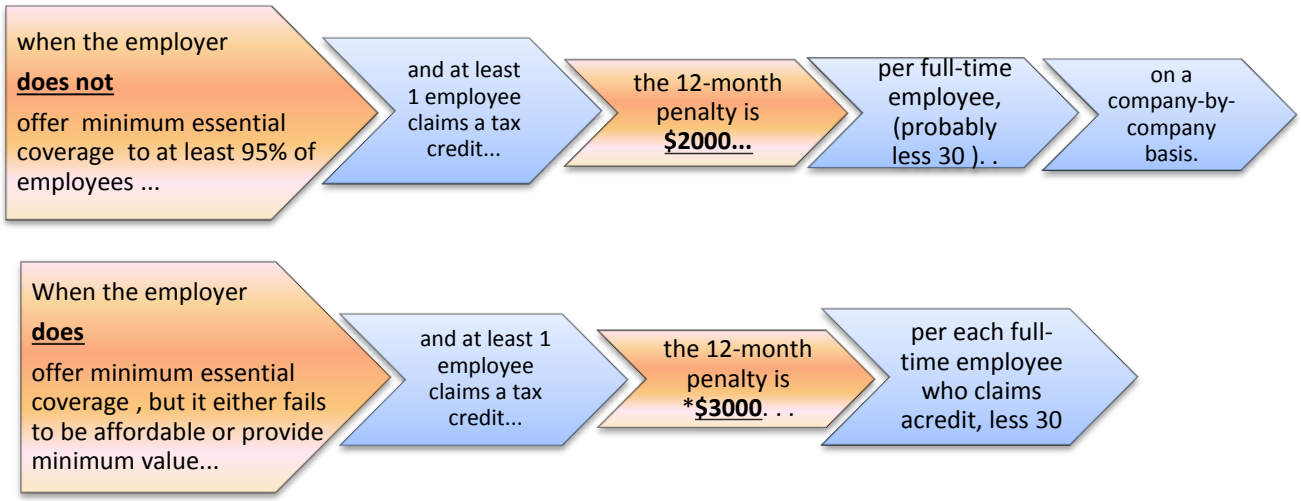
According to the Kaiser Family Foundation, "the average premium for single coverage in 2012 is $468 per month or $5,615 per year. The average premium for family coverage is $1,312 per month or $15,745 per year. (See http://ehbs.kff.org/?page=charts&id=1&sn=6&p=1).

This is obviously an over- simplification of the cost issue, but I introduce it as merely a starting point for this discussion.

The Cost of Penalties

A quick review: if you have over 50 employees, you have to pay a penalty if any employee is obtaining a health care tax credit but you do not have to pay a penalty if no employee is obtaining the tax credit. Next, you should consider that the exact penalty you face depends on whether you offer (to at least 95% of your employees): 1) affordable, 2) minimum essential coverage, 3) of minimum value. **Figure 3** below helps illustrate how the penalty works.

Figure 3: Here's how the tax penalty works:



*** The penalty is capped at the maximum penalty amount an employer would face if the employer did not offer any coverage at all (which is the case under the $2,000 penalty above).**

To ease your burden, you might consider negotiating an "indemnity clause" with your insurance company that would make them liable for the tax penalties incurred under the ACA.

You may have noticed that I listed the penalties as being "12-month penalties." This is because the penalty is imposed yearly. The full penalty above is not reached until you have been out of compliance for 12 months. If you are out of compliance, then the penalty is 1/12 of what you see above ($166.67 or $250 per month, respectively), multiplied by the number of months you are out of compliance—and imposed yearly. Consequently, penalties can be limited by fixing the compliance problem during the year. Further, considerations of whether to offer coverage or pay the penalty should be considered on the basis of the cost of monthly penalties.

Also be aware of the "substantial compliance" provision in the ACA. The IRS says it is looking for good faith efforts to comply and does not want to penalize inadvertent failures. The standard is considered met if the amount of employees not being offered coverage is under 5%, whether this happened intentionally or not. They will determine this on an employer-by-employer basis. I would suggest instituting some kind of oversight to be sure you comply here.

What Does It Mean to "Offer Coverage?"

The employee must have an effective opportunity to elect to either enroll or decline coverage at least once during the plan year. Any day that coverage is not being "offered" makes that whole month count toward the total. This is not black and white. Rather, the government will look for factors such as did the employee get adequate notice and an adequate period of time to accept, and what kinds of conditions were attached to the offer?

There are whistle-blower protections for employees who feel they were not given an adequate offer of coverage. Therefore, for declinations, I would strongly suggest consulting with an experienced lawyer to create a standardized form with the law clearly spelled out on it. Also, you should be prompt in getting the forms returned from employees.

Other Issues You May Hear Rumors About

One scary issue you should be aware of: the ACA says that the penalty falls on the "person" that failed to satisfy the mandate. It is not clear that individual officers or directors are not personally liable for these penalties. Presumably, the Treasury Department will issue regulations to clarify this.

Under the plain meaning of the language in the ACA, the penalties are only incurred when the employee obtains a tax credit for coverage on a state-exchange (exchanges are explained below). Ohio will not have a state exchange, only federal. So there is always a chance that there will be no penalties for any employer in Ohio. The Department of Treasury has said they will impose the fine anyway—but a Court will likely make the final decision as to whether Treasury will be required to adhere to the plain meaning of the text.

Question 4. How will Our Employee Composition Affect Us ?

Above, I discuss employer mandates, where the question was how many employees to maintain. Now, let's discuss community ratings mandates for insurance companies and the incentives they create, particularly regarding small employers. The question here is what employee characteristics the ACA will incentivize. Before I can explain employee composition issues, I have to familiarize you with the upcoming health insurance exchanges.

The Exchanges

The ACA provides that the states will set up health insurance exchanges (HIX) in their states, or the federal government will do it for them. These exchanges are intended to create an online marketplace for health insurance. The HIX's are required to set up a state-based Small Business Health Options Program (SHOP). This is a separate exchange—within the HIX—just for small businesses.

Small employers **(see Figure 4)** will be eligible to purchase coverage for employees, at a level of coverage the employer chooses, on the SHOP. To be "qualified," the employer must offer coverage to all its employees.

The enrollment period for the SHOP was supposed to begin in October of 2013, but has been delayed until October 2014 in the 34 states with federally-run exchanges (which includes Ohio). There has been some misinformation circulated about this point. *Employers* will be able to go on exchanges and have options in October of 2013. However, *employees* will not be able to do so until 2014—the employee choice provisions were delayed, not the employer choice. Till then, HHS says it will, "assist employers in choosing a single qualified health plan to offer their qualified employees."
(See: http://www.kaiserhealthnews.org/Daily-Reports/2013/April/02/health-reform-small-business-exchange.aspx).

Figure 4

Employee Counting on the SHOP

Prior to 2016, states will be allowed to define "small" employers as either 1-50 employees or 1-100 employees. This definition will affect which entities are eligible for the SHOP in each respective state. As of this writing, Ohio has not made its determination.

- Note that this is a different employee count than the employer mandate—SHOP's are governed under HHS employee counting rules, not IRS's rules.
- These HHS employee-counting rules do not distinguish between part-time and full-time employees.
- In 2017, the federal government will empower states to allow employers with over 100 employees on their HIX. Certain consequences of this will ultimately depend on where the state decides to draw the line between large and small employers. Ohio has not made this its rules on this yet.

It is expected that most small employers will not go on the exchanges at first, because their current plans will be grandfathered. According to the Kaiser Family Foundation, 72% of small businesses (defined as under 100 employees in this study) had at least one plan grandfathered under the ACA.
(See: http://ehbs.kff.org/pdf/2011/8225.pdf . I also include a discussion of grandfathering below).

So here is the situation for an employee of a small employer. Individuals have to get coverage under the individual mandate. Your employer is not penalized for failing to provide health insurance if it is under 50 employees (under IRS counting rules, discussed in detail above). The exchanges may be available to the employer, depending on

whether it is a small employer under HHS employee counting rules (see **Figure 4)**.

If your employer is under 25 employees, it will get subsidies to pay for your coverage, at least in the short term. If you were with a large employer, you would probably have good coverage and have to pay for only a limited part of it—employees who work for large employers have always benefited from being part of a big pool of people with similar risk-profiles.

But if you are in that small employer category—with over 25 employees—then you are in a unique situation. For insurers, this is a small group with hard to assess risk. The ACA attempts to sort this out. Below, I discuss how the ACA attempts to pool employees of small firms together, to create a similar effect to large company pools—and I show how it might affect different types of pools of employees.

So What About Employee Composition?

Let me preface this discussion by noting that there is a debate over whether the ACA will cause premiums to rise in the long-term. The Society of Actuaries predicted in 2013 that premiums will rise in most states, and Ohio was the second highest at an 80% expected increase. Recently, the Ohio Department of Insurance validated those claims. However, this is largely due to the fact that the Society had Ohio's current premiums at a relatively low rate—meaning that catching up with other state's premiums would produce a larger percentage increase. The CBO released a report in 2009 that predicted no increase in premiums. Both studies have come under scrutiny.

Speculation aside, in the 1990's seven states tried guaranteed issue and community ratings models similar to those mandated by the ACA. The results were that people with poorer health received more payouts and paid reduced premiums, while healthier people paid more.

So that takes us to today's ACA. The current underwriting practices of insurance companies serving small employers' plans must discontinue, or else they will not be listed on the HIX or SHOP. Instead, for insurers on the SHOP, the ACA first creates three common risk pools in each state: individual market, small employers market, and large employers market. For coverage offered in the individual and small market only, the ACA will impose "community rating" mandates on premiums. These limits will allow premium amounts to vary based solely on age, geography, and tobacco usage—and those variations only to a limited extent.

So what is the consequence of community rating mandates? Employers have more to gain if their employees tend to be older and/or less healthy. Currently, this group is probably paying very high premiums and is receiving high pay outs. For this group, under the ACA, payouts will probably increase as more coverage becomes more available. Also, the group will pay a lower premium because the insurance companies can no longer base premiums on health status/conditions.

It is the small employers with low-risk pools (i.e., younger, healthier employees) that have a tough decision here. For them, the requirements may be overly onerous and they may pay a higher premium, even though they require few payouts. If so, you might look at three considerations: 1) whether to offer employer coverage at all, 2) whether to add employees (because a large employer will not be subject to the community rating mandates), or 3) to consider self-insurance (possibly in a stop-loss plan which only covers major expenses).

The Self-Insurance Option

Self-insured plans are growing in popularity. Under a self-insured plan, the employer simply pays for its employee's medical expenses—sometimes through a third party administrator, sometimes out of their own general revenue.

I expand upon self-insurance in great detail here: http://omlohio.org/healthreform/Health%20Reform%20Road%20Map%20-%20Update%203%20-%20Self-Insurance.pdf

Question 5: What if I want to have different plans for different employees ?

The ACA has a "non-discrimination" section which attempts to forbid employers from offering different kinds of coverage to different classes of employees. By "classes," they mean you cannot classify employees with "pre-existing conditions" differently for insurance purposes.

Employers need to assess the legality of any premium differences between classes of employees. Here, the penalty for discrimination is an excise tax of $100 per-day, per affected participant for the duration of the violation.

Wellness Programs: Employers may provide incentives (such as discounts on premiums) to employees who participate in a wellness program. However, consistent with the nondiscrimination section, the incentive cannot be based on health-related status of the participant unless several requirements are met.

The ACA also increased previous wellness program incentives to 30% of the cost of coverage, allows for an administrative increase up to 50%, and may make your city eligible for certain grants (if you have fewer than 100 employees working 25 or more hours per week and did not provide a wellness program prior to March 23, 2010).

Question 6. Whether your existing plans will be grandfathered in ?

Grandfathered group health plans will be exempt from most aspects of the ACA. For example, they do not have to:

- offer "minimum essential health benefits" (which includes certain deductible caps);
- cover preventative services without cost-sharing;
- be subject to the rules regarding non-discrimination in favor of highly compensated individuals;
- report on their quality of care improvement activities;
- provide ACA appeal procedures (they still must provide those currently required under ERISA and state law);
- provide certain access to emergency, pediatric, obstetric, and gynecological services;
- cover the costs of routine clinical trials;
- be subject to prohibition of discriminating against providers based on their licensure status.

What you have to watch out for is making changes to a grandfathered plan. See **Figure 4** for a list of changes that will affect the grandfathered status of a plan.

Figure 4:

The following types of changes would cause your plan to lose its grandfathered status:	The following changes would not jeopardize grandfathered status:
• Elimination of all or substantially all benefits to diagnose or treat a particular condition. • Increase in a percentage cost-sharing requirement (e.g., raising an individual's coinsurance requirement from 20% to 25%) • Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points • Increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, $5 plus medical inflation) • Decrease in an employer's contribution rate towards the cost of coverage by more than 5 percentage points • Imposition of annual limits on the dollar value of all benefits below specified amounts • Changes in the insurance company • If the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan • If an employer transfers employees from one plan into another, for purposes of reducing benefits, and has no legitimate business reason for the transfer	• Enrolling new employees or their family members • Changing the plan to comply with state or federal law or to voluntarily comply with the ACA • Expanding or increasing the plan's benefits • Changing the third party administrator of a self-funded plan • Changing the plan pursuant to an amendment adopted before March 23, 2010 • Certain changes made between March 23, 2010 and June 17, 2010 may not jeopardize a plan's grandfathered status, even if they conflict with the ACA, as long as they were made in good faith • Non-federal retiree-only and excepted benefit plans are not subject to the ACA (HHS has urged the states to follow suit) • If the coverage is part of a collective bargaining agreement that was ratified before March 23, 2010, it might not be subject to new requirements of the health reform law until it terminates • When the employer and collective bargaining entity agree to changes, made to conform the agreement to the ACA, this will not be considered a termination of the original agreement

To be grandfathered in, generally the individuals affected must have been enrolled in the plan before March 23, 2010. There are two possible exceptions to the deadline (meaning that individuals enrolled subsequent to March 23, 2010 might still be in a grandfathered plan). First, is where a family member enrolls in an individual grandfathered plan. Second, is where new employees and their dependents enroll in grandfathered group plans. It has not been decided whether an employer's grandfathered plan will be considered exempt from future federal requirements on new plans. My guess is that some will be exempt, some will not.

Even if the plan is grandfathered in, several new requirements from the ACA will still apply to the coverage itself. For example, grandfathered plans will be newly subject to:

- Certain coverage and disclosure transparency provisions;
- Requirements that plans pay out a minimum of 80% or 85% of their premiums to cover health care claims;
- Prohibition against waiting periods in excess of 90 days;
- A ban on certain rescissions;
- The requirement that plans cover adult children up to the age of 26.

If an employer believes their plan is grandfathered, they must include a statement to that effect in all plan materials and provide contact information for questions and complaints. The regulations provide model language for this statement. Also, the employer must maintain and make available for inspection records documenting terms of the coverage that were in effect March 23, 2010.

Other issues

Constitutionality

This essay only discusses employer mandates, not individual mandates. The constitutional authority for the individual mandate arises from the Congress's power to tax, but what about the employer mandate? I found that at least 26 states have already challenged the employer mandate, as it applies to public employers. The Supreme Court has chosen not to review the employer mandate and the District Courts have upheld the employer mandate as Constitutional, under Congress's power to regulate interstate commerce.

Changes in Administrative Requirements

Under the ACA, if an employer decides to offer health coverage, and has over 200 employees, then the employer will be required to: 1) automatically enroll employees in the plan within 90 days (there must be an opt-out, but it is not all clear what plan the employee must be enrolled into); and 2) provide adequate notice to employees and new hires of the right to opt out of employer coverage (further guidance is expected on the full new hire notice requirements).

Also, the ACA imposes new reporting requirements with unique filing deadlines. Employees will be entitled to choose between their employer's coverage and coverage on the HIX. Employers are required to issue statements to employees, in a government established format, about what the employer reported to the IRS (the first is due March 1, 2013). This is likely a service your insurance company will provide. However, this could give rise to fiduciary or tort liability, so it is important that this information be accurate in describing any coverage.

You are already required to do certain W-2 reporting under IRC § 6051. In 2015, you will have additional reporting requirements under § 6055 and 6056. Here, you will be required to provide basic health coverage information to the IRS for their enforcement purposes. The guidance on the details has not been issued yet. The IRS is still taking public comment on this.

If the employer decides to offer health coverage, it must provide "free choice vouchers" to each "qualified employee." The vouchers basically allow the employee to choose a plan other than the plan the employer participates in, while still retaining the employer contribution. Most likely, those employees will purchase insurance on the health-care exchanges that the ACA creates.

Enforcement

One big question is how the government will enforce the employer mandate with public employers and non-profits, since there is no tax return on which to levy a penalty with these entities. The ACA merely says that the employer is penalized when an employee obtains a tax credit. This is still being worked out by the Department of Treasury, HHS, and the IRS.

I personally spoke with lawyers at Treasury, HHS, and the IRS and I was given the following guidance. The basic procedure will be that the employer will get a written notice when an employee receives a tax credit. The employer will be given a period of time to respond. If the response is not satisfactory, then the IRS will basically send a bill. The overall function is probably similar to an excise tax.

If the IRS does proceed this way, it means that you better have a good system in place to show compliance with ACA audits.

I did a detailed update about this issues here: http://omlohio.org/healthreform/Health%20Reform%20Road%20Map%20-%20Update%202%20%20How%20Does%20the%20Tax%20Penalty%20Work.pdf

Nursing Mothers Break Time Requirement
The ACA *currently* requires employers to provide reasonable break time for an employee to express breast milk for her nursing child for one year after the child's birth each time such employee has need to express the milk. Employers are also required to provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.

For more information, go to:
http://www.dol.gov/whd/nursingmothers/

Reinsurance Program for Retiree Coverage
A temporary reinsurance program for employers offering retiree coverage was created until 2014, when exchanges are supposed to be available. Also, under the ACA, employment-based plans providing health benefits to early retirees (ages 55-64 but not eligible for Medicare) and their dependents can apply to receive reimbursement for a portion of the cost of coverage. The reimbursement is substantial, covering 80% of retiree claims between $15,000 and $90,000 (however, these numbers will be adjusted each year). The reimbursements are limited to $5 billion and are given out on a first-come, first-serve basis. For more information, go to: http://www.errp.gov/

CLASS Issues No Longer Relevant
Originally, the ACA had incentive to provide subsidies for elder care. Those provisions will not be implemented because they were deemed to be unworkable.

Limited Exemptions
Employees may be eligible for multiple exemptions simultaneously—although they would still count as a full-time employee for purposes of the thresholds. Currently, the rules define nine exemption categories. Coverage will be offered to these people by either assigning the person to an exchange or the IRS. The following will go into exchanges: religious conscience objectors and hardship exemptions. The following will go into the IRS system: individuals who cannot afford coverage, are not lawfully present, in the midst of short coverage gaps, or are taxpayers with income below the filing threshold. Three remaining exemptions can be utilized through either the IRS or the Health Insurance Exchange: members of Indian tribes, members of a health care sharing ministry, and the incarcerated.

Likely Exception for Retiree-Only Plans:
Note: I go into great detail about this issue in my first weekly update, available at:
http://omlohio.org/healthreform/Upate%201%20-%20Retiree-only%20Coverage%20Exception.pdf

Non-federal retiree-only and "excepted benefit" plans are not subject to the ACA (HHS has urged the states to follow suit). The exception only applies if less than two employees in that plan are currently employed. Therefore, you want to make sure you separate your retiree plan from your current employees' plan.

The vast majority of municipalities (but not all) use OPERS or the Police and Fire Pension, which is a separate account. If your employees are using a state pension fund for retiree healthcare, then your municipality should be safe, as far as ACA compliance goes, in covering retirees. A problem may arise if you have other accounts for employees that could fall under the ACA or other regulations.

This retiree-only exception is based on a somewhat controversial interpretation of several federal statutes, made by the federal Departments of HHS, Treasury, and Labor, and expressed in a preamble (not the actual agency rule) to agency rules. Further, each Department has a "Memorandum of Understanding," stating that they will recognize this exception. However, it is really a non-enforcement policy. This policy has not been litigated by the Courts.
See: www.dol.gov/ebsa/faqs/faq-aca3.html.

However, the State of Ohio is also empowered to enforce this rule. If Ohio decides to enforce it, that could be a problem for (even arguably) non-compliant employers. Also, individual employees and others denied benefits could sue for this themselves. So you should follow this issue closely if your retiree-only or excepted benefits plans do not comply with the ACA.

Potential Tax Credit for Under 25 Employees

Tax exempt employers (which includes municipalities) may claim a refundable* tax credit against payroll taxes, if they; 1) are under 25 full-time employees, 2) have an average annual wages of less than $50,000, and 3) they contribute at least half of the total premium cost.

** "Refundable" means that, if the credit exceeds the amount you owe in taxes, you can receive the difference as a refund.*

From 2010-13 the maximum tax credit for tax-exempt employers is 25%. This is expected to be "enhanced" by the IRS in 2014 to 35%. Small employers will be able to carry the credit back or forward to other tax years.

Most employers are accustomed to getting a tax deduction for business expenses for health insurance premium payments. Premium payment made in excess of the tax credit above will still be deductible.

(For details, see: http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers).

Transition Relief

If your current plan is not rotating on a calendar year system (see Figure 2), you will find that once Jan 1, 2014 rolls around, you may still be in that plan. At the same time the ACA will implement new requirements that your plan may not conform to on that date. Therefore, you could be faced with a decision to either change the plan in the middle of the plan year or pay ACA penalties. To remedy this, the ACA penalties do not kick in until that old plan year ends—as long as those employees under the old plan were eligible (not enrolled) for that plan as of December 27, 2012.

If you are in a fiscal year plan you have a special deal: you do not have to pay any penalties until the first day of the fiscal plan year beginning 2014, if: 1) the plan was offered to at least one-third of employees during the most recent enrollment period before December 27, 2012; or 2) the plan covered at least 25% of your employees before December 27, 2012; and 3) those employees are offered adequate coverage under the ACA on the first day of fiscal year 2014.

If you offer a cafeteria plan that is on a fiscal year cycle, you may have employees who want to drop their employer coverage and get coverage on the health insurance exchanges. Usually, the original election in the cafeteria plan is irrevocable for the plan year. The ACA permits employers in a fiscal year cafeteria plan to amend the plan to permit an employee to change coverage during the plan year.

Resources

Below, I have listed a number of resources that you can turn to, to get good, up-to-date info on the ACA.

- Kaiser Family Foundation: http://healthreform.kff.org
- Health Policy Institute: http://healthpolicyohio.org
- U.S. Department of Labor, FAQ's: http://www.dol.gov/ebsa/faqs/faq-aca2.html
- U.S. Department of Labor, Insurance options for small businesses: http://www.dol.gov/ebsa/healthreform/
- Small Business Majority: http://www.smallbusinessmajority.org/hc-reform-faq/ http://www.businessgrouphealth.org/
- Small Business Administration, Information page: http://www.sba.gov/healthcare
- U.S. Department of Health and Human Services: http://www.healthcare.gov/
- IRS ACA Tax Provisions Page: http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions

Definitions

Minimum Essential Coverage	Currently undefined, but federal agencies are in the process of writing the rules. See: http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html http://cciio.cms.gov/resources/factsheets/ehb-2-20-2013.html
Full Time Employee (under the ACA)	30 hours per week
Full Time Equivalent Employees	Involves an IRS-created formula for determining when part-time (including seasonal or variable) employees are counted as full-time.
Look-Back Period	Refers to a period of time that an employer can have to assess what the employee actually worked before making a determination as whether that employee is "full-time."
Unaffordable Health Coverage	Under the ACA, employer sponsored coverage is "unaffordable" if the employee's share of the premium exceeds 9.5% of the employee's total household income.
Single Employer	All employers under common control a re considered a single employer. This is a private sector concept, based on ownership, that will have to be adapted to public sector institutions.
Free Choice Vouchers	Basically. these allow the employee to choose a plan other than the plan the employer participates in, while still retaining the employer contribution.
Substantial Compliance	When it comes to employer-based coverage, the IRS says it is looking for

	good faith efforts to comply and does not want to penalize inadvertent failures. The standard is considered met if the amount of employees not being offered coverage is under 5%, whether this happened intentionally or not. This is determined on an employer-by-employer basis.
Grandfathered Plans	Under the ACA, certain insurance plans that do not comply with the ACA will be allowed, provided they meet certain requirements and the employees were enrolled before March 23, 2010 (with some exceptions).
Minimum Value	The coverage employers offer must be of "minimum value" or it may trigger the ACA's tax penalties. This is determined according to actuarial value, which is discussed in detail here: http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf
Dependents	Some provisions require coverage of dependents up to the age of 26.
Controlled Group	Under IRS rules, all employers under a single "controlled group" are considered a single employer for purposes of the ACA's employee thresholds.
Community Ratings Mandates	The ACA first creates three common risk pools in each state: individual market, small employers market, and large employers market. For two of the three common risk pools—individual and small employers only—the ACA then mandates a "community rating" system for underwriting coverage on the HIX and SHOP. For these two pools, this basically creates state-wide, geographic-based ratings areas. This is intended to pool large groups of the employees of smaller employers together.

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This is a working paper, available at www.omlohio.org . To help improve this paper, we need your input. Please send your feedback and questions to jbrown@omlohio.org .