**PPACA Mandates**

**Minimum Essential Coverage and the Individual Mandate Tax**

Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) requires nearly all individuals to demonstrate and maintain proof of “minimum essential coverage,” which includes: qualified employer-sponsored health insurance plans, qualified plans purchased in the individual market, government-sponsored health insurance programs (e.g., Medicare, Medicaid), and grandfathered individual and group health plans.

Failure to demonstrate and maintain minimum essential coverage by March 31, 2014 will leave an individual subject to the individual mandate tax. For an individual, the tax begins in 2014 and will be $95 or 1 percent of household income above the filing threshold (whichever is greater). In 2015, the individual tax rises to $325 or 2 percent above the filing threshold. In 2016, the mandate tax reaches $695 or 2.5 percent above the filing threshold. After 2016, the amount will rise annually by a cost-of-living adjustment.

**Employer Mandate Penalties**

Beginning in 2015, the healthcare law requires “large” employers—businesses with 100 or more full-time or full-time equivalent (FTE) employees—to either offer minimum essential coverage to full-time employees or pay a penalty tax. If a “large” employer *does not* offer minimum essential coverage to at least 70 percent full-time employees, and one or more full-time employees claim a subsidy on the individual exchange (income between 100 and 400 percent of the federal poverty level), then the employer will be subject to a $2,000 per full-time employee penalty (minus 80 full-time employees).

In 2016, mid-size businesses with 50-99 full-time or FTE employees will also be subject to the employer mandate. Mid-size and large businesses will be required to offer minimum essential coverage to at least 95 percent of full-time employees and their dependents or pay penalties. Dependents are defined as children up to age 26. Spouses are not considered dependents.

If a “midsize” or “large” employer *does* offer minimum essential coverage to full-time employees and their dependents, but it is deemed unaffordable (self-only premiums exceed 9.5 percent of employee’s taxable income) or not of minimum value (60 percent actuarial value) for certain full-time employees, then the employer will be subject to the lesser of a $3,000 penalty for those certain full-time employees or $2,000 per full-time employee (minus 30 full-time employees).

The employer mandate was originally scheduled to begin in 2014, but regulations from the Treasury Department issued during July 2013 originally delayed the reporting requirements and penalties by one year to 2015. In February 2014, the Treasury Department further delayed and modified the employer mandate offering requirements and penalties for midsize businesses (50-99 FTEs) until 2016. Midsize businesses must still report and verify coverage with the IRS for the 2015 tax year.

*Full-Time Employees*

PPACA defines a full-time employee as an individual who is employed an average of at least 130 hours per month (30 hours per week).

Large employers may either determine current employees’ full-time status by using actual monthly hours or looking back at a standard measurement period of not less than three but not more than twelve consecutive months to determine whether the employee averaged at least 130 hour of service per month (30 hours per week).

Large employers must then offer minimum essential coverage to full-time employees and their dependents for a corresponding 6-12 month stability period if an employee averages full-time hours during the look-back measurement period. If an employer chooses not to offer minimum coverage to full-time employees and their dependents, and if one or more employees claim a tax credit on the individual exchange, they will pay employer mandate penalties annually.

*Part-time employees*

Part-time employees’ hours will be converted into FTE employees for the purposes of determining whether the employer is a large employer subject to the employer mandate. Conversion is done by adding all monthly hours worked by employees who are not full-time and dividing the total by 120. For example, if 6 part-time employees each work 20 hours per month, they will count as if the firm has one additional FTE employee, calculated monthly (6 employees x 20 hours per month = 120 monthly hours/120 = 1 FTE employee).

Large employers will not be required to offer minimum essential coverage to part-time employees, but part-time employee hours will be used to determine whether the employer is large and subject to the employer[[KK1]](http://www.nfib.com/business-resources/healthcare/mandates/%22%20%5Cl%20%22_msocom_1) .

*Seasonal Employees*

Seasonal employee hours will count toward an employer’s FTE monthly total. An employee is seasonal if they are employed for 6 months or fewer during a calendar year. An employer is not considered “large” (and thus, subject to the employer mandate) if the employer has 50 FTE employees for 120 days (or 4 calendar months) or fewer during a calendar year. This situation is known as the seasonal worker exception.

*How Will the Employer Mandate Affect Your Business?****[[1]](http://www.nfib.com/business-resources/healthcare/mandates/%22%20%5Cl%20%22_ftn1%22%20%5Co%20%22)***

How the employer mandate affects a particular business depends on a number of factors, including:

1.     The number of full-time employees (or part-time and seasonal employees counted as FTEs; see the sectionPart-time Employees);
<http://nfib.com/business-resources/healthcare/mandates#Part-time_employee_counting_requirements>

2.     Whether the business offers minimum essential coverage to full-time employees and dependents (full-time only for 2015; full-time and dependents in 2016); and

3.     Whether one or more employees qualify for and claim subsidies toward the purchase of health insurance in the individual exchange. An employee qualifies for a subsidy in the individual exchange if his or her required contribution for the self-only health insurance premium exceeds 9.5 percent of taxable income or if the insurance does not meet the 60 percent minimum actuarial value threshold.

Here are some scenarios:

Midsize and Large Non-Offering Firms:

         50 or more FTE employees.

         Does not offer minimum essential coverage to full-time employees and dependents. One or more full-time employees receive premium subsidies.

         Penalty = $2,000 per full-time employee (minus 30 full-time employees).

         For example, in 2016, Employer A has 100 full-time employees and does not offer health insurance coverage to full-time employees, 10 of whom receive a premium subsidy for the year for enrolling in an individual exchange. Employer A owes $2,000 per full-time employee (minus 30 full-time employees), for a total penalty of $140,000 (100 full-time employees – 30 full-time employees = 70, multiplied by $2,000 each).

Small Non-Offering Firms:

         Fewer than 50 FTE employees.

         Does not offer minimum essential coverage to full-time employees.

         No penalty.

Midsize and Large Offering Firms (coverage “unaffordable” or not meeting “minimum value”):

         50 or more FTE employees and offers minimum essential coverage to full-time employees.

         One or more full-time employees receiving premium subsidies because premiums exceed 9.5 percent of taxable income affordability test or no health insurance policies offered meet the 60 percent minimum value test.

         Penalty equals the lesser of $3,000 per subsidized full-time employee or $2,000 per full-time employee (minus 30 full-time employees).

         For example, in 2016, Employer B has 100 full-time employees and offers health coverage to full-time employees, 20 of whom receive a tax credit for the year for enrolling in an individual exchange because their contribution to the self-only premiums exceeds 9.5 percent of their taxable income. For each employee receiving a tax credit, the employer owes $3,000, for a total penalty of $60,000 (20 full-time employees x $3,000). The maximum penalty for Employer B is capped at the penalty amount that it would have been assessed for a failure to provide minimum essential coverage to full-time employees, or $140,000 ($2,000 multiplied by 70 (100-30)). Since the calculated penalty of $60,000 is less than the maximum amount, Employer B pays the lesser $60,000 penalty.

Midsize and Large Offering Firms (“affordable” coverage that meets “minimum value”):

         50[[JT2]](http://www.nfib.com/business-resources/healthcare/mandates/%22%20%5Cl%20%22_msocom_2) [[KK3]](http://www.nfib.com/business-resources/healthcare/mandates/%22%20%5Cl%20%22_msocom_3)  or more FTE employees.

         Offers minimum essential coverage to full-time employees that passes both “affordability” and “minimum value” tests.

         Has no full-time employees receiving premium subsidies.

         No penalty on employer.

*Other Factors Affecting “Large” Employers Subject to the Employer Mandate:*

         **Auto-Enrollment:** Beginning in 2015, employers with more than 200 employees will be required to auto-enroll employees in the employer’s health insurance coverage and allow employees to opt out. Auto-enrollment was scheduled to begin in 2014, but guidance from the Department of Labor has indicated this auto-enrollment requirement is delayed beyond 2014.

         **W-2 Reporting Requirements:**Beginning in 2013, businesses with more than 250 employees must reportthe aggregate cost of health insurance coverage under an employer-sponsored group health plan in Box 12 (using code DD) of an employee’s W-2 form. The amount reported should include both the portion paid by the employer and the portion paid by the employee. Businesses with fewer than 250 employees have transition relief from this increased employer reporting requirement until the IRS issues further regulations.

**Factors Affecting All Employers Offering Health Insurance, Whether or Not Businesses are Subject to the Employer Mandate:**

**Individual and Small Group Market Changes**

There are many changes being made in the individual and small group marketplaces for health insurance (both inside and outside of exchanges). The small group market is currently defined as 1–50 or 2–50 employees in every state. In 2016, the small group market will increase to businesses with up to 100 employees in every state.

These markets have historically been regulated at the state level. Currently, differences exist in how the individual market and small group market function in each state. The state rules dictate how insurers can determine their expected costs, and therefore, price your premium. The changes created by the healthcare law will adjust these differences, making the two marketplaces more similar, and will shift much of insurance regulation from state governments to the federal government.

**Nondiscrimination Requirements**

Employers cannot provide more generous health insurance benefits or higher employer contributions to highly-compensated employees. This prohibition was supposed to begin in 2010, but was delayed. It will not be enforced until the IRS issues further regulations.

**Essential Health Benefits**

Beginning in 2014, all non-grandfathered and early renewed individual and small group market health insurance plans must cover a broad list of ten mandated benefit categories known as Essential Health Benefits. The Department of Health and Human Services (HHS) has mandated that states choose base-benchmark plans for transition years 2014-2015 from a limited menu of options or HHS will select the largest small group plan in the state as the default base-benchmark plan.

Section 1302 of the PPACA specifies that all plans meeting Essential Health Benefits requirements will include at least the following categories:

         Ambulatory patient services

         Emergency services

         Hospitalization

         Maternity and newborn care

         Mental health and substance use disorder services, including behavioral health treatment

         Prescription drugs

         Rehabilitative and habilitative services and devices

         Laboratory services

         Preventive and wellness services and chronic disease management

         Pediatric services, including oral and vision care

No base-benchmark plans cover all Essential Health Benefit categories. Thus, all base-benchmark plans must be supplemented with additional services in order to comply with the law. The more costly supplemented plans will be known as Essential Health Benefit-Benchmark Plans.

The Secretary of the HHS will be allowed to review and update the Essential Health Benefits package annually beginning in January 2016. Also in 2016, the small group market will expand to businesses with up to 100 employees, forcing more businesses to comply with the Essential Health Benefits package.

**Prohibition from Offering Stand-Alone Health Reimbursement Arrangements (HRAs)**

Beginning in 2014, employers can no longer offer stand-alone health reimbursement arrangements (HRAs) that allow employees tax-free funds to purchase health insurance in the individual market. The Department of Labor (DOL), Internal Revenue Service (IRS), and Department of Health and Human Services (HHS) issued regulations requiring HRAs to be integrated with group health insurance coverage (such as a high-deductible health plan). Employers can provide employees with funds to purchase health insurance on the individual market, but it must now be considered taxable income to the employee.

**Waiting Period Limitations**

Beginning in 2014, there are extra penalties for businesses that have a waiting period exceeding 90 days before eligible employees must be enrolled in minimum essential coverage. Waiting period limitations apply to all group coverage, not just large employers.

**Prohibition of Annual and Lifetime Limits**

Beginning on September 23, 2010, new plans are prohibited from placing annual and lifetime limits on the dollar value of coverage. For example, some policies previously had a $1 million dollar lifetime cap on the amount an insurance company would pay out on a policy. The prohibition on lifetime limits took full effect on January 1, 2014. The new rules on lifetime limits apply to all plans. The rules on annual limits apply to all plans, except for individual market plans that maintain grandfathered status.

**Annual Limitations on Out-of-Pocket Spending**

Beginning in 2014, there are limits on annual cost sharing for in-network services, and they are tied to current Health Savings Account (HSA) maximum out-of-pocket limits (for 2014, the limits are $6,350 for individuals and $12,700 for families).

Separate plan service providers may impose different levels of out-of-pocket spending maximums. For example, a major medical coverage insurer may have one maximum and a prescription drug plan may have a separate maximum.

**Dependent Coverage**

Beginning on September 23, 2010, all employers that offer dependent coverage are required to provide dependent coverage for children up to age 26.

**Coverage of Preventive Services**

Beginning on September 23, 2010, all non-grandfathered plans are required to provide 100 percent coverage (no cost-sharing – deductibles or co-pays) for:

  Items or services with an “A” or “B” rating in the [current recommendations](http://www.healthcare.gov/center/regulations/prevention.html) of the United States Preventive Services Task Force (USPSTF);

  Immunizations for routine use as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

  Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration (HRSA); and

  Preventive care and screening for women provided for in guidelines supported by HRSA.

**Minimum Value**

Beginning in 2014, all non-grandfathered health insurance plans must meet a 60 percent minimum actuarial value standard. Actuarial value is the amount of expected healthcare expenses that health insurance plans must cover once an individual has met their deductible. Enrollees are responsible for the remaining costs in the form of coinsurance and co-pays. Annual employer contributions to Health Savings Accounts (HSAs) and amounts made available under Health Reimbursement Arrangements (HRAs) for the current year will count toward the actuarial value threshold.

**Other Insurance Requirements**

In 2014, all plans in the individual and small group markets (both inside and outside of exchanges) will be required to have guaranteed issue and renewability.

Premiums may only vary by:

  Age (3:1 maximum)

  Tobacco (1.5:1 maximum)

  Geographic rating area

  Individual or family coverage (family size)

[[1]](http://www.nfib.com/business-resources/healthcare/mandates/%22%20%5Cl%20%22_ftnref1%22%20%5Co%20%22) For the purpose of describing the employer mandate requirements and penalties, the Playbook assumes the mandate is fully implemented for “midsize” (50-99 FTEs) and “large” (100+ FTEs) businesses in 2016. For 2015, only “large” (100+ FTEs) businesses must offer coverage to full-time employees or pay penalties. Non-offering “large” businesses may subtract 80 from their non-offering penalty liability in 2015.