



Federal Health Reform: Impact on Small- and Medium-Sized Employers

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Background

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA or health reform) into law. Many provisions in the 2,000+ page legislation went into effect right away, while others are set to phase-in between now and as late as 2020.

The legislation, in part, aims to assist small businesses in providing health coverage to and promoting the health of their employees; it also sets new provisions for medium and large employers. Small business employers (those with 3-9 employees) often struggle to provide health coverage for their employees because of the unaffordable costs fiscal burden they face, including 10-18% higher administrative costs due to the lack of economies of scale.¹ Because of these high costs, only 65% of California small businesses offer coverage compared to 99-100% of large businesses (those with 200+ employees).²

ITUP has conducted several training sessions for employers throughout the state over the past few months and has come across many with similar sets of concerns. This paper outlines how the PPACA will affect small- and medium-sized businesses, and address many relevant questions and concerns.

Tax Credits

As of the day the legislation was signed, small, low-wage businesses that pay for 50% or more of their employees' premiums became eligible for a tax credit up to 35% of the employer contribution. A small, low wage-business is one that has 25 or less full time equivalent (FTE) employees with average salaries under \$50,000. Because this is a sliding scale credit, employers with 10 or fewer FTE employees with average salaries of under \$25,000 will receive the maximum credit. The credit is phased down as the number of employees grows and the average wage rises.

Starting January 1, 2014, the maximum tax credit will increase to 50% and will only be available through the health benefit exchanges also established by the PPACA.

For the tax credit calculation, a full time employee is one who works 30+ hours per week. Part time (PT) employees are factored in based on the number of monthly hours divided by 120.³ For example, if a company has 20 FT employees

¹ Lucie L, Jacobs K & Graham-Squire D. (March 2010). Federal Health Reform: Impact on California Small Businesses, Their Employees and the Self-Employed. University of California, Berkeley, Center for Labor Research and Education. Accessed from: <http://laborcenter.berkeley.edu/healthcare/>

² California HealthCare Foundation/NORC California Employer Health Benefits Survey: 2006, 2007, 2008, 2009.

³ Benefit Logic, Inc. (July 2010). Health Care Reform: Potential Penalties for Employers Under the "Pay or Play" Rules. Accessed from: <http://benefitlogicblog.com/2010/07/16/health-care-reform-potential-penalties-for-employers-under-the-pay-or-play-rules/>

and 4 PT employees who work 15 hours per week, i.e. 60 hours per month, the calculation would be as follows:

$$20 + 2*(60/120) = 22 \text{ FTEs}$$

When calculating FTEs, seasonal workers who work less than 120 days out of the year are not counted. When calculating average salaries, the wages of the owner(s) are not included.

The Exchange

The most significant element of federal health reform are the health benefits exchanges. The exchanges can be thought of as a hybrid of “priceline.com” and “travelocity.com” for health coverage. An individual will be able to plug in his/her information into a web portal and the site will provide him/her with negotiated rates for different health plans. The goal of the exchanges is to promote transparency and competition between plans, providing individuals with more information and choice about the price and quality of health plans and thus, in theory, driving down premiums through a stronger and fairer marketplace.

PPACA provides that employers with less than 100 employees would be eligible for the exchange in 2014, but allows states the flexibility to set this lower to 50 in 2014 based on local market conditions. In 2017 states could decide to expand beyond 100 employees.

Four levels of benefits will be offered in the exchanges – Platinum, Gold, Silver, and Bronze – and a catastrophic plan. The Platinum level will cover 90% of expected medical costs, whereas Bronze will cover 60%. Catastrophic plans will be available to young adults under 30 or individuals with financial hardships. Every insurer operating within the exchange will have to offer at least one plan at each benefit level.

Individuals whose incomes fall between 133% (\$14,000 for an individual) and 400% of the Federal Poverty Level (FPL; \$88,000 for a family of four) will qualify for refundable tax credits for premium payments for plans in the exchanges. The refundable tax credits are designed to improve affordability of individual premiums. The individual’s premium contributions are “capped” between 2-9.5% of income, so that an individual who makes 133% FPL does not pay more than 2% of his/her income towards premiums and an individual who makes just under 400% FPL does not pay more than 9.5% of his/her income towards premiums. Premium subsidies will be tied to the second lowest Silver plans, which cover 70% of expected medical costs.⁴ Citizens and legal permanent (more than 5 years) residents with incomes under 133% FPL will be eligible for the public program, Medi-Cal. Currently, Medi-Cal is not available to adults without minor children living at home.

⁴ Henry J. Kaiser Family Foundation. (April 2010). Health Care Reform: Questions About Health Insurance Exchanges. Accessed from: www.kff.org/healthreform/upload/7908-02.pdf

Both inside and outside the exchanges, health plan premiums may only vary by age (3:1), geography, family size, and tobacco use (50%). This means an elderly person's premiums can only be three times those of a younger person; a tobacco smoker can pay up to 50% higher premiums than a non-tobacco smoker; and a resident of the Bay Area, where medical care tends to be more expensive, might pay more than an individual who lives in Los Angeles. Health plans can no longer raise premiums based on an individual's health status (2014).

The formation of each exchange is left to the states, and the Department of Health and Human Services has the responsibility of establishing state Exchanges if states do not. Exchanges can be statewide, regional between states (a cluster of states), regional within states (multiple pools within the state for larger states) or federal. The PPACA left many decisions to the states, including exchange governance, negotiations, administration, etc. PPACA also requires that the Office of Personnel Management (OPM), which currently administers the Federal Employee Health Benefit Program (FEHBP), provide two or more national plans through each state Exchange, which will be critical in states with fewer insurers competing in the Exchange. The California legislature recently passed two pieces of legislation, SB 900 (Alquist & Steinberg) and AB 1602 (Perez) that create the California Health Benefit Exchange. As envisioned by the two bills, the Exchange will operate independent of the state budget and will be funded by assessments on participating health plans. The bills are currently awaiting the Governor's signature.

Increased competitiveness will allow small employers more choice in selecting health plans, similar to the choice large employers today. In addition, the Exchange will likely allow small businesses to pay premiums similar to large businesses while also providing these employers with tax credits to subsidize coverage.

Exchanges must be operational by January 1, 2014.

Pay-or-Play (Free Rider) Provision

Under the PPACA, employers with less than 50 FTE employees will face no additional requirements. Employers with more than 200 employees will be required to offer coverage to their employees; however, this mandate will have little impact since 99-100% of large employers already offer coverage. Employers with 50-200 employees will face a new "Pay-or-Play" provision, wherein the employer can choose to either offer coverage or pay a penalty if one or more of their employees receive subsidized coverage in the exchange. For the pay-or-play provision, a full time equivalent employee is considered one who works 40+ hours a week (compared to 30+ for the tax credit calculation)

To be clear, if an employer of over 50 employees offers adequate and affordable coverage (the plan covers at least 60% of expected medical costs and the employee's contribution is below 9.5% of his/her income), there is no penalty. If an employer does not offer coverage and none of their employees receive tax

credits in the exchange, there is no penalty. An employer with over 50 employees will only be penalized if they do not offer coverage or affordable coverage AND an employee receives tax credits in the Exchange (i.e. a family income of less than 400% FPL). An employer who offers coverage that is either inadequate or unaffordable for the employee will pay the lesser of the two calculations below (right) if one or more employees receive tax credits in the Exchange.⁵

The calculation is as follows:⁶

Does Not Offer Coverage		Offers Coverage	
No FTEs receive credits in the Exchange	One or more FTEs receives credits in the Exchange	No FTEs receive credits in the Exchange	One or more FTEs receives credits in the Exchange
No Penalty	$[(\# \text{ of FTEs}) - 30] * \$2,000$	No Penalty	$[(\# \text{ of FTEs}) - 30] * \$2,000$ OR $(\# \text{ FTE receiving credits in the Exchange}) * \$3,000$

If an employer offers affordable coverage and yet the employee chooses not to take it and remains uninsured, the employee is subject to an individual penalty, cannot get subsidies in the exchange and the employer is not penalized. In one limited circumstance, that employee can use the exchange with the contribution offered by the employer. This is the “free choice” voucher that is available if the employee’s premium contribution falls between 8-9.8% of the employee’s income. The free choice voucher is a credit towards the cost of coverage in the exchange and must be worth the amount that the employer would otherwise pay towards employee premiums.

Individual Responsibility

Starting in 2014, all individuals will be required to have minimum health coverage or be required to pay a fee. There will be exemptions for financial hardships (e.g. incomes below the tax filing threshold or if the cost of bronze coverage exceeds 9.5% of the individual’s income) and religious beliefs. The minimum essential health coverage must cover at least 60% of expected medical costs (Bronze level coverage). If the individual is under 30 or faces financial hardships in purchasing coverage (premiums exceed 8% of the employee’s income), he/she may purchase “catastrophic coverage,” which covers primary and emergency care only. Any individual with coverage prior to 2014, no matter how limited in scope, can keep it with no penalties; this is known as “grandfathered coverage.”

Individuals who choose to forego health insurance will pay the higher of the following: flat payment rate of \$95 in 2014, \$325 in 2015 and \$695 in 2016 and

⁵ The Cavanagh Law Firm (2010). Patient Protection and Affordable Care Act (PPACA). Accessed from: <http://www.cavanaghlaw.com/publications-presentations/details/3>

⁶ Benefit Logic, Inc (2010)

thereafter; OR 1% of income in 2014, 2% in 2015, and 2.5% in 2016 and thereafter.

New Taxes

Half of the health reform overhaul is funded by new revenues and half by savings due to increased efficiency of the current system. Starting in 2013, individuals with incomes of over \$200,000 and families with incomes of over \$250,000 will see a small increase (0.9%) in their Medicare payroll tax on their incremental income above this threshold; this tax does not apply to employers. The incremental tax will be 2.35% compared to the current 1.45%. In addition, the unearned income for these individuals in excess of the threshold will be subject to the Medicare tax at a rate of 3.8%. There will be no employer contribution.

The other new tax relevant to employers is referred to as the “Cadillac tax.” The Cadillac tax is a 40% excise tax on high-cost, or “gold-plated” health insurance plans set to begin in 2018. These are plans that cost more than \$10,200/year for an individual and \$27,500 for a family. The tax is on the incremental cost above the threshold, and the tax threshold will be indexed to CPI plus 1%. This tax is paid by the health plan and the tax threshold is higher for coverage of retirees and high-risk occupations. This tax only applies to employer coverage and not to individual coverage.

Reporting Requirements

Fiscal year 2011 W-2s will have a new section in which employers will report information about employee health coverage. Initially, this is for informational purposes only and will not affect the employers in any way. Starting in 2018, it may be used as the method to determine which plans are considered Cadillac plans.

Beginning in March 2013, employers will be required to provide written notice to employees regarding exchange coverage opportunities at the time of hiring. This information must include the existence of an exchange, including services and contact information, an employee’s potential eligibility for credits and subsidies, and the employee’s potential loss of employer contribution if he/she chooses to purchase a plan through the exchange and is not eligible for a free choice voucher. Starting in 2014, large employers and all employers offering health coverage will have specific reporting requirements, including waiting periods, coverage availability, premiums, employer share/employee contribution, number of FTE employees, tax IDs and other relevant information for each FTE.⁷

Dependent Coverage Extension

Commencing September 23, 2010, health plans that offer dependent coverage must extend that coverage to adult children up to age 26. Young adult children

⁷ Benefit Logic, Inc (2010)

qualify for this extension regardless of marital, tax, academic status, and geographical location. This means that a married adult child who is not claimed as a dependent, is not enrolled in an academic institution and lives in a different state is still eligible for dependent coverage. However, the adult child's spouse and children are not eligible for the coverage.

For plans that were in place before March 23, 2010, the provision only applies if the child does not have access to an employer plan. For plans in place after March 23, 2010, the child is eligible regardless of whether or not he/she has access to an employer plan. Starting in 2014, access to an employer plan will not be considered.

Plans must offer the same level of benefits and charge the same amount of premiums that they would for an underage dependent. They must also provide written notice to individuals who might qualify for this coverage extension and allow a 30-day enrollment period. Some plan renewals might not occur until January 1, 2011 and at that point this provision kicks in.

Early Retiree Program

The PPACA allocated \$5B towards an Early Retiree Program, which began on June 1, 2010. The program offers financial relief to employers who want to offer coverage to younger retirees (ages 55 through 64 and therefore not yet eligible for Medicare). These individuals often experience hardship obtaining coverage once they retire or face premiums up to four times higher than young adults. Under the program, health care costs between \$15,000 and \$90,000 are 80% subsidized by the federal government for services that would be covered by Medicare. The funds are intended to slow the decline of businesses offering early retirement assistance and help lower premium costs for early retirees.

Pre-Existing Conditions & High Risk Pools

Starting in 2014, plans will no longer be able to deny health coverage to an individual because he/she has a pre-existing condition. Between now and then, the federal government allotted \$5 billion for individuals who have had difficulty obtaining health coverage due to a pre-existing condition. States had the opportunity to expand on an existing pool, create a new pool, or join the federal pool. California decided to begin a new pool, the Pre-Existing Condition Insurance Pool (PCIP), which will draw down \$761 million over the next 3.5 years to cover high-risk individuals. To be eligible for health coverage through PCIP, an individual must have one or more pre-existing conditions, be uninsured for 6 months or more, and have difficulty purchasing coverage because they have either been denied or cannot afford it. There will be no annual or lifetime caps on benefits. Premiums and co-pays for PCIP enrollees will be comparable to those on the individual market for healthy individuals; federal subsidies pay the difference. To request an application, individuals can email pcip@mrmib.gov. They will begin offering coverage in September 2010.

Conclusion

Small- to medium-sized employers will have four choices as of January 1, 2014; they may keep their current health plan (as long as no changes are made to the plan, this is known as “grandfathered”), purchase insurance through the Exchange, purchase insurance outside the Exchange, or opt out of providing coverage to their employees. It is crucial that the Exchange is fully operative in 2014 so that it will attract small employers and accumulate enough participants to be successful.

Small businesses have much to gain from federal health care reform. Those with fewer than 50 employees are not subject to any new requirements. Rather, they now have additional types of assistance to offer health coverage to their employees in the form of the exchange, tax credits, and \$200 million in wellness grants to support innovative employee wellness programs. Medium-sized employers face a choice of offering coverage or paying a fee if one or more employees use the tax credits in the exchange (note that 92% of medium-sized employers between 50 and 199 employees currently offer coverage in California).⁸ The legislation is predicted to have a very small impact on large businesses, since the majority already offers health coverage.

The new legislation aims to make coverage more available and affordable for small businesses. It also provides employees and employers with greater freedom when changing jobs by guaranteeing access to coverage if they are no longer eligible for their current employer’s insurance. In addition, employer assistance has the potential to encourage new business creation and entrepreneurship, in that it largely eases the financial burden of offering health benefits for start up employers. This financial support for the self-employed and smaller businesses has the potential to boost business and job growth.

⁸ Lucie, et. al (2010)