Health Care Reform Frequently Asked Questions

What are health exchanges, or marketplaces, and when are they going to be available?

Health insurance exchanges, now called health insurance marketplaces, are web-based health-insurance markets that will allow employers and individuals to compare uniform plans and premiums across multiple insurance companies, purchase coverage, and enroll. They were established in each state and the District of Columbia for coverage starting January 2014 with an open enrollment period that began in October 2013 and ended in March 2014. The marketplaces are either run by the state government or federal government depending on the choice of each state. The coverage is still offered by private insurers with the marketplace serving as a means of comparing and purchasing coverage.

Both individuals and employers can find information at www.healthcare.gov. The site includes links to each state's Marketplace, whether state- or federally-run. Individuals and small employers can apply for coverage at this site as well. Individuals eligible for tax assistance/subsidy of health insurance premiums must purchase coverage through a public Marketplace to receive the subsidy.

What is the difference between the Marketplace for individuals and SHOP for small businesses?

The law provides for a separate marketplace for small businesses (Small Business Health Options Program, or SHOP) and one for individuals (American Benefits Exchange, ABE). Information for both is available at www.healthcare.gov. The small group market is defined as employers with 1-100 employees. However, a state may limit small group participation to employers with 50 or fewer workers from 2014 through 2016. Beginning in 2017, employers with 100 or fewer employees may participate in the marketplace. States may allow businesses with more than 100 employees to participate after 2017. States can also choose to combine the individual and small business marketplace because expanding the pool would lead to more competition among insurers.

Do employers that offer coverage have to offer the same benefits and contribution levels to all employees?

Health care reform expands non-discrimination-testing requirements to insured health plans. With the exception of any plans that are classified as "grandfathered" (meaning they were in place as of March 23, 2010 and have remained largely unchanged), employers will not be able to discriminate in favor of highly compensated employees in terms of access to benefits, levels of coverage, and contributions. With that said, the language around how to test for non-discrimination and the penalties for non-compliance have not been clarified. As of April 2014, the rules and time frame for complying with non-discrimination requirements had not been set. It is expected that the rules will be issued some time in 2014 and that businesses will be given a grace period to comply.

Businesses that are subject to the shared-responsibility provision because of having 50 or more FTEs will be considered as not offering coverage if less than 95% of full-time employees are eligible to enroll. Separate from any non-discrimination requirements, therefore, large businesses will need to offer coverage to nearly all full-time employees in order to avoid penalties. Small businesses that have fewer than 50 FTEs could conceivably continue limiting access to benefits among full-time employees until further guidance is provided on non-discrimination requirements.

TLC COMPANIES

What are the coverage levels available in the public Marketplace?

The marketplace provides a choice of four categories of insurance packages or "qualified health plans," each with essential minimum benefits, plus "catastrophic only" insurance for select populations (under 30 years of age or low income). The law allows a variety of products and benefits to be sold within those four levels as long as they meet the minimum standards of coverage. This will allow easier comparison among plans. If the employer is offering coverage through the marketplace, the employer will decide what level of coverage to offer, and employees may pick any plan offered within the marketplace at that level.

The four coverage levels within the marketplace are based on the percentage of costs the plan will cover. The percentage reflects the portion of total allowed health costs the plan is expected to cover. It is referred to as the actuarial value:

Bronze = 60%
Silver = 70%
Gold = 80%
Platinum = 90%

Also, if an insurer offers a qualified health plan, they must also offer a child-only plan at the same level of coverage.

The options within the four coverage levels must also limit cost sharing:

- Out-of-pocket costs can't exceed Health Spending Account (HSA) limits. These limits are $6,350 for individuals and $12,700 for families in 2014, and these amounts will be indexed in future years.
- Annual deductibles were originally going to be limited to $2,000 for individuals and $4,000 for families in the small group market. However, this limit was repealed on April 1, 2014.
- No cost-sharing for preventive services.
- No annual or lifetime caps on the dollar value of services.

What, if any, differences will exist between health benefits available through TLC and those available in the open market and/or insurance marketplace?

As a sponsor of health benefits, TLC is considered to be a large group for insurance purposes. As a result, TLC can provide eligible clients with:

- Unique plan designs not otherwise available to small employers. For example, offering a choice of several plan options to employees. Many small-group plans are limited to only one plan choice.
- Higher medical-loss-ratio requirement applies to large-group plans. Insurance companies are required to spend 85% of premium on claims in the large-group market as opposed to only 80% in the small-group market. This means that more of every premium dollar goes toward claims and not the insurer.
- Access to a large-group medical risk pool unique to TLC.
- Full benefits administration. TLC handles all administrative tasks of the plan, including employee communications, payroll deductions, open enrollment, renewals, vendor bill reconciliation and payments, COBRA administration and other compliance.

TLC COMPANIES

What are “essential health benefits”?

The law established broad benefit categories of typical employer coverage, called “essential health benefits” which include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health disorder and substance use services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care). The HHS Secretary will define specific services that must be covered within these categories. This provision is designed to make sure coverage is comprehensive.

Does a relationship with a PEO affect an employer’s PPACA responsibilities?

No. The issue of an employer’s relationship with a Professional Employer Organization (“PEO”) under healthcare reform was addressed in a colloquy that occurred on the floor of the U.S. Senate. A “colloquy” is a verbal exchange that is made part of the federal register in order to clarify legislative intent. The colloquy indicated that under healthcare reform, the rules regarding non-discrimination, tax credits, and shared-responsibility (“pay or play”) penalties would apply to each client organization separately and not at the PEO level.

As a result of the colloquy, it has been determined that a relationship with a PEO does not change an employer’s eligibility or exposure to these key provisions of healthcare reform.

What size range of employers could be exposed to the shared-responsibility or “pay to play” tax penalties?

Most small businesses are exempt. Employers with fewer than 50 full-time equivalent employees (FTEs) are not subject to the shared-responsibility provision (tax penalties) that takes effect January 1, 2015. If a business has at least 50 FTEs but no employee receives an individual premium tax credit or cost-sharing reduction (both based on income), there’s no penalty—whether or not an employer offers health insurance.

The calculation of FTEs for determining eligibility for tax credits is different than the calculation for determining exposure to tax penalties. The calculation of FTEs for exposure to tax penalties is performed monthly and counts all part-time hours worked for the month divided by 120, added to the total number of full-time employees. The monthly results are averaged to determine the result for the year.

The time period used to evaluate exposure to tax penalties is either the full preceding calendar year or any consecutive six-month period in the preceding calendar year. Once the determination is made for the year, it is fixed for the year regardless of changes to employer size in that year.

Note, for an employer to correctly calculate their eligibility for tax credits and exposure to tax penalties under health care reform, they must evaluate themselves according to the “controlled group” rules that currently pertain to 401k plans. Controlled groups are businesses that are related through direct or overlapping (“common”) ownership. Three types of controlled groups are parent-subsidiary, brother-sister, and affiliated service groups. These rules are covered under section 414 (b), (c), (m), and (o) of the Internal Revenue Code. The combined size of the controlled group is used to determine the size of an employer for purposes of credits and penalties.

TLC COMPANIES

When would the shared-responsibility or "pay to play" penalties first apply to employers with 50 or more FTE's?

The shared-responsibility penalties apply as of a plan's first renewal on or after January 1, 2015.

What size employers have to notify employees about Marketplace, and is there a model notice?

The PPACA required employers with one or more employees to notify current employees before October 1, 2013, about the existence of the new Marketplaces. New employees going forward must also receive a notice. Model notices have been provided by the DOL. If the employer sponsors a group health plan, some basic information about the plan may be included in the notice. If the employer does not sponsor a group health plan, the notice may state that coverage is not offered by the employer.

What type of businesses are eligible for tax credits?

Small employers that provide qualified healthcare coverage may be eligible for the Small Business Tax Credits under PPACA (considered a "qualified employer") if:

- They have fewer than 25 full-time equivalent employees (FTEs) for the tax year
- The average annual wage is less than $50,000 per FTE
- The employer pays at least 50% of the premium of a plan purchased through the Marketplace for small business (Small Business Health Options Program, or SHOP). This contribution requirement also applies to add-on coverage including vision, dental and other limited-scope coverage.

The calculation of FTEs for determining eligibility for tax credits is different than the calculation for determining exposure to tax penalties. To calculate number of FTEs for tax credits, add up the total hours paid by the employer during the tax year (but not more than 2,080 hours for any employee), divided by 2,080, and rounded down to the next lowest whole number, not less than one. The result is the FTE count for eligibility for tax credits. To calculate wages for tax credits, add up total wages paid by the employer during the tax year divided by total FTEs, rounded down to the nearest $1,000. The result is the average wage for eligibility for tax credits.

For hourly employees, employers must use actual hours of service (including leave) for which payment is made or due. For non-hourly employees, employers may choose to count hours in one of three different ways, to maximize the credit and minimize their bookkeeping burden. These include actual hours of service, estimated hours based on total days of service, and estimated hours based on total weeks of service.

The time period used to evaluate FTEs for tax-credit purposes is the preceding tax year. For tax years of less than 12 months, the 2,080 hours (representing 52 weeks at 40 hours per week) should be pro-rated for the applicable time period.

Note, for an employer to correctly calculate their eligibility for tax credits and exposure to tax penalties under health care reform, they must evaluate themselves according to the "controlled group" rules that currently pertain to 401k plans. Controlled groups are businesses that are related through direct or overlapping ("common") ownership. Three types of controlled groups are parent-subsidiary, brother-sister, and affiliated service groups. These rules are covered under section 414 (b), (c), (m), and (o) of the Internal Revenue Code. The combined size of the controlled group is used to determine the size of an employer for purposes of credits and penalties.

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How does an individual qualify for individual tax assistance/subsidy of health insurance premium?

Individuals and families earning less than four times the Federal Poverty Level may qualify for a subsidy of health insurance purchased through the public Marketplace. For more information or to apply for the subsidy, visit www.healthcare.gov.

If an employee waives employer-sponsored qualified coverage for any reason other than that it doesn't meet the affordability test, they can still purchase coverage through the Marketplace but will not be eligible for a government subsidy.

Does an employee have to take an employer's insurance if offered?

No. Employees can join their spouse's coverage or purchase coverage through the Marketplace or the individual market. Employees may also take advantage of Veterans' plans or Medicare, if they are eligible. However, as of January 1, 2014 when individual responsibility requirements took effect, if an employee refuses employer coverage and doesn't obtain coverage on his or her own, the employee will be subject to a penalty.

If an employee waives employer-sponsored qualified coverage for any reason other than that it doesn't meet the affordability test, they can still purchase coverage through the Marketplace but will not be eligible for a government subsidy.

What is the minimum coverage that everyone is required to carry?

For most, the minimum coverage will be the standard Bronze benefit package available through the Marketplace that covers 60% of the costs or an equivalent plan secured through the open market (including large group).

Catastrophic-only coverage is available through the Marketplace (but only in the individual market) to those under age 30. It's also available to those deemed exempt from the individual coverage requirement due to hardship and/or because they can't find a qualified plan with a premium that costs less than 8% of their adjusted gross income. This option must still cover essential benefits, with at least three annual visits to a primary care physician for preventive care. Catastrophic-only plans will have a large deductible, and cost-sharing will be capped at the out-of-pocket limits under HSAs.

TLC COMPANIES