Lge Group if any of ACA stands

Large group mandates from the Affordable Care Act (ACA) were completely separate from the Supreme Court ruling regarding the Individual Mandate. Unless, ACA was ruled unconstitutional in its entirety, large groups were going to be subjected to numerous mandates regardless.

Because other aspects of ACA were not stricken, employers of 51 or more employees are defined as large groups by ACA. However, two key points need to be stressed that had been the cause of much fear, confusion and consternation.

1. ACA does **not** mandate all groups with more than 50 employees to offer and pay for group insurance.
2. Legislative action, since the passage of ACA on March 23, 2010, has removed the "voucher program." This was the mandate on large groups to provide vouchers equal to the value of the medical plan to employees who qualified for a government subsidy. In addition to the voucher, the employer would also have to pay a penalty.

Never the less, a considerable amount of ACA remains devoted to this insurance market segment. The law also appears quite clear on its directives, except for some inconsistencies related to self-insured plans.

Taxes, fees and penalties will still apply. Much of these sources of revenues to the federal government will be redirected into subsidies for those people who qualify for aid.

Those revenue generators include:

-40% excise tax (so-called "Cadillac Tax") on high-cost plans beginning in 2018. The formulas are unknown at this time.

-Changes to Flexible Spending Accounts, Health Savings Accounts, and Health Reimbursement Arrangements limiting maximum contributions and eliminating some previously allowable expenses. Began in 2011.

-FSA salary deferrals limited to $2500 (indexed for inflation). Begins in 2013.

-Over-the-counter drugs are not eligible for HSA reimbursement without a written prescription from a physician.

-Penalty for non-health related withdrawals from HSAs increased to 20% from 10%. Began in 2011.

-Tax deduction to employers who pay for employees' Medicare Part D premiums are eliminated. Begins 2013.

-The medical expense deduction threshold on an individual tax return form Schedule A is raised from $7500 to $10,000. Begins 2013.

-The Medicare payroll tax is increased by .9% on individual income of $200,000 and $2500,000 on joint filers. Begins 2013.

- A new 3.8% tax on investment gains is imposed for the gains derived from the sale of assets from unearned income on incomes of $200,000 or $250,000. This is known as the "tax for selling your house." Begins 2013.

-Other fees on health insurance plans and employer plans to fund "comparative effectiveness research projects" are planned for 2012.

Other revenue "enhancements" are also included in ACA that are derived from sources directly related to an employer's salary structure or if the employer does or does not offer coverage. The most well-known of these is the "play or pay" penalty for not offering coverage.

As stated earlier, ACA does not require an employer with 50 or more employees to offer and pay for health insurance for its employees. Too, a penalty will **not** accrue to that employer if **none** of the employees qualify and apply for federally subsidized medical insurance through the Exchange.

However, if just one employee qualifies for the subsidy and applies for and is issued insurance through the Exchange, the employer will have to pay a penalty. The penalty is the lesser of $3000/employee receiving a subsidy or, $2000/employee of all employees considered eligible employees. ACA allows a 30-employee deductible. That means, for a 50-employee group, the employer will be assessed a $2000 penalty for the remaining employees for the year. Remember, the penalty is the lesser of the two calculation methods.

If no employees receive a subsidy, no penalty will be assessed.

If 10 employees apply for and receive the subsidy, the calculation for the penalty is the lesser of the $3000 X 10 employees ($30,000) or, 20 employees X $2000 ($40,000). So the employer must pay a $30,000 penalty.

Employers who do offer and contribute to a group health insurance plan face another issue. If the employee contribution is 9.5% or more of his household income or, if his contribution covers 60% or more of the total charges (including out of pocket expenses) the same penalty calculations apply.

The penalties apply equally to groups who do not offer coverage as to groups who do offer coverage but do not pay enough toward the coverage or do not pay employees enough wages to allow them to climb above the 9.5% threshold.

To accurately make that determination, employers will be required to obtain accurate household incomes annually.

Employees who will be eligible for a government subsidy are those whose household incomes are up to 400% of the Federal Poverty Level. Simply stated, a family of four with household income of up to $88,000/year will qualify for a subsidy. That means an employee whose family of 4 makes $88,000 or less/year are eligible to apply for a subsidy. He must apply through the Exchange and when the

subsidy is approved, his employer must pay the penalty or raise wages above the threshold to avoid the penalty.

Remember…**If an employer does not offer a health plan AND none of the employees receive a subsidy, the employer is not assessed a penalty.**

Groups with fewer than 50 employees are under no compulsion by ACA to offer and pay for health insurance for its employees. Too, no penalties accrue to those groups for not offering coverage.

ACA does, however, broaden the definition of what constitutes a large group.

1. Businesses under common ownership are grouped together to determine total headcount. If the combined headcount is 50 or more, the group is classified as a large group, even if each group maintains separate health plans.
2. ACA also counts part time employees toward the headcount, using a formula to determine Full Time Equivalent (FTE) employees. The law allows the employer to use the usual number of hours generally worked in an average week by its FT employees as the benchmark for full time equivalent. For example, if the average full time workweek is 35 hours and the employer has 3 part time employees who work 15 hours per week, the FTE calculation is: 3 X 15 = 45 total hours. Then, 45 divided by 35 FT avg hours/wk = 1.28. The employer is considered to have one FTE employee who must be included in the total headcount. When the total of actual full timers and FTEs equal 50, the group is considered a large group.

In 2013, W-2 reporting will begin. That is, W-2s distributed in January 2013, for income earned in 2012, must also report at least the minimum value of the employer's health insurance plan. HHS will issue final rulings clarifying this definition by January 2013. The reporting of the value was initially for the purpose of determining whether a "Cadillac tax" would apply by 2018. Secondarily, it may be used to monitor compliance with participation rules that may be in effect at that time.

ACA does exempt some people and benefit plans from the W-2 reporting. Groups exempt from this requirement include:

-Retirees (They do not receive W-2s from the employer even though they may still remain on the employer's health plan under retiree benefits.)

-Employers with fewer than 250 W-2s to distribute are exempt from reporting the value of health plans on W-2s.

-Dental and vision plans are not to be reported.

-HRAs are exempt.

-Self-insured health plans are exempt.

There are certain types of health plans that must be included in the W-2 report.

-Group long term care plans, although there is considerable debate whether ACA intended to include LTC coverage as reportable on W-2s. ACA does not require LTC plains to be included in determination of MLR.

-Fully insured major medical plans,

-Employee-paid "after tax" supplemental plans for "specified conditions" or hospital indemnity plans.

-Multi-employer health plan participants are also excluded, at least temporarily, pending future guidance from the IRS, cut certainly not until January 2014, for 2013 earnings.

As mentioned above in the opening paragraphs, the voucher program was repealed earlier in 2012. Many employers with 50 or more employees were concerned about the accounting burdens this would place on bookkeeping. AS originally intended, the voucher program required employers who offered group medical insurance, to issue a voucher to employees who qualified for a subsidy and applied for and were issued insurance through the Exchange. The voucher would be equal to the value of the employer's contribution toward the group plan. The employer would simultaneously be subject to the penalty described earlier.

The voucher program is no longer part of ACA, but the penalties as mentioned earlier remain.

Groups of 200 or more employees are required under ACA to set up mechanisms to "auto enroll" new eligible employees. That is, the employer is not allowed to require the employee to complete an enrollment form to be enrolled in health insurance, except for the purposes of insuring dependents. The employee will be automatically enrolled whether he/she completes an enrollment form or not. Individual opt-out is allowed, but the employee must complete a waiver form to opt out.

The Department of Labor has issued a statement saying the 2014 date could be postponed until final regulations can be worked out that make accommodations for employers who already have an "auto enroll" system in place even if that system may conflict with DOL final rulings on "auto enroll."

The DOL intends to have final rulings in place by 2014, but, if not, the start date for "auto enroll" could be pushed back.

ACA also makes accommodations for large groups from 50 to 100 employees to purchase insurance through the Exchange. Self insured plans are not allowed, nor are stop/loss plans available through the Exchange.

Self insured plans receive other exemptions from ACA, mostly because of the categorization as ERISA programs. Plans who choose to self insure and/or purchase stop/loss insurance are not required to report minimum benefit values on W-2s. They may also:

-Charge additional charges for persons with pre-existing conditions

-Escape the requirements of the Medical Loss Ratio

-Avoid having to justify with HHS any unreasonable rate increases.

The Medical Loss Ratio (MLR) applies to fully insured plans only. Insurance plans on groups of 50 or more full time and FTEs must pay no less than 85% of premium volume in claims and wellness programs. In years when the MLR results in claims payments of less than 85%, a refund must be paid to enrollees of the plan. The MLR began in 2011.

A lot of confusion has arisen on whether a group qualifies as a small group or large group for MLR calculations. Small groups are subject to an 80%. ACA allows the definition of a small group to acquiesce to the various states' definition of a small group for groups with 50 to 100 employees.

ACA's upper limit for claiming the 80% MLR (i.e. small group designation) is 100 employees. However if a state maintains an upper limit of 50 employees in its definition of a small group, the state will have to elect to define small groups as those with no more than 100 employees. On January 1, 2016, that election will not be available; the Act's definition of 100 is mandated for all states.

Keep in mind, HHS retains much discretionary power in interpretation of various mandates of ACA. While most of the above is "as we now know it", things can change. The voucher is one example. Another example of the discretionary authority of the Secretary of HHS is power to define benefits. ACA mandated preventive care be covered at 100% without any out of pocket costs to an insured. HHS Secretary broadened the scope of that provision to include colonoscopies, contraception, sterilization, etc. More such rulings are likely in the months ahead.