

**SMALL AND MEDIUM-SIZED ENTERPRISES (SME) AND THE AFFORDABLE
CARE ACT OF 2010 (ACA)¹**

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¹ On March 23, 2010, President Barack Obama signed into law The Patient Protection and Affordable Care Act (ACA), and on March, 30, 2010 ACA was amended with the Health Care and Education Reconciliation Act of 2010. The “Affordable Care Act” (or ACA) refers jointly to the Patient Protection and Affordable Care Act (or PPACA) – Pub. L. No. 111-148, 124 Stat. 119 (2010) – and the Health Care Education Reconciliation Act of 2010 – Pub. L. No. 111-152, 124 Stat. 119 (2010). These laws are the basis for health care reform in the United States. The goal is to reduce the number of uninsured residents by 32 million in 2016. The cost over 10 years may approximate \$971 billion through 2019, paid by individual tax payers and companies. (U.S. Congressional Budget Office, Accessed Apr 4, 2011, www.cbo.gov). The U.S. Supreme court held ACA constitutional in a split decision that was swung to being constitutional by Chief Justice Kennedy, based on the constitutional power to tax. *See* Comm. on the Robert Wood Johnson Found. Initiative on the Future of Nursing, Nat. Acads. Inst. of Med., *The Future of Nursing: Leading Change, Advancing Health* 2 (2011), available at http://www.nap.edu/catalog.php?record_id=12956 (“The ACA represents the broadest changes to the health care system since the 1965 creation of the Medicare and Medicaid programs and is expected to provide insurance coverage for an additional 32 million previously uninsured Americans.”).

Robert Pear, *Brawling Over Health Care Moves to Rules on Exchanges*, N.Y. TIMES, July 7, 2012 at A14.

Paul Krugman, *Krugman calls Senate health care bill similar to law in Massachusetts*, PolitiFact.com. Tampa Bay Times, Jan. 31, 2010.

See The White House, *A More Secure Future: What the New Health Law Means for You and Your Family*, [http:// www.whitehouse.gov/healthreform/healthcare-overview](http://www.whitehouse.gov/healthreform/healthcare-overview) (last visited Oct. 12, 2013).

42 U.S.C.A. § 18031 Sec. 1311(a).

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Abstract— ACA and Small & Medium Sized Enterprises (SMEs)

A dominant Enterprise Risk Management (ERM) consideration for small and medium sized enterprises (SMEs) is managing opportunities and risks under ACA considering total compensation including health insurance for owners and employees. Management of total compensation requires a strategic and tactical approach to capitalize on opportunities and to manage ACA risks. SMEs must work with trusted professionals including a CPA, attorney, and an insurance advisor who have SMEs clients and experience working with ACA. Waiting until ACA mandates and penalties may apply to your small enterprise will miss significant opportunities to manage compensation and be more competitive in hiring employees, mitigating risks and containing costs. Strategic planning and tactical action is required because current costs and opportunities are based on prior year’s employment data, household income, and the number of full-time employees.

ACA defines small employers as enterprises with fewer than 50 employees, and large employers have 50 or more employees, so Medium-Sized employers are included as large employers under ACA. With an a competent team of advisors SMEs can benefit from increased competition among insurance companies and increased accountability among health care providers in private and public health insurance markets, even though state and federal exchanges have had an erratic start.

The Patient Protection and Affordable Care Act of 2010 (ACA)

Called “Obama Care” by some, The Patient Protection and Affordable Care Act of 2010 (ACA) is the most extensive reform to the U.S. healthcare system since the creation of Medicare and Medicaid in 1965.² The Affordable Care Act aims to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public (Medicaid) and private insurance coverage, and contain the rise in costs of healthcare for individuals and taxpayers.

² See Comm. on the Robert Wood Johnson Found. Initiative on the Future of Nursing, Nat. Acads. Inst. of Med., *The Future of Nursing: Leading Change, Advancing Health 2* (2011), available at http://www.nap.edu/catalog.php?record_id=12956 (“The ACA represents the broadest changes to the health care system since the 1965 creation of the Medicare and Medicaid programs and is expected to provide insurance coverage for an additional 32 million previously uninsured Americans.”).

ACA provides a number of mechanisms including mandates, subsidies, and insurance exchanges to increase coverage and affordability uniquely directed to benefit small enterprises, owners and employees. On June 28, 2012, the U.S. Supreme Court ruled the Patient Protection and Affordable Care Act constitutional and, therefore, all individuals are required to have health insurance by 2014. Businesses must now decide how to handle their health insurance.

(Reference: (Glossary of Health Coverage and Medical Terms;
<http://www.cms.gov/ccio/index.html>)

I. A RISK MANAGEMENT PROCESS FOR SMEs

Risk Management Topics

This section reviews: Impact of ACA on Small and Medium-sized Enterprises-Owners and Employees; Opportunities and Obligations for SME Owners and Employees; Eligibility for Individual Premium Subsidy or Tax Credit; ACA Implementation Deadlines; Impact of ACA on Unknowing Individuals. The topics are applicable to all types of enterprises, private, public, partnerships, joint ventures, and are not exclusive to business firms. Small enterprises do not have risk managers on staff as do large enterprises who are members of the Risk and Insurance Management Society (RIMS) or the Public Risk and Insurance Management Society (PRIMA). Small enterprises must rely on a team of advisors to execute their ERM approaches to ACA: Insurance agent/broker/consultant, CPA, and outsourced Human Resource (HR), and legal functions.

Under ACA, SMEs can manage risks based on the risk profile and total compensation package of owners and employees to optimize recruiting, retaining, and retiring. The options to control ACA risks are very specific to geographic location. National or state averages are misleading indicators. What is feasible or optimal in one geographic location may be inapplicable in another geographic location even in the same state, however regardless of location an ERM process is applicable to in a strategic approach to identify, measure opportunities and risks, and apply strategic and tactical options.

A Risk Management Process for SMEs

A dominant consideration for small and medium sized enterprises (SMEs) is how to manage the upside and downside risks of ACA. ERM offers a guide for owners and employees to control risks and optimize their desired compensation package. Firms can risk manage the uncertainty, pending deadlines, issues, and penalties under ACA through a process of risk identification and assessment, selection of the best combination of methods to capitalize on opportunities and control potential loss.

SMEs are benefiting from fierce pricing competition in the newly competitive health insurance markets: State Exchanges, Federal Exchanges, Private Exchanges, Insurance Companies & Agents. Insurers are in competition both within and outside of government exchanges and with other markets. There are new accountability standards and competition among health care providers. The degree of competition and cost containment is geographically specific, even to locations within one state. For example, even though Minnesota offers the lowest premiums of

any state, one area in MN has higher premiums. Under ACA cost containment can rise from over 100 pilots/experiments under ACA which include the development of Accountable Care Organizations (ACO).

Preliminary Findings and Common Questions and Answers

The preliminary findings of Eide Bailly show the following types of businesses will see the greatest financial difference between the ACA options they face:

- Small businesses that currently don't offer insurance
- Businesses with large numbers of part-time or seasonal workers
- Businesses with employees who receive, on average, lower wages

In one case, the numbers indicated a potential 40% savings to the organization by sending employees to an Exchange, while increasing salaries to cover employees' costs for those who are not subsidy-eligible.

Common Questions and Answers by Eide Bailly:

(http://www.eidebailly.com/media/651755/health_care_reform_services_brochureupdate.pdf)

1. Will we be assessed the penalty if our employees go to a health insurance Exchange, but do not receive a subsidy?

No.

If you are an employer with more than 50 full-time equivalent employees, you do not offer health insurance and none of your employees receive an Exchange subsidy, then you will not have to pay the penalty. However, if an employer-sponsored plan is not offered and one employee receives an Exchange subsidy, then you will pay a \$2,000 penalty per full-time employee (minus the first 30 full-time employees).

Additionally, if you offer affordable health insurance coverage and an employee decides to go to an Exchange, you would not have to pay the penalty.

2. How will we know what type of coverage our employees have if we drop coverage? Are they required to report to us?

Employers who do not offer health insurance will not know what type of coverage or plan their employees will choose through an Exchange. Employees are not required to report the type of coverage or plan they choose to their employer.

3. Can we offer an employer-sponsored health insurance plan and also give employees the option to go to an Exchange?

Yes.

An employer can continue to offer an employer-sponsored plan and allow employees to go to an Exchange to purchase health insurance. However, employees who go to an Exchange to enroll in a plan, while their employer's plan is deemed to be affordable, will not be eligible for an Exchange subsidy.

4. Is health insurance coverage required just for U.S. citizens or all individuals, including green card holders?

Health insurance coverage is required for U.S. citizens and lawfully residing non-citizen immigrants. Therefore, both U.S. citizens and lawfully residing non-citizen immigrants

are subject to the individual mandate tax and are eligible to receive an Exchange subsidy.

For a National insurance coverage see **Appendix I. National Insured Population: Large Employer- 71%; Individual & Small Enterprises- 8%.**

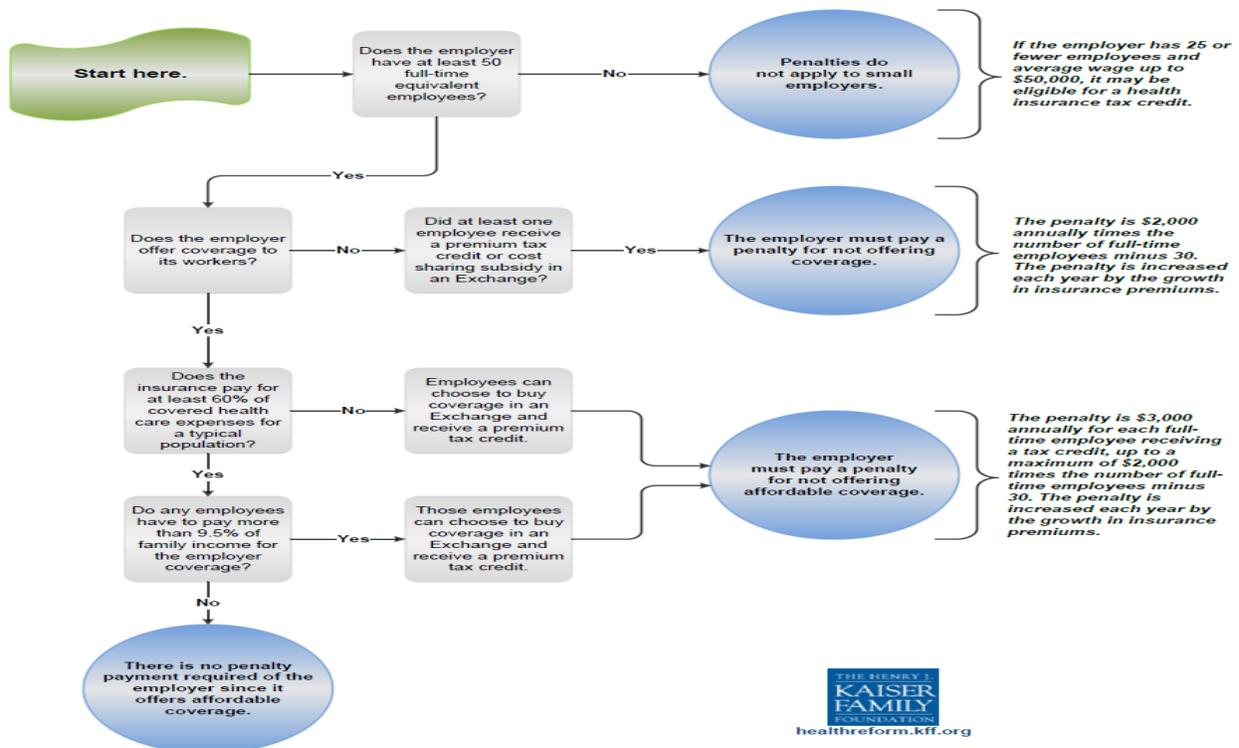
Initial ERM Check List (With Items Expanded in Later Sections)

This ERM process allows you to distinguish from competitors and anticipate how you and competitors may be impacted by ACA. Making sound business decisions requires assessing the opportunities and risks within a total compensation context in a strategic plan with tactical options. The strategic plan defines your goals over one to three years and then creates a plan to achieve your goals anticipating the future.

For example a key goal of your degree of growth begins with your current size in number of employees which directly determines your opportunities and risks under ACA. Your total compensation plan considers your firm’s unique culture, vision, trends, opportunities and threats in the market place for employees and products verses competitors. The information and check list below permits you to do a SWAT analysis identifying your strengths, weaknesses, opportunities, and threats presented by ACA.

The following Figure 1. shows a summary of the decision process for you to Pay penalties or Play by providing health insurance, "Pay or Play"; each step is explained in the check list and information in chapter sections:

Figure 1. “Pay or Play” Decisions



To determine an SME must "Pay or Play", the following questions must be answered: (These questions are addressed in a later section)

- Who are full time employees, and what is their household income?
- What was the number of full-time Employees? (Fulltime Employee Equivalents)
- Independent contractor vs. employee status.
- What Is Minimum Essential Coverage?
- What is Affordable Health Coverage?
- What is minimum coverage?
- What are the Penalties and when do they apply?

Large employers with 50 or more full-time equivalent employees include medium sized employers:

ACA affects all businesses; however, "large" employers with 50 or more full-time equivalent employees are required to:

1. Provide affordable health insurance coverage for all full-time equivalent employees, or
2. Elect not to provide health insurance coverage, pay defined penalties, and send employees to a state, regional or federal Exchange to purchase insurance, or with advisors, or
3. Develop a new hybrid plan.

These "large" employers who elect not to provide health insurance coverage will be assessed a penalty of \$2,000 annually per full-time employee, minus the first 30 full-time employees if at least one employee receives an Exchange subsidy. Additionally, if they offer employer sponsored coverage which is deemed unaffordable

(i.e., an employee's "self-only" premium exceeds 9.5% of their wages and receives an Exchange subsidy), the employer will be fined \$3,000 for that employee.

Small Organizations with less than 50 full-time employees:

Small organizations which have less than 50 full-time employees can begin to take advantage of opportunities under ACA even though they are not subject to the penalties.

Because of the perceived cost-savings of not providing coverage, it can be tempting for small organizations with less than 50 full-time equivalent employees to simply opt not to offer health insurance to employees without taking the time to determine how to advise owners and employees and to determine if not offering insurance is the best business move. It is critical to consider all aspects of the situation in order to make an informed decision that is in the best interest of company owners, employees, and their families.

Making health care decisions is difficult because... 1. Health care is inherently complex; 2. Health care is personal, and 3. Insurance cost and access to care is local, and widely varies by geographic location.

Begin your ERM assessment by reviewing the following check list while working with an accountant and insurance advisor experienced with ACA. Each item on the list is expanded in a later section. ((The statement under each item below that "it is described in a later section could be deleted or could be keyed to a specific section title))

1. Establish a budget including "total compensation" designed to meet the needs of owners and employees. Total compensation including the health care benefit options described in later sections.

2. Great opportunities to stay competitive in recruiting, retaining and retiring workers arise from determining what salary and benefit packages meet the needs of owners, highly paid executives and all other employees. Total compensation packages may include company ownership, stock options, salary, wages and employee benefits including health insurance, and ownership and protection of intellectual property. Risk management and insurance for major assets such as intellectual property, loss of income and property is treated in Chapter titled Risk Managing Intellectual Property.
3. Are you a small firm with less than 50 employees or a medium and large sized firm with 50+full-time equivalent employees? ACA creates opportunities without penalties for small firms. For larger firms with 50+ FTE employees ACA imposes mandates, penalties and taxes for failure to comply. Later sections describe how to control the number of full-time employees.
4. Check options explained in later sections to keep full-time employees under 50 to avoid the ACA mandate and penalties. Later sections explain ways to avoid penalties by keeping the number of full-time employee equivalents under 50.
5. Check options to keep full-time employees at fewer than 30 for tax credits as explained in a later section.
6. For firms with 50 + full-time employees total compensation packages commonly include employee benefits such as flexible spending accounts (FSA), health insurance options, such as health saving accounts (HSA) or health reimbursement accounts and cafeteria plans. An employee can elect to fund FSAs for medical services (up to \$2500) not paid by insurance, and for schooling and services (up to \$5,000) for dependent children and dependent adults. As explained in a later section it pays to review flexible spending account (FSA) options because these accounts avoid FICA taxes which employees pay 7.45% of W-2 wages and employers pay 7.45%, and FSAs avoid income taxes.
7. For firms with 50 + full-time employees self-insurance may be a viable option with control and cost reduction opportunities. Determine the options for health plans in your geographic area: fully insured or self-insured; this is expanded upon in a later section.
8. For firms with 50 + full-time employees, is the employer sponsored health insurance “affordable as specifically defined in the ACA?
9. What is each individual’s total cost of health insurance? The premium (after any subsidies), plus copays, deductibles, coinsurance, capped by out-of-pocket limits, and uncovered health expenses. Each owner and employee household should determine their annual medical expenditures by frequency and dollar amount and estimated for next year. This will be helpful in selecting among health insurance plans everyone must have in 2014, as explained in a later section.

10. Gather prior year's employment data: age, gender, household income, number and age of dependents, benefits available at a spouse's employment, and the number of full time equivalent employees. Every health insurance choice under ACA is keyed to each employee's household income and to the health care provider network they want. This is expanded in later sections.
11. Premium and cost-sharing subsidies are keyed to household income so check household income to see if any owners or employees are eligible for premium subsidies.
12. There are two subsidies available only at government exchanges, the premium subsidy and the cost-sharing subsidy when household income is below poverty level. For 2013, the Federal Poverty Level in the continental U.S. is \$11,490 for an individual and \$23,550 for a family of four and is indexed to increase. An employee is not eligible for a premium subsidy if the employee is either (i) enrolled in an employer-sponsored plan or (ii) eligible for an employer-sponsored plan that meets the affordability and minimum value requirements, or (iii) elects the lowest premium catastrophe plan. People with low or no household income can gain medical coverage through Medicaid (Medical Assistance (MA) or other State programs such as Minnesota Care). In states that have not elected to expand Medicaid under the ACA there is a health insurance coverage gap when income is too high for Medicaid eligibility and too high for premium subsidies.
13. Will you individually be subject to a penalty? If you are single, a couple or a family and you do not have health insurance in 2014, you will incur a financial penalty. One option is to apply for a catastrophe plan which is lowest premium option and is available until you are 30 years old. However the premium is not subject to a subsidy. This option, as explained later is useful for individuals of moderate to high income.
14. If you are covered under an affordable employer plan with ACA qualified benefits, you are not required to buy health insurance, but you should check your options on the government exchange to compare your required employee contribution with the exchange premium which could be lower if you have below poverty level household income or you need family coverage, not single employee coverage (affordability is measure only by the single employee's premium), as explained in a later section.
15. Consider joining a Small Business Health Options Program ("SHOP") created by ACA in and outside of government exchanges. In 2014 or 2015, businesses with up to 100 employees may be able to use state-based SHOP exchanges to purchase coverage. The opportunities and risks of SHOP options are explained in a later section. However firms with a young, healthy and a low health care utilization group of employees are likely to pay higher premiums if other firms in the SHOP have a higher age, or sick and high utilization groups of employees.
16. Determine which health care providers are important for you and employees to access. Which health insurance plans offers in-network health care providers, accessible at lower

copays? Assess to your preferred health care providers is often the key personal and local determinate as explained in a later section.

17. When selecting an insurance company plan determine which insurers are fair in processing claims. Which insurers return a higher percent of premiums in claim payments, have higher claims to premium ratios, and have good reputations for claims payment. An independent insurance advisor can assist as explained in a later section.
18. With an insurance advisor evaluate the likelihood of premium increases in the future. Insurance plans can give you their premium determination formula including past claims plus trend, and stop-loss premium. This process is explained in later sections.
19. Selection of agents and health insurance plans should not occur annually. Plan stay with an agent or insured for at least three years.

If a small business with less than 50 full-time employees has not offered health insurance they probably will not now offer an employer sponsored plan. The new exchanges and markets for individual insurance offer reasons not to offer employee health insurance. These employees are better served by selecting in the market coverage which best meets family needs. Good coverage may be available at an exchange with a premium subsidy and cost sharing subsidy for low income employees, while higher income employees may select the lowest premium plan, the catastrophic plan. So exchanges actually give some small businesses more reasons to not offer health insurance coverage. However consideration of total compensation design as explained in later section may be the best way to facilitate recruiting, retaining and retiring employees. (<http://www.businessweek.com/small-business>)

ERM Begins With SMEs Total Compensation and An Insurance Portfolio

Application of an ERM process begins with SME's total compensation and traditional insurance portfolio of commercial insurance, employee benefits, and personal insurance. The risk spectrum includes financial risks, human resources, intellectual and tangible property, and legal liability. An SME needs experienced competent advisors to address the complex impact of ACA: insurance advisors, CPA's and attorney's knowledge about the applicable government laws and rules.

Costs of Compensation, Benefits, Insurance and Taxes

SME costs for total compensation, employee benefits and insurance can be measured. Total compensation includes salary/W2 wages, mandatory and discretionary employee benefits, tax savings, health insurance, and funding options such as Flexible Spending Accounts, HSAs, and Cafeteria plans.

A general sense of total compensation costs is derived from the US government website, www.bls.gov. These costs for SMEs are a starting point for budget planning and quantifying the

cost and options of benefits and insurance. The following is an excerpt from a BLS new release, based on September 2011 data:

“Employer costs for employee compensation averaged \$30.11 per hour per worker in September 2011. Wages and salaries averaged \$20.91 per hour worked and accounted for 69.4 percent of these costs while benefits averaged \$9.21 and accounted of the remaining 30.6 percent. Total employers compensation costs for private industry workers averaged \$28.24 per hour.” (US Department of Labor, “Employer Costs for Employee Compensation, September 2011, “USDI, 11-1718. Accessed from www.bls.gov.)

Generally total compensation includes wages and salary about 70% and employee benefits about 30%. The cost percentages vary significantly by size of employer, location, and occupational classification. However they represent a base from which SMEs can begin to allocate and control costs.

For “The Management, Professional, and Related Occupational Group” the following costs per hour are shown: (This occupational group has the highest total per hour of the seven occupational groups on the DOL website and is compared to the lowest Group on the website.) This highest per hour group of \$50.11 is compared with the lowest per hour group of \$16.48 as a percent of total compensation:

Wages and salaries 69.9% v. 71% - about 70% of Total compensation

Total Benefits 30.1 % v. 29% - about 30% of Total compensation (includes legally required)

The 30% of Total compensation benefits includes **health insurance of about 8% to 12% of total compensation.**

Tax saving can be -----about 8% to 40% of Total compensation

Legally required insurance as a percent of total compensation:

Insurance 4.03% v. 8.5%

Legally required 6.61% v. 9.3% (roughly double for sole proprietors 14% v.19%)

Fed/State Unemployment .4% v. 1.1%

Workers Compensation .8 v. 2%

Several types of State and Federal government insurance mandates are briefly discussed.

States mandate auto insurance and workers compensation, and the federal government mandates Social Security and Medicare, and Federal/State Unemployment Insurance, and now ACA. The premiums and taxes for these programs must be paid by SMEs and vary from about 10% to 20% of payroll.

Taxes/Premiums for Government Insurance:

Most SMEs are required to pay significant taxes and premiums which can amount to between 10% and 20% of payroll. Workers compensation premium and unemployment could be 1% to 4% of payroll and Federal Insurance Contributions Act (FICA) taxes on W-2 payroll are from 7% to 9% (Double for sole proprietors and for combined employer and employee taxes). Health insurance can average 8 to 12% of total compensation.

II. THE TYPE OF INSURANCE

Workers Compensation – Can Be The Best Health Insurance

ACA mandates the third type of health insurance for all enterprises. Worker's compensation (WC) and automobile insurance have long been State required insurance; both include types of health insurance, and income loss/indemnity benefits. In many states, workers compensation can provide an SME with comprehensive health insurance, both medical and income loss, for job connected sickness and injuries. SME owners are almost always on the job! Workers compensation medical benefits are typically broader than health insurance and are unlimited, with no copays or co-insurance.

Management of all insurance for SMEs is addressed in the chapter on risk managing intellectual property. Life and disability insurance for key business owners and employees is important to provide cash for rehab or replacement of key employees, and to fund transfer to surviving or new SME owners.

Self-Insurance Considerations

Workers compensation and health insurance are self-insured by most large enterprises (Self-Funded = Self-insured); but many SMEs do not have over 100 employees commonly required for self-insurance. Self-insurance offers employers increased risk but more control and claim reduction incentives, and can reduce administrative expense, fees, premium taxes and insurance company profits.

Employers with self-insured plans can more easily manage incentives to avoid ACA penalties by keeping employees from going to the government website. For example increasing the employer contribution for single employees can satisfy the excess of 9.5 % of household income standard and keep individuals from going to the exchange, which might incur penalties.

SMEs with more than 50 Employee FTEs might consider a self-insurance option, and could outsource the management of its self-funded health plan to consultants, third party claims administrators (TPAs), and advisors.

Self-insured workers compensation requires state insurance department approval.

Under ACA, enterprises with more than 50 employee FTEs should consider newly available self-insurance frameworks which satisfy ACA requirements, and may avoid penalties and possibly gain tax credits. Self-insured employer plans may be exempt from offering coverage for the 10 Essential ACA required Benefits including hospitalization, prescription drugs, maternity care and preventive services. However state law may require a list of minimum coverage items. SMEs will need stop-loss insurance to help pay unpredictable, high-cost claims. Firms experiencing high premium increases for stop-loss coverage may opt to buy regular health coverage at the government or private market places. Redesigned stop-loss coverages options are now available. Stop loss insurance pays a medical claim in excess of a specific claim stop loss, such as \$100,000, and also pays claims over an aggregate for the policy year, which is commonly all claims plus 15% of an estimate of all claims.

Process for Buying Insurance

Select Agents

When initially buying insurance, select two agents to help explore the market and find the best fit of a few insurance companies. One agent can be an exclusive agent selling primarily for one insurance company; the other can be an independent agent selling for a several insurance companies. Ask the independent agent which companies/markets the agency will approach to obtain quotes. Give the agency an agent- of- record letter specifying permission to approach only those companies/markets. It is best to have all or most property and casualty insurance with one agent and one company. The health, life and employee benefits, maybe with the same or with another agent.

Agents /Insurance Company Services

The agent(s) will work with you to identify risks and available insurance by priority. Independent agents while help select and stay with a health plan that reasonably and fairly pays claim. Agree that lowest premium is not the primary company/insurance selection criteria. List criteria as a basis for your ultimate selection: the insurer's claims payment reputation, service, and premium stability over three years. Plan to stay with this agent(s) and insurance company (ies) for at least three years before again testing the insurance market place. Agree to a three year service contact which lists services, compensation and selection criteria.

Risk Identification and Coverage Assessment

Agents should assist with the process risk identification regarding all types of insurance, the details of which are beyond the scope to this chapter. Some important insurance coverages typically missed by small businesses are addressed in the chapter on Risk Managing Intellectual Property.

III. MEASURING IMPACT OF ACA ON SMES.

Now is the time for insurance agencies, risk managers and other experts to assist small business in risk managing the impact of ACA. They will help you recognize the financial opportunities and risks of ERM approach.

Up to 4 million small businesses that offer healthcare coverage to their employees may be eligible for a tax credit. At an Exchange find out if you qualify for a tax credit:

- Are you a small business with fewer than 25 full-time equivalent employees?
- Pay average annual wages below \$50,000 per FTE?
- Contribute at least 50% of each employee's premium?

Notes: Owners are excluded, and should not be counted in number of employees, wages, or premium contribution amount. Tax credits can't be larger than actual income tax liability.

Input the following data for a preliminary estimate, contingent upon accurate inputs for FTEs, average wages, and employer premium contribution as defined by the provisions of the healthcare legislation.

- Number of full-time equivalent employees:

- Total annual wages paid for all employees:
- Total annual employer premium contribution:
- Are you a tax-exempt/nonprofit employer?

Go to the IRS website for more information.

<http://mn.gov/hix/calculators/main/BusinessCalculator.jsp>.

ACA Risks & Opportunities Vary By Individual, Household, Firm Size and Location

The risks under ACA vary among individuals, small and Medium-sized enterprises: (ACA definitions of small –exempt (have less than 50 FTEs (and large enterprises have 50 or more FTEs) as described later in this chapter)

1. Small Enterprises- Exempt from ACA Mandates, must manage ACA risks
2. Medium-sized Enterprises with more than 50 employees earning over 30 FTEs (This may change to 40 FTEs) must choose to provide affordable health insurance or pay penalties.(The play or pay decision)

Government (federal and state exchanges) exchanges are designed to make health insurance affordable and available by

- a. enrolling Medicaid, poverty level insureds
- b. subsidizing the premium and co-payments of low income poverty level insureds,
- c. enrolling higher income individuals with no premium subsidies. (In competition with private exchanges and private insurance markets.)

b. & c. make up only a small percent, 3 to 8%, of all people who may obtain required health insurance, but the millions of people in c. (including the owners and employees of small ACA exempt enterprises) are target markets for private health insurance companies.

Before ACA this c. group faced high premiums and inadequate health insurance coverage. Now Small and Medium-sized Enterprises have new opportunities to assess their own needs and review both the b. and c. markets in their specific geographic areas within their state.

SMEs Facing ACA Benefits and Risks: Taxes/Credits | Penalties/Exemptions | Compliance

ACA impact for SMEs and individuals:

- Requires individuals and SMEs with 50 or more employees to have qualifying health coverage
- Possible premium discounts cost sharing subsidies, but only if purchased through a Government Exchange, can really reduce costs. These affordability subsidies are available to eligible individuals and families with incomes between 100- 400% Federal Poverty Level.

- Both premium subsidies AND Cost Sharing Subsidies. Cost Sharing Subsidies, means lower co-payments or lower deductibles, for those in the 100-250% Federal Poverty Level.
- More standardized & mandated benefits packages - the four metals plans, plus a lowest premium, catastrophe high deductible plan, are offered. Each insurance company offers several plans; choice is complex.
- **Two possible penalties can be avoided by some SMEs:** There is no penalty if no full-time employee receives an Exchange subsidy, and of course no penalty if the employer offers “affordable, compliant coverage. (penalties are not tax-deductible)
- **Employers with (50+ FTE employees) who do not offer "compliant" coverage will not owe a "no coverage penalty" of \$2,000 per year (adjusted for inflation) unless one of the full-time employees goes to a government exchange and gets a subsidy. This is the penalty that an employer should be prepared to pay if it does not offer compliant group health coverage to its employees. After one employee gets a subsidy, the total penalty is \$2000 times the number of full-time employees, less 30.**
- **Employers (50+ FTE employees) who do offer "compliant" coverage** are subject to a non-deductible \$3,000 penalty for every employee that receives a subsidy by going to the government exchange. The number 30 is not deducted in determining the penalty. This is an "inadequate coverage penalty" which is \$3,000 per person and is calculated on the single employee who receives an exchange subsidy, not on the employer's total number of full-time employees. (Furthermore the penalty is capped each month by the maximum potential "no coverage penalty") Because Exchange subsidies are available only to individuals with household incomes of at least 100 percent and up to 400 percent of the federal poverty line (in 2013, a maximum of \$44,680 for an individual and \$92,200 for a family of four), employers that pay relatively high wages may not be at risk for the penalty, even if they fail to provide coverage that satisfies the affordability and minimum value requirements. Likewise, because Exchange subsidies are not available to individuals who are eligible for Medicaid, employers may be partially immune to the penalty with respect to their low-wage employees, particularly in states that elect the Medicaid expansion. Furthermore employers might avoid penalties by providing compliant coverage only for low household income employees who would otherwise be eligible for Exchange subsidies, so employers can ensure they are not subject to any penalty, even if they don't compliant coverage for all employees.
- Tax credits: The tax credit is for small businesses that contribute 50% or more to employee- health insurance premiums. However, health insurance premiums increase from 35% to 50% may be experienced for some participating in SHOPS described below.
- Small business health options program (SHOP): These SHOPS, combine the experience of a number of SMEs and may increase purchasing power by joining with other small enterprises to create a larger pool; variation risk, may be lowered and fixed cost spread to a larger base, but not an attractive option if your employee average age is lower and utilization is lower than the other employers in the SHOP.
- Permits employers to offer employees rewards up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards
- Report value of health care benefits on employees' W-2-Now for employers who issue 250+ W'2s Expanded 1099 filing- was repealed!

- Voluntary federal Long Term custodial Care (LTC) program made available to worker-Indefinitely delayed due to lack of funding
- Small employers (fewer than 100 lives) allowed to adopt “Simple Cafeteria Plans”
- Grants to small employers that establish wellness programs
- Large employers (more than 200 employees) to auto-enroll employees in health plan (with opt-out)
- No cost sharing and coverage requirements for in-network preventive health services for women (non-grandfathered only)
- New Women’s Preventative Care Benefits including free contraceptives and more. Certain non-profit groups with religious objections have delayed it; their suit has reached the U S Supreme Court with a decision scheduled for summer 2014.
- Medicare tax for high income taxpayers – the tax is .09% above the 1.45% or 2.35% in total for: (This FICA tax is avoided on low and high incomes with payments from employer sponsored flexible spending accounts (FSAs)
 - a) \$200,000 on wages for an individual
 - b) \$250,000 for married couples filing jointly
 - c) \$125,000 for married filing separate
- 3.8% assessment tax on unearned income for higher-income taxpayers based on modified adjusted gross income exceeding:
 - a) \$200,000 single
 - b) \$250,000 married filing jointly
 - c) \$125,000 for married filing separate
- Notification of state insurance marketplaces (exchanges) – Employees must get notice within 14 days of an employee’s start date, <http://www.dol.gov/ebsa/healthreform/>
- Employers with 50+full-time employees which offer employer sponsored health insurance, and FSAs should know the .
- \$2,500 FSA limit - Does not apply to any types of contributions or amounts available for reimbursement under dependent care reimbursement accounts up to \$5,000, health savings accounts, or health reimbursement arrangements, or to salary reduction contributions to cafeteria plans that are used to pay an employee’s share of health coverage premiums (or the corresponding employee share under a self-insured employer-sponsored health plan)

Taxes and Unexpected Financial Consequences

A few examples demonstrate that failing to properly advise and act can be very expensive. In the absence of expert advice, there could be many surprises that will occur when it is too late to avoid devastating financial consequences. (Computations of likely premium costs are from the Henry.KaiserFamilyFoundation website, kff.org and www.Healthreform.kff.org/subsidvcalator.aspx.)

Examples of drastic financial consequences:

100% tax on incremental income: An individual family household income is \$80,000, and the family is advised, to distribute in 2013 \$13,000 from their

401(k) to bridge the income gap before social security payment begins. This family will lose about \$7,400 in premium subsidies at the health insurance Exchange because Household Income of \$93,000 is over the \$92,200 premium subsidy “cliff.” The household income for the premiums subsidy is measured by 2013 household income. (Based on an estimated premium cost of \$15,000 for a family of four, using 2012 Poverty Guidelines, U.S. Department of Health and Human Services website, aspe.hhs.gov, and IRC 36b(a)(3)(A) which specifies the income based percentage subsidies).

The total marginal tax rate on the \$13,000 is 100%. The marginal tax rate is 57% = $\$7,400/\$13,000$ on the on the incremental gross income; plus a 22% combined marginal federal and state income tax rate; plus the FICA and Medicare taxes on the incremental income.

A retired single person age 58 whose income is \$36,000 and who takes a \$12,000 distribution in 2012 from an IRA, 401(k) or deferred compensation plan, will lose a \$6,265 premium credit. This assumes a midrange estimate of the annual base insurance premium of \$9,685.

Should these people take a double distribution, about \$24,000 every two years, to get the premium credit every other year? They could not even do that if they just locked into a \$13,000 life annuity!

At least amend ACA to turn the “Cliffs” into hills using a three year average household income base for the poverty level and the subsidy.

Small Exempt Employers Can Benefit From The Mandates and Affordability:

Do not ignore ACA just because you are small, less than 50 FTEs, and exempt from the mandate. True, SMEs with less than 50 employees with FTEs are exempt from the ACA mandate and penalties. However,

1. Individuals are not exempt, and the owners and employees need a compensation/insurance portfolio including health insurance.
2. In addition if household income is low employees and owners may be eligible for no or low premium health insurance.
3. If you have a business with 25 full-time equivalent employees, you may be able to get federal tax credits that pay up to 50% of premium costs.
4. Your total compensation considerations and competitive labor market position may demand attractive health benefits
5. You might comply, get tax credits, and favor single employees by paying over 9.5% of their total household income (contribution for the lowest-cost self-only coverage option; what an employer contributes to couple or family dependent health insurance is not considered in determining compliance), and you can consider offering an HSA-, Cafeteria plan, Flexible Spending accounts, thus favoring higher income employees.

IV. NEW INSURANCE MARKETS FOR SMES

Government Exchanges: Options for SMEs -25 or 50 FTEs

Government Exchanges were designed to provide assistance to individuals and small businesses. There is a small employer tax credit for fewer than 25 full time equivalent employees. An employer penalty exemption – employers with fewer than 50 full time equivalent employees are exempt from the employer shared responsibility penalties. Exchanges provide tax credits for lower income people who enroll in individual policies on the exchange

SHOP – opens to smaller employers (50 – 100 sized employees depending on size)
In 2017 – SHOP may open up to all employers. However according to the CBO, larger employers will continue to offer their own self-funded or fully insured health plan.

Small Business Health Options SHOPS for SMEs

Before ACA, states had special market requirements for groups of less than 25 employees. These requirements have for the most part been incorporated in ACA SHOPS, Groups of small enterprises with pooled experience for premium determination. SHOPS are both in government exchanges and outside of exchanges. One indication of the variations in ACA implementation by geographic location is that SHOPS will not be available on the federal exchange until 2015; in some states, SHOPS are available either in or outside of the state exchange. SHOP – opens to smaller employers (50 – 100 sized employees depending on size)

In 2017 – SHOP may open up to all employers.

The federal rules allow a state to operate a State-based Small Business Health Options Program (SHOP) while HHS would operate an individual market Federally-facilitated Marketplace in that state. States can provide reasonable assurances through the Exchange Blueprint submission and/or amendment process that they will be able to establish and operate a SHOP.

If a small ACA exempt enterprise has poverty level and low household income people to qualify for no premium or low premium subsidies, it's likely that an employer offered plan in a SHOP would require higher premium. However the small enterprise may offer a type of flexible spending account which can be used to reimburse health expenditures for employees and their dependents, and employers can offer HSAs or cafeteria plans giving employees options to purchase insurance.

Small Business Calculator

Exchanges, government and private, increase competition among health insurers and make it easier for small businesses to cover the cost of health insurance for their employees. If you have a business with 2–50 full-time equivalent employees, you may be able to get federal tax credits that pay up to 50% of premium costs. Small employers can use a calculator key to their own state to help estimate what size tax credit you might qualify for, for example:

Up to 4 million small businesses that offer healthcare coverage to their employees may be eligible for a tax credit. Calculators require filling in the amounts below to find out what your tax credit will be.

To qualify, a small business must:

- Have fewer than 25 full-time equivalent employees
- Pay average annual wages below \$50,000 per FTE
- Contribute at least 50% of each employee's premium

Notes:

Owners are excluded, and should not be counted in number of employees, wages, or premium contribution amount.

Tax credits can't be larger than actual income tax liability.

For detailed information about how the tax credit works and other issues related to the new law and small businesses, see this list of [frequently asked questions](#). Tax calculator are available to be applied to a specific state and an area within a state.

Small Businesses Should Take Advantage of New Health Insurance Tax Credit

(Originally in a Minnesota Chamber of Commerce newsletter from September 13, 2011)

As Commissioner, it concerns me that small businesses pay, on average, 18 percent more than large businesses to provide health insurance for their employees. That is why I am encouraging you to review whether your business is eligible for the Small Business Health Care Tax Credit. If you own a business with less than 25 full-time employees, pay average annual wages below \$50,000, and provide health insurance for your employees, you might be one of the 94,900 small businesses in Minnesota eligible for this health insurance tax credit.

The Small Business Health Care Tax Credit provides direct tax relief for small businesses, helping offset the cost of purchasing health coverage for your employees. The tax credit could reduce your health insurance costs by as much as 35 percent depending on average wages and number of full-time workers. It was passed as part of the Affordable Care Act of 2010 (ACA). To take advantage of this tax credit, you have to file by a certain date. According to the Internal Revenue Service (IRS), there are two important tax filing deadlines you should be aware of: Corporations that file on a calendar year basis and requested an extension to file to September 15 can calculate the small employer health care credit on Form 8941 and claim it as part of the general business credit on Form 3800, which they would include with their corporate income tax return.

Sole proprietors who file Form 1040 and partners and S-corporation shareholders who report their income on Form 1040 have until October 17 to complete their returns. They would also use Form 8941 to calculate the small employer health care credit and claim it as a general business credit on Form 3800, reflected on line 53 of Form 1040.

Additional information about eligibility requirements and calculating the credit can be found on the Small Business Health Care Tax Credit for Small Employers page of www.irs.gov.

Unanticipated Litigation

The combination of ACA and existing laws could result in unanticipated litigation against employers for workforce adjustment. Employers cannot discharge or take adverse employment action against employees based on collection of benefits or benefit claims. If a company with 53 employees wanted to readjust its workforce to drop below the 50-employee mark to avoid coverage requirements, those terminated may have legal recourse.

The burden of proof under the federal law primarily falls on the employer – the employee only has to show that benefit collection was a factor in their termination. There is a risk that this could limit workforce control for fear of potential lawsuits. (*Brian Rosemeyer at brian.rosemeyer@ecm-inc.com*)

See Appendix III. for a Summary Statement from IAEBPs explaining Sections II – V.

V. THE PAY OR PLAY DECISION

The employer shared responsibility referred to as **“Pay or Play”** mandate will officially apply for most employers on January 1, 2015, recently changed from January, 2014. * (‘Shared Responsibility for employers Regarding Health coverage, proposed IRS reg. Jan 2, 2013, to be applied prospectively to give more time to come into compliance.) The Figure 1. At the beginning of this chapter shows the decision process involving the Pay or Play decision.

Certain small and Medium-Sized (SME) enterprises (all types of enterprises, businesses, government, not for profit) must sponsor health insurance for employees by January 1, 2015, if they have an average of at least 50 “full-time equivalent FTEs on business days based on a specified look-back time, “determination period”. Employees, with 30 hours per week on business days during the preceding year are used to make the determination.

By 2015, states have the option to define the upper limit for small employer as between 50 and 100 employees. By 2016, small employers must be defined as employing up to 100 employees. Proposed legislation would increase the 30 FTE to 40. SMEs with less than 50 employees in one year can elect to sponsor health insurance for employees.

If the employer is close to employing 50 full-time employees in a given month, it should pay attention to the number of hours worked by part-time staff because the aggregate number of hours worked may push the employer over the 50 full-time employees threshold and expose the employer to pay or play penalties; a seasonal worker exception may apply.

Employers must offer coverage, minimum essential, minimum value and affordable health coverage to at least 95% of the full-time employees and their dependents, those working an average of 30 hours per week, or be subject to penalties, computed and assessed on a monthly basis. Penalties apply only if an employer meets the definition of an “applicable large employer” and then only when the employer fails to provide minimum essential coverage that is affordable,

and an employee receives subsidized insurance at a government exchange. Employers should keep a record of this calculation in order to support their decision in case the IRS requests an explanation at a later time. Hours worked include paid vacations, leaves of absence, but does not include hours worked outside the US. Employee handbooks that define employees who work less than 32 hours as part-time will have to be changed.

Many employers are calculating whether the cost to provide coverage outweighs the cost of the penalties, then placing this in the context of their total compensation package personally and in a competitive labor market.

Large/Medium-Sized Employers Must Play or Play

Large/medium-sized employers are given the responsibility to offer coverage that is **affordable**, meaning the employee premium portion for single coverage is less than 9.5% of their household income (HHI). 2010 Census household income was...\$50,000. Kaiser Premium Survey: Average single = \$5,884

Large/medium-sized employers are given the responsibility to offer coverage that is **adequate**, meaning the plan requires a minimum value above 60% of the average actuarial value of benefits. No more than 40% of costs on average can be spent by an insured on covered out of pocket expenses (OOPs) including the Deductible, Copays & Co-insurance. The premium amount varies inversely with the OOP limits and directly with the percent of actuarial value covered: 60%, 70%, 80%, and 90%. The higher the premium for lower OOPs and for lower percent covered.

Medium Sized Business Cases: Play or Pay?

For executives in the retail and hospitality sectors who don't offer insurance, the coverage mandate represents a major shift in how they do business. The considerations are outlined in the following case of D. Brian's All Natural Deli and Catering owner Doug Sams to pay more or risk alienating workers.

*(ST. PAUL, Minn. — A while back, D. Brian's All Natural Deli and Catering owner Doug Sams grappled with a tough decision. (Minn. businesses struggle with ACA employer mandate, by Catharine Richer, Minnesota Public Radio, August 16, 2013))

Under the Affordable Care Act, Sams has to offer his 80 full-time employees in the Twin Cities health insurance coverage. If he does not he faces fines. At first, Sams thought he would pay the penalty, which would have cost him well over \$100,000 a year. But he decided that was too much. Next, he considered cutting back his employees' hours. The law's "employer mandate" only applies to businesses with more than 50 employees who work more than 30 hours a week. So, if he cut workers' hours to fewer than 30, he wouldn't have to insure them. But trimming schedules would have been unpopular and unfair to his staff. Sams settled on giving all his workers insurance through Blue Cross Blue Shield -- and he hopes they don't take him up on the

offer. Sams predicted his employees will still view his plan's \$90 monthly premiums and annual deductibles as too expensive, even though, as a matter of law, they'll be considered "affordable." That's because his employees generally pass up the 401(k) retirement plan he offers. "They're paycheck to paycheck, their kids need new shoes, there's never enough money ... to pay the bills," said Sams. "They look at me and say 'Doug, sounds great. I can't afford it.' "

Sams estimates seven new people will enroll in the company health plan, which will cost him about \$17,000. In the meantime, he has asked U.S. Sens. Amy Klobuchar and Al Franken to consider legislation that would define full-time workers as people who work 40 hours or more each week.

As Sams discovered, employers who run afoul of the law's requirements face steep penalties. Employers with 50 or more full-time employees have to provide insurance that is "affordable" within the definition in law.

Let's say you have 50 or more full-time employees but don't offer them insurance. If they work at least 30 hours a week, the law considers them full-time employees. If just one of them qualifies for a federal subsidy to buy coverage on the state's health insurance exchange, the employer could be faced with a \$2,000 per employee annual fine -- after subtracting the first 30 employees.

With more than 29 full time employees you may have to a penalty if you don't offer a certain minimum coverage to at least 95 percent of your payroll employees.

For large businesses that already offer insurance, the penalties aren't too much of a concern as long as they cover most of their employees.

The mandate is a particular problem for retail, hospitality and restaurant businesses because they traditionally haven't extended benefits to all hourly workers, and doing so will cost them a lot of money, and to not do so may incur penalties. They're more likely to trigger a fine because their relatively low-paid employees will probably qualify for government subsidies on the exchange.

"The administration's decision to delay the mandate by a year is a reprieve for some businesses, but that doesn't mean they've stopped mulling their options, said Don Scroggins, senior vice president of employee benefits for Marsh & McLennan Companies, a human resources consulting firm. "Most of them are weighing the cost/benefit of 'do I offer coverage, or don't I? Do I reduce hours to less than 30 hours or do we increase it?' " Scroggins said. "

Reduce to 29 hours per week?

"The City of Faribault crunched the numbers and decided to cut a few employees' hours. Starting next summer, four city workers will work less than 30 hours each week so the city doesn't have to offer them insurance," Human Resources Coordinator Kevin Bushard said.

"Providing insurance would have cost Faribault \$60,000. Working fewer hours will cost the employees a combined \$4,000, but the city is looking at ways to make up for the lost wages."

“It's not unusual for employers to trim hours to avoid offering benefits. But it's a tactic that companies may use more,” Minneapolis attorney Christiana Finnern said.

"I do think you'll probably see increases ... in the number of part-time people who are kept part-time because their employers don't want to be responsible for providing coverage," said Finnern, a specialist in health law at Winthrop and Weinstein.

But the firms that do so may represent a minority of employers. According to a recent survey by the International Foundation for Employee Benefit Plans, 17.8 percent of Midwest businesses, including firms located in Minnesota, have or will cut hours because of the health care law requirements.

“That strategy comes with financial trade-offs,” Scroggins said. “For instance, a restaurant that cuts employee hours may need to hire more part-time workers to make up for the staffing deficit.”

Companies may choose to pay the fines. But every time insurance broker David Cornell has run the numbers for his clients, the penalties turn out to be too expensive, partly because the expense isn't tax deductible.

That was the case for a construction firm Cornell works with. They plan to offer employees insurance as soon as the mandate kicks in.

"They don't want to pay the penalty and then get nothing for it," said Cornell, president of Cornell Insurance Services in St. Paul. "At least pay something, which is going to be a lot less than the penalty, have it as a business expense, and use it as a tool to keep employees."

As the economy recovers, more businesses may offer coverage to stay competitive, Scroggins said. But he said Sams' strategy, may not get him far. That's because individuals are required to have insurance or pay a penalty.

The first year that penalty is small -- \$95 for an individual or one percent of their income.

"As that penalty increases in 2016 and 2017, I think you may see more people look at their employer plan and jump on," Scroggins said.”

(Use sources:

IRS including “Questions and answers on the Employer Shared Responsibility provision. www.irs.gov/euac/

Department of Health and Human Services, www.hhs.gov.

Kaiser Permanente: <http://kff.org/health-reform/>)

The “Pay or Play” Decision Process Questions

Who are full-time employees?

ACA IRS regulation defines “employee” under the common law definition which recognizes that an employment relationship exists when the person who for whom the services are performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished, but also as to the details and means by which the result is accomplished. If an employer has the right to control, even if it never does, it’s an employment relationship. This differs from the definition of “employee” under other employment laws, such as the Fair Labor Standards Act. ** Under the IRS proposed rule, a sole proprietor, a partner, or a 2% S corporation shareholder are not considered employees. But a person who provides services as both an employee and a non-employee, such as a company director, is considered an employee under ACA.

Independent contractor vs. employee status.

A person engaged as an independent contractor can cost the SME less in benefits, insurance, and taxes, but the choice and status should be risk managed. An independent contractor should be engaged using a process that considers the costs and benefits. An independent contractor must be engaged without any provisions that allow the employer the right to control the worker’s services. In agreements to engage a person, it is important to avoid any language which might make that worker an employee under ACA, workers compensation, FICA tax or other government regulations. An independent contractor should not be an employee of an outside company and be covered by appropriate workers compensation and liability insurance from that company.

Here’s a case example: One of the graphic designers at Mauricio’s company is about to go out on maternity leave. Mauricio plans to hire an independent contractor to handle the extra workload while she’s gone. Before Mauricio proceeds, he needs to make sure he understands how the IRS differentiates between independent contractors and employees. Otherwise, he could incur costly tax penalties. Generally, if Mauricio directs only the result of the work, the worker is probably an independent contractor. However, if he directs the work and how it is done, the worker is probably an employee.

To classify a worker, the IRS considers the degree of direction and control the company exercises. For example, the IRS might look at whether Mauricio provides training and gives detailed instructions on how the work is to be done. Also important would be whether the worker pays business expenses without reimbursement and if he or she is in a position to realize a profit or incur a loss from the business relationship with Mauricio’s company. And if Mauricio and his new worker have a written contract, the IRS may review it to determine both parties’ intentions.

The distinction between the two classifications is important for employment-tax reasons. Mauricio is required to withhold and pay certain federal taxes on wages paid to employees but not on payments to independent contractors. Also, independent contractors are not subject to state and federal laws governing such things as employee benefit plans and overtime pay.

An annual review of your worker classifications can help you avoid misclassifications and potential tax and penalty assessments.

What Is Minimum Essential Coverage?

The proposed regulation defines minimum essential coverage as coverage under certain government programs such as Medicare Part A, coverage under an employer-sponsored plan, plans in the individual market, grandfathered plans and other coverage recognized by the Department of Health and Human Services (DHHS)

What is Affordable Health Coverage?

Coverage is “affordable “ if the employee’s required contribution for self –only coverage does not exceed 9.5% of the employee’s household income for the taxable years. Because most employers will not know an employee’s household income, there are three safe harbor provisions and any combination of which consistently applied will avoid affordability penalties:

1. The W-2 safe harbor, 2. The rate of pay safe harbor and 3. The federal poverty line safe harbor.
2. Employers should analysis each safe-harbor provision to determine which one to rely on.
3. Large employers may prefer the rate of pay safe harbor since it avoids individual calculation for each employee on affordability.

What is minimum coverage?

To provide minimum coverage, a plan must pay on average at least 60% of covered health costs. If coverage is less the minimum value, an employee may be eligible for a premium tax credit, which would likely trigger a penalty. There are several means of determining whether an employer-sponsored plan provides minimum coverage:

1. Calculators.
2. Design-based safe harbors:
3. Plans with nonstandard features may be certified by an actuary that the plan provides minimum value.

What are the Penalties and when do they apply?

An employer may be subject to pay or play penalties if it does not provide minimum essential coverage, or if it provides minimum essential coverage, but does not provide minimum value; there are different penalties for each which were describe above under **SMEs Facing ACA Risks: Taxes/Credits |Penalties/Exemptions | Compliance**

How Can Employers Prepare?

1. Determine whether they are a large employer subject to the pay or play mandate.
2. Decide whether they offer health or continue offering health benefits to full-time employees, and if coverage is minimum essential and affordable and provides minimum value, penalties are avoided. If one full-time employee receives a subsidy on an exchange, the employee may be assessed a penalty.

Required Notice to Employees;

All employers large and small whether or not subject to the pay or play are responsible for dissemination of exchange information to employees; must provide employees with a market place notice by October 1, 2013, a notice about the upcoming coverage options through the health care market (the exchange). The Wage and Hours Division of the Department of Labor and Hour Division of the Department of Labor provides an online till to assist employers in determining whether this requirement applies.

Advisors Offer SMEs An Assessment of Options

Advisors are offering SMEs an assessment of options to prepare for and deal with the ACA. SMEs can work with advisors to analyze options and provide you with information to make an informed decision for your business and employees. Some advisors offer a proprietary calculator that analyzes your current health insurance plan costs, and projects them forward to the next year. For firms with more than 50 fulltime employees it also compares what the cost would be to pay the penalty and send your employees to an insurance exchange, and identifies how many employees would be eligible for an exchange subsidy.

With this analysis you can you have information you need 1. To make the best decision for your business regarding health insurance; 2. To provide coverage for your employees; or send them to an Exchange or 3. Develop a new hybrid plan. 4. The impact of discontinuing health care coverage may have on recruitment and retention. 5. What other companies do and how it affects your competitive advantage. 6. The potential cost savings and how that money can be used in other areas of your business 7. The current and future cost of health care coverage vs. annual mandated penalties. 8. Whether you will need to increase employee salaries if you discontinue coverage. 9. The possibility of developing a hybrid plan that better fits the diverse needs of your employees.

Two examples:

1. Through Eide Bailly, "Benefits by Eide Bailly," Shawn Deluhery MBA, CPA, Manager Consultant - Health Care, Minneapolis, MN, offers Analytics to Help Employers Make Decisions Under the ACA.
2. Models by Seth J. Chandler help employers make decisions under ACA. <http://demonstrations.wolfram.com/EmployerHealthInsuranceChoicesUnderHR3590AndHR3962/>

The models that assist employer's in evaluating choices require ranges of the following data and variables:

- Effective marginal tax rate
- Number of employees, age, tobacco use, location and household income
- Proportion of employees electing coverage
- Individual ratio
- Individual premium cost
- Faction of individual premium paid by the employer
- Family premium cost

- Fraction of family premium paid by employer
- No coverage cost factor
- No coverage wage bonus

Defined Contribution Options

More SMEs are likely to contribute a defined amount maybe \$1000 to \$2000 into an health savings account (HSA) permitting each employee to buy health insurance rather than the employer contracting with one or two health insurance plans and paying a large portion of the premium with employees contributing a portion of the premium. Large employers are doing this in waves for retirees and employees.

VI. TIMELINE OF ACA IMPLEMENTATION

The following provides the general timeline of ACA implementation for large and medium sized employers:

2013:

- Healthcare Flexible Spending Account limited to \$2,500; Flexible spending/reimbursement accounts for dependent care include preschool remains capped at \$5,000.
- January 1, 2013, the employee portion of Medicare Part A increases to 2.35% for employees with incomes over \$200,000; employer's portion is unchanged.
- Some minor changes in benefits
- Changes in the way that appeals are handled
- Value of 2012 tax-exempt medical insurance shows on W-2
- Gearing up for extra customer service demands that has resulted from the Exchanges starting up

2014:

- **1/1/14** – Health Insurance Marketplaces (Exchanges) begin
- 1/1/14 – Expanded Medicaid begins (for opted States)
- 1/1/14 – Individual Mandate begins
- Adult child dependent coverage to age 26. This cost plans millions each year.
- No Pre-existing conditions
- No waiting period +90 days
- Minimum essential coverage and Minimum Value
- Guaranteed Issue | Guaranteed Renewal | Community rating
- No lifetime or annual limits on essential health benefits
- Enhanced wellness program incentives (non grandfathered only)
- Most large employers, we will “play” (*pay or play*)
- Benefits remain a key component of the employee total compensation value. Although the Employer Mandate generally takes effect on January

1, 2014, the effective date is deferred for employers with fiscal year plans that meet certain requirements.

- According to rules proposed by the Internal Revenue Service, employers' obligation is to provide affordable insurance to cover their full-time employees. The rules seem to offer no guarantee of affordable insurance for a worker's children or spouse. To avoid a possible tax penalty, employers with 50 or more full-time employees must offer affordable coverage to those employees. However, the meaning of "affordable" depends entirely on the cost of individual coverage for the employee, what the worker would pay for "self-only coverage."
- This may create an incentive for employers to put money into insurance for their employees rather than dependents. It is unclear whether the spouse and children of an employee will be able to obtain federal subsidies to help them buy coverage — separate from the employee — through insurance Exchanges
- Employees eligible for employer-provided health coverage will not have to wait more than 90 days.
- Medical loss ratio rebates: Insurance companies must spend at least 80% of premium dollars on medical care rather than administrative costs or provide rebates to policyholders. Millions in rebates have already been returned to insureds.
- Business/Enterprise Size: Rules change based on business employee size; less than 25, less than 50, less than 75, or self-employed. Understand the rules for your business size.
- Disclosure rules: Employers are required to provide employees with "Summary of Benefits and Coverage" explaining coverage and costs. This has been a requirement for large employer sponsored plans under ERISA.

2015:

- Informational Tax Returns
- § 6055 Minimum Essential Coverage Filing
- § 6056 Applicable Large Employer Report of Coverage
- Due January 31 of the proceeding calendar year
- Jan 1 – Dec 31 2015 is due by Jan 31, 2016
- Employer pay or play shared responsibility penalties

2015:

- Auto-enrollment required
- New employees will automatically be enrolled for employee-only coverage. They will have to enroll their dependents to get coverage, and can opt out if desired.
- May be conflicts with State Law

2018:

- Cadillac Tax on high-cost employer sponsored plans
- \$10,200 single | \$27,500 any other non-single plan
- Most will avoid the Excise tax (Cadillac tax) imposed on high value employer & union plans by increasing deductibles and co-pays.

- The employer/union plan goal is to maintain as much of the value of the plan as possible, while avoiding the Excise Tax and managing healthcare trend. “Value” here is measured in quality, affordability, and choice. This will make some employers and unions change to lower value plans even after they have done everything possible to contain costs.
- Cadillac Tax: Any plan valued at \$10,200 for individuals or \$27,500 for families will be subject to an excise tax of 40 percent of the value that exceeds the threshold (levied on insurers and self-insured employers, not employees) 2020: Increased for inflation.
- Plans which exceed 90% of “Plan Value” must reduce benefits or pay high excise taxes. Applies to the value of pre-tax health benefits in excess of maximum allowed “Plan Value”, defined by the ACA as the sum of: Employer contribution to premium + Employee contribution to premium+ any Health Flexible Spending Account amounts

Regardless of where you live, all plans in the Exchanges are separated into four “metallic” levels – Bronze, Silver, Gold and Platinum – based on how you and the plan can expect to share your health care costs. Below key terms are explained: total cost and coverage levels to help you decide among Bronze, Silver, Gold and Platinum health insurance plans.

VII. SELECTING THE BEST PLAN INITIALLY AND EACH YEAR

Your Total Cost and The “Metals” Degrees of Coverage

Total Costs = Premium + ((deductibles + co-pays + co-insurance) < out-of-pocket maximum OOP). These terms are explained below:

You pay the *premium* whether or not you go to the doctor, visit the hospital or buy prescription medications. When health care your costs increase above the premium based on your plan’s deductible, copayment, coinsurance capped by out-of-pocket maximum (OOP). They apply cost covered by the insurance. Any uncovered medical costs are also added to your total cost. All of these costs should be estimated for you and your covered dependents before you select a health insurance plan. In order to make informed choices when comparing and purchasing health care plans it is important to understand these terms.

A *deductible* is the amount you have to pay for covered services before your insurance starts to pay. For instance, if you have a \$2,000 deductible, you will pay 100% of your health care expenses in a policy year until the amount you have paid reaches \$2,000. After you meet your deductible, some services might be covered at 80%, 90% or 100% while you pay 20%, 10% or none to pay coinsurance, all limited to the OOP limit. (more on that below).

A *copayment* (sometimes called “copay”) is a fixed dollar amount that you pay for certain health care services. Typically, you will have different copayment amounts for different types of service, such as a \$25 copayment for a doctor’s office visit or a \$100 copayment for an

emergency room visit. In most cases, any copayments typically do not count toward your deductible but do count toward the OOP limit.

Your share of covered costs is coinsurance. Typically, this is figured as a fixed percentage of the total charge for a service, such as 10% or 20%. Coinsurance applies after you've met your deductible. For example, assume you've already met your \$2,000 deductible and your plan's coinsurance is 15%. If you have a hospital charge of \$1,000, your share of the costs would be \$150 (15% of \$1,000). If your coinsurance was 20%, your share would be \$200.

A plan's out-of-pocket maximum (or out-of-pocket limit) is the most you pay during a policy period (typically a year) before your plan starts to pay 100% of the covered costs. The policy doesn't cover a list of excluded items (e.g. cosmetic surgery) which do not count toward your out-of-pocket maximum. Depending on your plan, your deductible, copayments and/or coinsurance may apply towards the out-of-pocket limit. The ACA health care plans have different out-of-pocket limits; however, under health care reform, the 2014 maximum limits are \$6,350 for individuals and \$12,700 for families. ACA policies are Bronze, Silver, Gold or Platinum coverages with – the same set of *Essential Health Benefits* (EHB) list above.

Covered benefits are the health care services that your insurer pays for under your plan. You may still be required to pay a copayment or coinsurance, but the service is recognized by your plan. By comparison, if a service is not covered – such as a cosmetic or experimental surgery you are pay 100% of the uncovered.

The Essential Health Benefits are the *minimum* requirements for all plans in the Marketplace; certain plans will offer additional coverage, but no plan can offer less.

Metals of Coverage

The five levels of health plans from lowest premium to highest premium are – Catastrophe plan (100% paid after \$6,350 deductible), Bronze, Silver, Gold and Platinum – are differentiated based on their *actuarial value*: the percentage of average health care expenses that will be paid by the plan. The higher the percentage (i.e. Gold and Platinum), the higher your premium but the more the plan will pay towards your health care expenses and the lower your costs for things such as:

- Deductibles – the amount you owe for covered services before insurance kicks in;
- Copayments – a fixed amount you pay for a covered health care service; and
- Coinsurance – your share of the costs of a covered health care service.

A higher premium requires lower amounts paid by you. In order to calculate total cost premium must be added to estimates of usage of the plan deductibles and co-payment must be accessed from each health insurer.

The Premium Cost

The premium is based on several factors including:

- Your age
- Whether or not you smoke (in some states you will pay a “surcharge” if you are a smoker)
- Where you live
- How many people are enrolling with you (spouse and/or child?)
- The insurance company and plan you select

A Silver plan from one company may cost more or less than the same plan offered by a different insurer. Plans offered by the same company, however, will increase in price as percent of the actuarial value the plan pays go up. Starting in 2014 the federal limit for annual out-of-pocket expense for individuals (not including monthly premiums) is expected to be capped at \$6,350; the family cap is \$12,700. Certain plans may have even lower out-of-pocket limits.

The Bottom Line on Premium Plus Co-pays

When choosing a plan, it is helpful to remember that all plans – Bronze, Silver, Gold and Platinum – cover the same Essential Health Benefits. Your monthly health insurance premium will be higher if you choose a higher level plan, such as Gold or Platinum. But you will also pay less each time you visit a health care provider or get a prescription filled. Conversely, your monthly premium will be lower if you choose a Bronze or Silver plan, but you will pay more for each doctor visit, prescription or health care service that you use.

Finding a balance between coverage and costs can be challenging. You will be able to compare plans on the Marketplace to find the coverage that is the best fit for your financial situation and health care needs. You will also be able to apply for federal subsidies that can help reduce your health care costs. Remember the most important criteria is not the cost of premium and co-pays. The most important criteria are access to the desired health care providers and the reputation of the insurance plan in paying claims.

VIII. OPPORTUNITIES WITH INCREASED MARKET COMPETITION

Fierce pricing and underwriting competition is playing out in this newly competitive health insurance market among: State Exchanges, Federal Exchanges, Private Exchanges, Insurance Companies & Agents. Insurers are in competition both within state exchanges and with private exchanges, and other markets, creating new opportunities for SMEs.

Generally ACA has increased competition at two levels, in insurance markets, and among health care providers who contract with employer groups and insurance companies as members of provider networks. All insureds including SMEs benefit from this competition, however the level of competition varies considerably by geographic location. When there is only one provider

group and its services are relatively high cost, insurance premiums are likely to be higher. SME advisors should be able to access a variety of health insurance markets and providers networks.

Many private exchanges and other health insurance markets also compete with the government exchanges.

- Individual Exchange – marketplace where consumers can shop for coverage
- Commercial Plans, Subsidized Insurance, Essential Health Benefits, Adequate coverage (i.e. metal tiers)
- Small Employer Exchange (SHOP) – marketplace where small employers can access exchange insurance (states may limit between 50 - 100 employees in 2014 - 2016, and can open it up to all employers by 2017) State SHOPS are now available; the federal changes announced it will delay its SHOP until 2015. Each year SHOPS will have an Open Enrollment period.

See **Appendix II. A Variety of Private Exchanges Increase Competition**, for more on increased competition.

By June 2013, 19 states have been conditionally approved to operate State-based Marketplaces, including Mississippi and Utah, which have been conditionally approved to operate a Small Business Health Options (SHOP) Marketplace for small business owners and their employees. Additionally, seven states have been conditionally approved to operate a State Partnership Marketplace. Consumers could attempt to enroll in an Exchange starting in October 2013 and health plan coverage begins January 1, 2014. Although most government exchanges had a rocky start, the federal exchange had more problems than most the state exchanges. If there is no state exchange, the federal exchange may be accessed.

Impact on insurance markets is evolving and selective. Present choices may look different in 2016 than in 2014. The market share of carriers offering health insurance products is changing for Insurance Companies, HMOs, Blue Cross, Employer or Union Sponsored plans, and Multiple Employer Plans and SMEs.

VIII. CONCLUSION

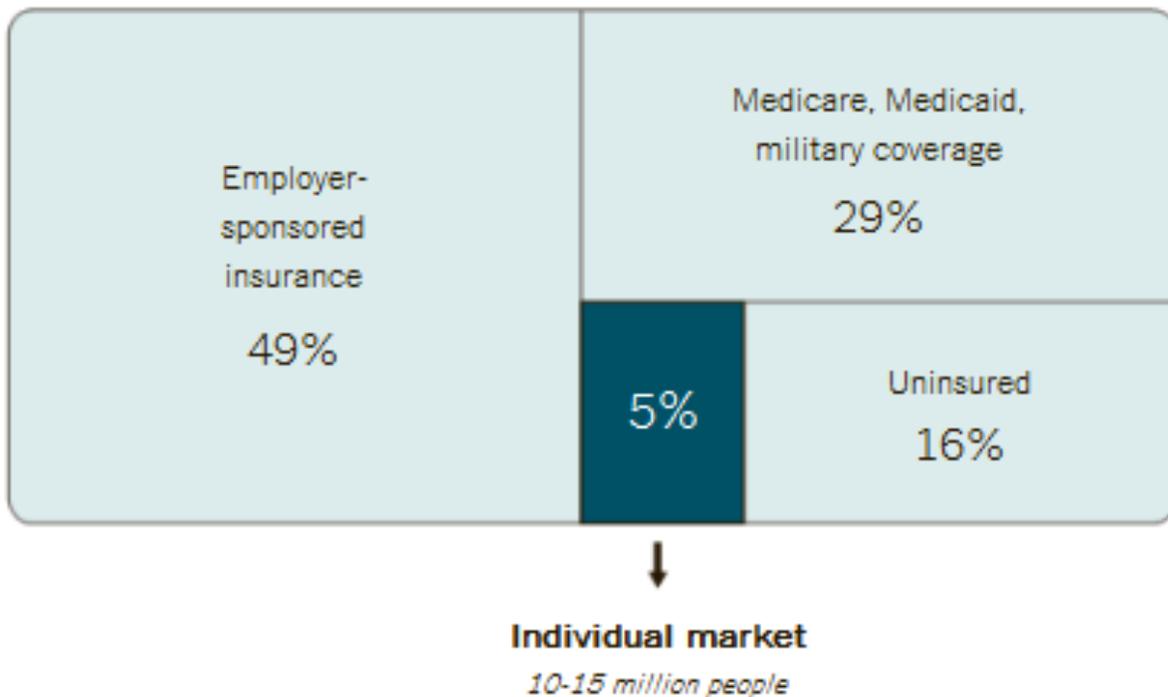
The dominant ERM consideration for SMEs is managing opportunities and risks under ACA considering total compensation for owners and employees. ERM allows firms to risk manage the uncertainty, pending deadlines, issues, and penalties on a strategic and holistic basis. This approach facilitates recruiting, retaining and retiring employees. ACA defined small and large employers, and Medium-Sized are included as large employers under ACA. If a small business with less than 50 employees has not offered health insurance the new exchanges and markets for individual insurance provide reasons to not offer employee health benefits, but each owner and employee can individually select coverage which best meets family needs. Good coverage may be available with a premium subsidy for low income employees, while higher income employees may select the lowest premium plan, the catastrophic plan. However waiting until ACA mandates and penalties apply to your SME is too late to manage opportunities and mitigate risks. Strategic planning and tactical action is required now because opportunities and penalties are based on last year's employment data, household income, and the number of full-time employees. Professional advisors should today warn and guide clients to act now.

Appendix 1.

National Insured Population: Large Employer- 71%; Individual & Small Enterprises- 8%

Before ACA about 70% of the non-Medicare, non-Medicaid, non-military, population had health benefits/insurance from large employers, about 8% had individual or small group policies, and about 22% were not insured, all with great variation by State. ACA basically provides incentives and standards for all US citizens to have affordable and adequate health insurance or Medicaid benefits. The state and federal health insurance exchanges offer coverage to both uninsured, the very poor eligible for Medicaid, and some offer coverage to small and medium sized enterprises. Some owners and employees of SMEs may be included in the uninsured, underinsured, and low household income population.

Health Insurance Coverage: Insureds and Uninsureds:



The new government exchanges and private markets are providing more insurance to the US population: about the 8% more individuals, not small firms, will buy health insurance from government exchanges and private markets. In addition many uninsured, below poverty level people, are able to obtain Medicaid benefits at the government exchanges. However there is great variation in health insurance markets by state and by geographic area within a state. There several reasons why individual owners and employee will buy from the exchanges but the small firm will not offer employer sponsored health insurance.

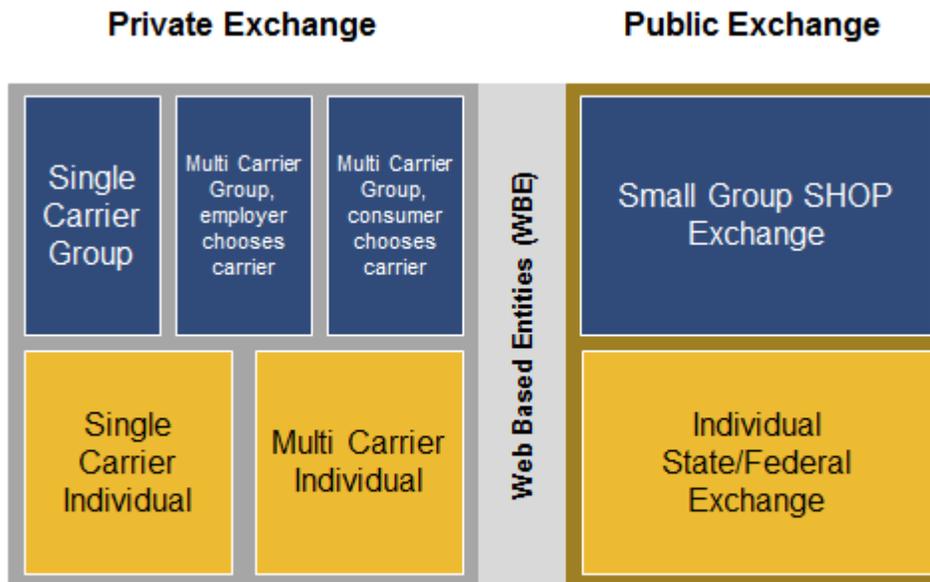
Appendix II. A Variety of Private Exchanges Increase Competition

There are a variety of types of Private exchanges. Some launched by employers some by brokers, some by insurance companies.

Different Exchange Types



Less Complex	More Complex
Consumer-based and Funded	Employer-based and Funded (at least partially)
Single Carrier	Multiple Carriers
Health Insurance Only	Multiple Benefits (i.e., Dental/Vision, Life, Accident, Critical Illness, DI, LTC)
Defined Benefits (employer choice)	Defined Contribution (employee choice)
One-time Upfront Purchase Only	Year-round, Ongoing Administration



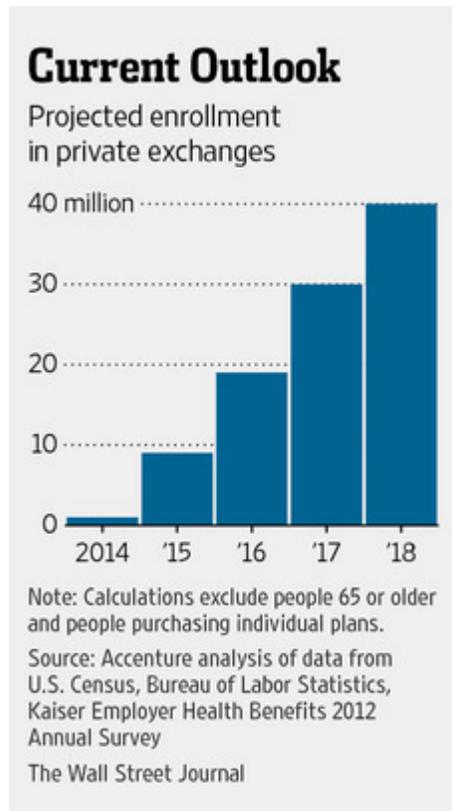
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41

More insurance companies and agencies are launching the online marketplaces, known as private exchanges, some let employers offer their workers a range of choices. Now offering this option are consulting firms like [Xerox Corp.](#)'s Buck Consultants, [Marsh & McLennan Cos.](#) Mercer and [Towers Watson & Co.](#), as well as insurance brokerages such as Willis Group Holdings PLC and Digital Insurance Inc. This sets the stage that 2014 is the beginning of significant competition and growth over the next few years.

*(Anna Wilde Mathews at anna.mathews@wsj.com. September 4, 2013, on page B1 in the U.S. edition of The Wall Street Journal, with the headline: More Employers Overhaul Health Benefits.)

The private exchanges for employers are separate from the government-operated marketplaces that are being created in each state under the federal health law, which will serve individual consumers and small companies.



Anna Wilde Mathews at anna.mathews@wsj.com has described this private exchange development:

“[Employers hope the exchanges will trim costs](#) and make their health spending more predictable. But some experts say workers could be squeezed by the fixed-sum approach if the dollars allotted each year don't keep up with the rising cost of coverage. "Is the defined contribution going to increase with premiums, and how much is it going to go up? It is a question," said Paul Fronstin, director of health research at the nonprofit Employee Benefit Research Institute.

Tequila maker Tanteo Spirits LLC, which has 20 employees, switched to the new approach in June. The New York firm said its contribution is big enough to pay for a rich health plan, as well as vision and dental coverage, for each employee. "We wanted to be really generous," said Neil Grosscup, chief operating officer. He wants the sum to rise as quickly as premiums, he said, but the company will "be able to look at our budget for 2014 and dictate how much we can actually spend on it."

At least a few bigger employers are also moving: Bob Evans Farms Inc., which owns about 560 restaurants and has around 34,000 employees including part-timers, will start directing workers to an exchange from Xerox's Buck unit that will start next January.

In a statement, provided through Buck, the company, which is based in Columbus, Ohio, said the setup offered "an opportunity to more cost-effectively deliver a competitive employer-sponsored

benefit program while providing expanded plan options." Through Buck, the firm declined to comment on details of its setup.

Operators of employer health-insurance marketplaces say many workers pick cheaper coverage than they previously had and that is one way the exchange approach can save money.

In an exchange run by Liazon Corp. that has around 60,000 people enrolled, about 75% of the workers have chosen less-expensive plans, accepting bigger deductibles and other out-of-pocket charges, as well as smaller choices of health-care providers and restrictions such as primary-care gatekeepers. "They want value for their money," said Alan Cohen, Liazon's chief strategy officer.

Some employers are opting to use exchanges, but without the fixed-sum contribution approach.

Also, the private-employer exchanges themselves vary widely. Buck's setup generally involves offering health plans from just one insurer in a particular location. The company chose the lowest-cost carrier available in each geographic area, an approach that it said pushes down costs. Marketplaces from individual insurers are also typically stocked only with different flavors of their own plans.

But most of the employer exchanges are expected to offer an array of carriers. Those operators argue that the competition among insurers should reduce the cost of coverage over time.

Anna Wilde Mathews at anna.mathews@wsj.com. A version of this article appeared September 4, 2013, on page B1 in the U.S. edition of The Wall Street Journal, with the headline: More Employers Overhaul Health Benefits.

Appendix III. Summary Statement from IFEBP

The following is from a March 14, 2013 International Foundation of Employee Benefit Plans (IFEBC) Monday Business Briefing:³

"Minimum essential coverage" includes coverage under an employer-sponsored group health plan, whether it be fully insured or self-insured, but does not include stand-alone dental or vision coverage, or flexible spending accounts. Coverage is "affordable" if an employee's required contribution for the lowest-cost self-only coverage option offered by the employer does not exceed 9.5 percent of the employee's household income. Coverage provides "minimum value" if the plan's share of the actuarially projected cost of covered benefits is at least 60 percent. Generally speaking, "large employers" are employers that had an average of 50 or more full-time or full-time equivalent employees on business days during the preceding year. "Full-time employees" include all employees who work at least 30 hours on average each week. In 2014 large employers who "play" must pay a fee of \$63 for each insured employee, and plan to avoid the Cadillac excise tax in 2015.

³ IFEBC Monday Business Briefing, March 14, 2013 Thursday United States: Deciding Whether To Play Or Pay Under The Affordable Care Act, by Marlene Frank, Sarah H. Griffin, Daniel C. Hagen, Elena Kaplan, F. Curt Kirschner Jr., Catherine E. Livingston, Evan Miller, Kirstin Poirier-Whitley and Mary M. Reil.

The first scenario occurs when an employer does not offer health coverage to "substantially all" of its full-time employees and any one of its full-time employees both enrolls in health coverage offered through a State Insurance Exchange, which is also being called a Marketplace (an "Exchange"), and receives a premium tax credit or a cost-sharing subsidy (each an "Exchange subsidy"). In this scenario, the employer will owe a "no coverage penalty." The no coverage penalty is \$2,000 per year (adjusted for inflation) for each of the employer's full-time employees (excluding the first 30). This is the penalty that an employer should be prepared to pay if it is contemplating not offering group health coverage to its employees.

The second scenario occurs when an employer does provide health coverage to its employees, but such coverage is deemed inadequate for Employer Mandate purposes, either because it is not "affordable," does not provide at least "minimum value," or the employer offers coverage to substantially all (but not all) of its full-time employees and one or more of its full-time employees both enrolls in Exchange coverage and receives an Exchange subsidy. In this second scenario, the employer will owe an "inadequate coverage penalty." The inadequate coverage penalty is \$3,000 per person and is calculated, based not on the employer's total number of full-time employees, but only on each full-time employee who receives an Exchange subsidy. (Furthermore, the penalty is capped each month by the maximum potential "no coverage penalty" discussed above).

Because Exchange subsidies are available only to individuals with household incomes of at least 100 percent and up to 400 percent of the federal poverty line (in 2013, a maximum of \$44,680 for an individual and \$92,200 for a family of four), employers that pay relatively high wages may not be at risk for the penalty, even if they fail to provide coverage that satisfies the affordability and minimum value requirements. Likewise, because Exchange subsidies are not available to individuals who are eligible for Medicaid, employers may be partially immune to the penalty with respect to their low-wage employees, particularly in states that elect the Medicaid expansion...

In addition, Exchange subsidies will not be available to any employee whose employer offers the employee affordable coverage that provides minimum value. Thus, by "playing" for employees who would otherwise be eligible for an Exchange subsidy, employers can ensure they are not subject to any penalty, even if they don't "play" for all employees." In addition, Exchange subsidies will not be available to any employee whose employer offers the employee affordable coverage that provides minimum value. Thus, by "playing" for employees who would otherwise be eligible for an Exchange subsidy, employers can ensure they are not subject to any penalty, even if they don't "play" for all employees.

Two things must occur before any penalty is assessed. First, one of the employer's full-time employees must enroll in health coverage offered through an Exchange. Second, that full-time employee must receive an Exchange subsidy (a premium

tax credit or cost-sharing subsidy). Thus, an employer should consider which of its employees are potentially eligible for an Exchange subsidy when deciding how to comply with the Employer Mandate. It is important to note that the employee must qualify for the Exchange subsidy; receipt of an Exchange subsidy by an employee's dependent (for an example, an adult child who is not a tax dependent of the employee) will not give rise to an Employer Mandate penalty.

“Companies and other plan providers will together pay \$25 billion over three years to create a fund for insurance companies to offset the cost of covering people with high medical bills: \$12 in 2014, \$8 in 2015 and \$5 in 2016.” (Footnote 4) Large employers, who do not provide compliant health insurance, may have to pay a penalty per employee.

ACA References

1. Minnesota References

MNSure opens for enrollment in October 2013. Until then, here are some resources you may find helpful.

[HealthCare.gov](#) - Find health plans in Minnesota

[Minnesota Department of Commerce](#) - Consumer resources on health insurance

[Minnesota Department of Health](#) – Community and Family Health Division

[Minnesota Health Care Programs \(MHCP\)](#)

- Medical Assistance
- MinnesotaCare
- Minnesota Family Planning Program
- Home and community-based waiver programs

[Online application](#) / [General information brochure](#) / [Program Income Levels](#) / [Minnesota Tribal and County Health Care Directory](#)

Questions? Call the Health Care Access Phone Line, 800-657-3629 or 651-431-2283.

[Minnesota Comprehensive Health Association](#)

Offers individual health insurance to Minnesota residents who have been turned down for health coverage in the private marketplace because they have a pre-existing health condition.

Additional Resources

[Medicare](#) – federal website

[Medicare Savings Program](#) – Medicare cost assistance

[Bridge to Benefits](#) – a screening tool for public assistance programs

[MinnesotaHelp.info](#) – online directory of statewide community resources

[Minnesota Dental Association](#) – resources for low-cost dental care

[Prescription Expense Assistance](#) – prescription drug patient assistance programs

[Minnesota Association of Community Health Centers](#) – statewide community medical clinics

[Portico Healthnet](#) – non-profit that helps Minnesotans access health coverage and care

[Health Reform Minnesota](#) – Minnesota’s official resource of health reform information

[MDH](#) – Division of Health Policy

[Small Employer Health Care Tax Credit](#)

[Sage Program](#) - provides free breast and cervical cancer exams, heart health screening and colorectal cancer screening for eligible women

From the MN Department of Commerce Website

Can't find what you're looking for? Try these links to other web sites with additional information on health and medical insurance.

[MN Board on Aging](#) -- The Minnesota Board on Aging (MBA) is a gateway to services for Minnesota seniors and their families. The website provides information on services such as the Senior LinkAge Line, Return to Community Initiative, Transition Consultations, and RxConnect.

[MN Department of Commerce](#) -- The Insurance Commissioner's office in Minnesota is housed within the Department of Commerce. The Insurance Gateway provides information for consumers on a variety of insurance topics, instructions for filing a complaint against an insurance company or agent, tools to verify whether a company or agent is licensed, and information on enforcement actions taken against companies or agents by the department. The Insurance Gateway also provides instructions and bulletins for insurance companies.

[MN Health Care Programs](#) -- Information from the Minnesota Department of Human Services regarding Minnesota public health care programs including Medical Assistance, MinnesotaCare, and General Assistance Medical Care (GAMC).

[MN Health Information](#) -- Minnesotahealthinfo.org provides a guide to health care quality and cost, providing a wide range of health care info, whether you want to compare certain providers, learn how to be a wise health care consumer, or identify ways to better manage your personal health. The site was created by the Governor's Health Cabinet to help Minnesotans better understand health care options, costs and quality. Check back now and then for more information.

[MN Health Information Clearinghouse](#) -- The Minnesota Health Information Clearinghouse is a resource for health-related information and publications, including information on health coverage options for consumers and small businesses in Minnesota and information on health policy and Minnesota's Health Economics program for providers and policymakers.

[MN Help Info](#) -- MinnesotaHelp.info is an online directory of services designed to help people in Minnesota find human services, information and referral, financial assistance, and other forms of help. It is especially rich in resource information for seniors and their caregivers; people with disabilities and their caregivers; parents and families; and low income people.

[MN Long-Term Care Partnership](#) -- The Minnesota Long Term Care Partnership is a public/private arrangement between long-term care insurers and Minnesota's Medical Assistance program. It enables residents who purchase certain long-term care insurance to have more of their assets protected if they later need the state to help pay for their long-term

care. Minnesota is using this approach to give people more control over how they finance long-term care and to help shore up the public safety net.

[Minnesota Comprehensive Health Association](#) -- MCHA was established in 1976 by the Minnesota Legislature to offer policies of individual health insurance to Minnesota residents who have been turned down for health insurance by the private market, due to pre-existing health conditions. MCHA is sometimes referred to as Minnesota's "high risk pool" for health insurance or health insurance of last resort. Currently, about 30,000 Minnesota residents are insured by MCHA throughout the State of Minnesota.

2. National references

[HealthCare.gov](#) -- Official website of the U.S. Department of Health and Human Services (HHS) to provide information about federal health care reform and HHS's role in implementing it.

[Kaiser Family Foundation](#) -- The Kaiser Family Foundation is a non-profit, private operating foundation focusing on health care issues.

[National Assoc. of Insurance Commissioners](#) -- The National Association of Insurance Commissioners (NAIC) is the enterprise of insurance regulators from the 50 states, the District of Columbia and the five U.S. territories. The NAIC provides a forum for the development of uniform policy when uniformity is appropriate. The NAIC mission is to assist state insurance regulators, in serving the public interest and achieving fundamental insurance regulatory goals in a responsive, efficient and cost effective manner.

Essential Health Benefits (EHB)

Under the Affordable Care Act (ACA), health plans must cover ten benefit categories called Essential Health Benefits (EHB) offered in the individual and small group markets, both inside and outside of Health Insurance Exchanges and Medicaid plans must also cover these services by 2014.

The EHB plan must take into account the health care needs of Minnesota's diverse segments of the population, and may not discriminate based on age, disability, or expected length of life.

The EHB plan must include and set an appropriate balance between the **ten specific categories of services listed below**:

1. ambulatory patient services
2. emergency services
3. hospitalization
4. maternity and newborn care
5. mental health and substance use disorder services, including behavioral health treatment

6. prescription drugs
7. rehabilitative and habilitative services and devices
8. laboratory services
9. preventive and wellness services and chronic disease management
10. pediatric services, including oral and vision care

The EHB must also:

- Reflect **typical employer health benefit plans**
- Comply with **Mental Health Parity and Addiction Equity Act of 2008**
- **Balance comprehensiveness and affordability** for those purchasing coverage
- Starting with plan years or policy years that began on or after September 23, 2010, **health plans can no longer impose a lifetime dollar limit on spending for these services.** All health plans, except grandfathered individual health insurance policies, must phase out annual dollar spending limits for these services by 2014.

Selection of EHB “Benchmark Plan”

In order to implement the Essential Health Benefits, the U.S. Department of Health and Human Services (HHS) decided to use a benchmark approach for 2014 and 2015, allowing states to select a benchmark plan that reflects the scope of services offered by a “typical employee plan.” HHS identified four options of health plans, for states to select from to be the EHB “Benchmark Plan” for each state, or a default plan will be selected.

The four options for states to choose from, and the health plans for Minnesota that fulfill these options, are listed below:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state’s small group market;
 - HealthPartners Small Group Product (HealthPartners 500 25 Open Access PPO)
 - Blue Cross/Blue Shield Comprehensive Major Medical with Deductible Plan
 - Blue Cross/Blue Shield Options Blue HSA 100
2. Any of the three largest state employee health benefit plans by enrollment;
 - Minnesota Advantage Health Plan (SEGIP)
3. Any of the three largest Federal Employee Health Benefit Plan (FEHBP) options by enrollment; or
4. The largest insured commercial non-Medicaid HMO operating in the state.
 - Health Partners Open Access

HHS also determined that if states choose not to select one of the four options, then that state’s default plan will be the small group plan with the largest enrollment in the state. **HHS has determined that the HealthPartners Small Group Product is the small group plan with the largest enrollment in Minnesota, and thus will be Minnesota’s default EHB Benchmark Plan.** In addition, the Governor’s Health Reform and its Task Force Access Work Group

reviewed this default plan and confirmed it contains all of Minnesota's state mandated coverages.

HHS originally required a state's selection by September 30, 2012 as part of a data request. However, HHS's confirmation of the EHB Benchmark Plan has been postponed until December 26, 2012. The Commerce Department, in consultation with the Minnesota Department of Health, submitted information regarding Minnesota's state mandated benefits to HHS as part of the September 30th data reporting request. At the time of this data request, Minnesota did not submit a choice from the four HHS options to be the state's EHB Benchmark Plan. Thus, HHS indicated the **HealthPartners Small Group Product** as the default plan for Minnesota's EHB Benchmark Plan in the Notice for Proposed Rulemaking released on November 26, 2012.

Who makes the EHB determination?

- HHS provided guidance on this subject in the *CMS Frequently Asked Questions on Essential Health Benefits Bulletin*:

Each State would be permitted to select a benchmark plan from the options provided by HHS by whatever process and through whatever State entity is appropriate under State law. In general, we expect that the State executive branch would have the authority to select the benchmark plan. It is also possible that, in some States, legislation would be necessary for benchmark plan selection. It is important to note that, regardless of the entity making these State selections, it is the State Medicaid Agency that will be held responsible for the implementation of the EHB through the Medicaid benchmark coverage option.

- Minnesota statutes and rules do not explicitly delegate the responsibility to any specific state agency to select the EHB option.
- Minnesota continues to have the flexibility to choose one of the four EHB options for Minnesota during HHS's Notice for Proposed Rulemaking (NPRM) 30-day comment period, ending December 26, 2012. Otherwise, the default option (HealthPartners 500 25 Open Access PPO) will be selected under HHS's process for EHB selection.
- The state communicated to HHS directly that although the default would be indicated for Minnesota in the NPRM, that the state is awaiting additional guidance from HHS on EHB and may elect to indicate a different choice during the rulemaking period.

Where are we now?

- HHS used the information submitted by states for the September 30, 2012 data reporting deadline to prepare a Notice of Proposed Rulemaking (NPRM) which will provide further guidance with regards to EHB. During the NPRM comment period, states will have the opportunity to choose an EHB.
- Dave Knutson
<http://mediasite.csom.umn.edu/Mediasite/Play/9200199d19a94572affb3577d0b63e391d>

University of Minnesota Benefit Information

- 2012 Presentation, Ryan Gourde, Health Programs Finance Manager, University of Minnesota Employee Benefits
- <http://policy.umn.edu/Policies/hr/Compensation/COMPPA.html>
- <http://www1.umn.edu/ohr/benefits/>
- <http://www1.umn.edu/ohr/benefits/openenroll/>
- http://www1.umn.edu/ohr/prod/groups/ohr/@pub/@ohr/documents/asset/ohr_asset_046761.pdf
- <http://www.naic.org/store/free/ASE-OP.pdf>
- http://www1.umn.edu/ohr/prod/groups/ohr/@pub/@ohr/documents/asset/ohr_56712.pdf
- <http://www1.umn.edu/ohr/benefits/medical/aca/index.html>
 - http://www1.umn.edu/ohr/prod/groups/ohr/@pub/@ohr/@benefits/documents/asset/ohr_asset_455184.pdf

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Federal Law

The Department of Labor's [Employee Benefits Security Administration \(EBSA\)](#) is responsible for administering and enforcing these provisions of ERISA. As part of carrying out its responsibilities, the agency provides [consumer information on health plans](#) as well as [compliance assistance](#) for employers, plan service providers, and others to help them comply with ERISA.

The [Fair Labor Standards Act \(FLSA\)](#) does not address benefits such as life insurance, long-term care insurance, medical insurance accounts or wellness benefits. These benefits are generally a matter of agreement between an employer and an employee (or the employee's representative).

For the tax provisions in the Internal Revenue Code relating to health plans, the [Internal Revenue Service](#).

For issues under the Public Health Service Act, contact the Center for Medicare and Medicaid Services in the [Department of Health and Human Services \(HHS\)](#).

[Employee Benefits in the United States](#) (PDF 3.5Mb)

This Bureau of Labor Statistics (BLS) bulletin shows access and participation in and key provisions of employee benefit plans for workers in private industry and state and local governments.

Laws rules & regulations http://www.dol.gov/ebsa/consumer_info_health.htm

From National Association of insurance commissioner (NAIC)
http://www.insureonline.org/consumer_health_rights.htm

[Deleted section below:](#)

ACA Defines Small and Large (Includes Medium-Sized Enterprises):

Small enterprises have less than 50 full time employee equivalents (FTE defined as 30 hrs./wk. maybe increased to 40 hrs./wk.) Full-time equivalent employees are calculated by a factor of the total hours of all part- time employees worked in a month.

Large employers are defined...as those with at least 50 full time equivalent employees, full time employees + part time employee equivalents.

Small enterprises with less than 50 FTE employees have no penalties and no requirement to provide insurance, but do have obligations to assess options, notify employees, and determine the best option for individual owners and employees, and may have opportunities to compete in the labor market by providing options: "affordable" health insurance, defined contributions to HSAs or a cafeteria plan and to offer FSAs and favorable total compensation packages.

In 2009/2010 in Minnesota, an estimated 38% of small employers offered health insurance. Nationally, small businesses pay up to 18% more per worker than large firms for the same health insurance coverage. (The White House Report on Small Business and Health Reform, July 2009)