The UN-affordable Care Act – Part II, Who pays the price

Over the past week I have participated in 3 webinars on the Affordable Care Act – one from E&Y, one from ADP and one from the SBA (Small Business Administration). I must say that the SBA webinar was the most interesting to me because it was presented from the Government's perspective, not the employers' as the others were. There is such a divergence of perception and reality between the two that it's truly no wonder nothing can get resolved.

First, let me try to cut to the chase and simplify the requirements. If you are a small business with 50 or less employees, you do NOT need to do ANYTHING! You are exempt from the law. That's pretty much where the good news ends. Even though your business does not need to offer health insurance or participate in any special calculations or reporting, your employees are still required to obtain coverage for themselves and their dependents to avoid the "shared responsibility" penalty. If they can't get coverage from you, they may look for another job with a larger company that does provide health insurance, so retention of talent may become an issue for you. Now, I'm definitely not a government advocate, but the heathcare.gov website has something called the Shop Marketplace where small businesses can get coverage for their employees. It allows you to research medical and dental plans, determine what you want your contribution to be and decide if you want to offer coverage to dependents and if you want to offer them choices as to the level of coverage and whether they choose medical, dental or both. From the presentation, the system seemed pretty slick and I encourage you to check it out.

Now, if you are an ALE (Applicable Large Employer) you must offer "minimum essential coverage" that is "affordable" and that provides "minimum value" to your full-time employees and their dependents or you may be assessed an employer shared responsibility payment to the IRS, which is sometimes referred to as the "employer mandate". Your ALE status is determined by the size of your workforce the previous year. If you had 50 FTEs (full-time equivalent) employees during the preceding calendar year, you will be an ALE for the entire succeeding year. Tax exempt and government organizations (except CONGRESS) also fall into this category.

The full-time equivalent calculation takes a battery of actuaries to determine, so I won't bore you with the specifics, suffice it to say that limiting your employees to 29 hours per week isn't necessarily the answer. Also, "dependents" do NOT include spouses, stepchildren or foster children. Funny, I thought the whole point of this was to make sure EVERYONE was covered . . . especially the children. So, if your spouse is self-employed and your employer does not offer coverage to spouses, they have to go to HealthCare.gov and get their own policy, but I'm getting ahead of myself . . .

There are two types of employer mandates. An employer will owe the first type of employer shared responsibility payment (ESRP) if:

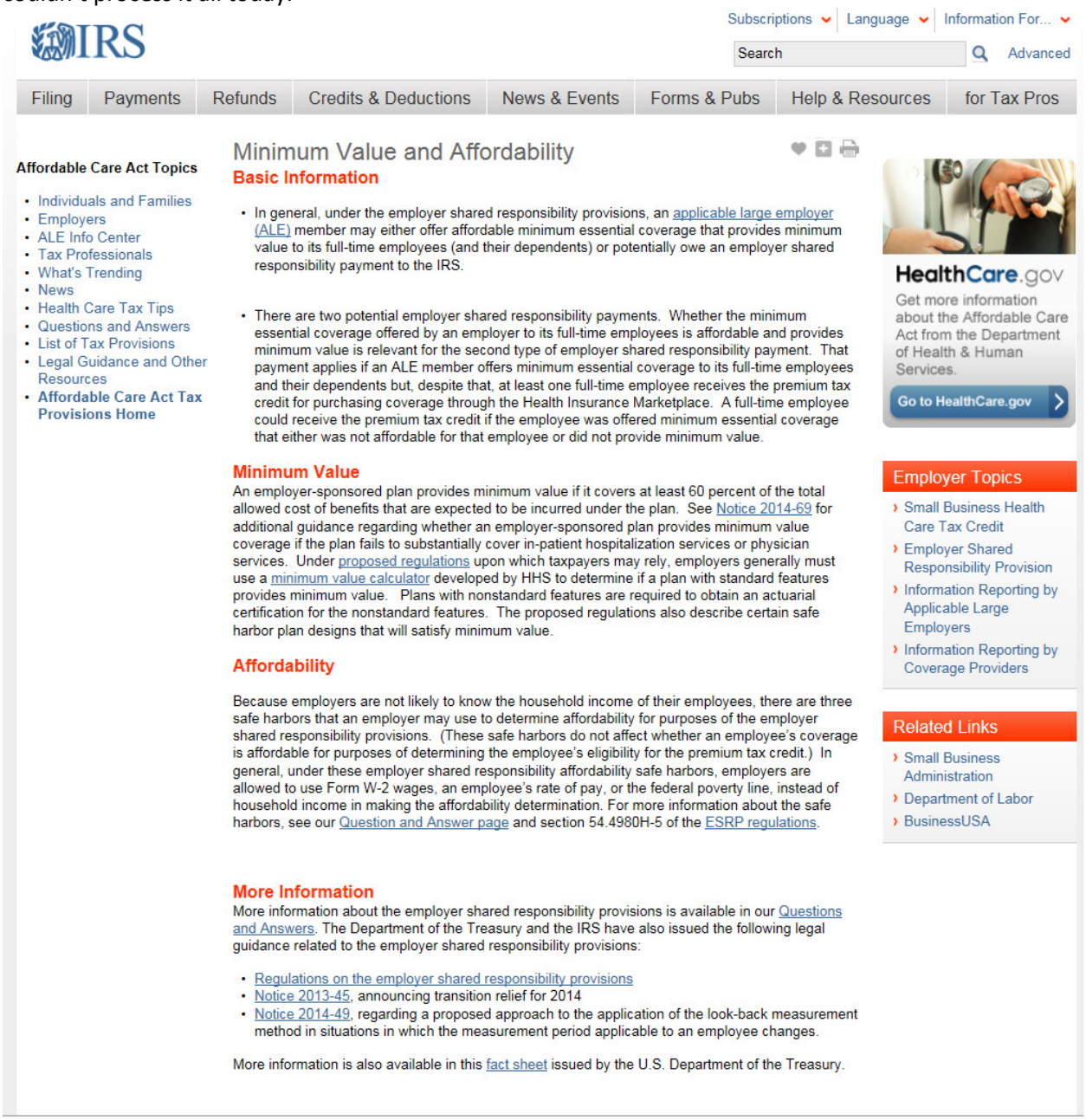
1. It does NOT offer "minimum essential coverage" to at least 95% of its FTEs and their dependents AND
2. at least ONE full-time employee receives the premium tax credit for purchasing coverage through HealthCare.gov. An employee may qualify for a premium tax credit if:
    a. the "minimum essential coverage" the employer offers to the employee is not "affordable"
    b. the "minimum essential coverage" the employer offers does not provide ***minimum value***
    c. the employee is not one of the "at least 95%" of FTEs offered minimum essential coverage

If an employer violates 1. above, the penalty is $2,000 for each full-time employee over 30. So, if you have 51 employees which would make you an ALE and subject to the ESRP and only ONE employee who is eligible for the premium tax credit purchases health insurance from healthcare.gov instead of the coverage you offer, you will be penalized $2,000 x 21 employees (over the 30 threshold) or $42,000. This payment is not tax deductible.

If an employer violates 2. above, they will be fined $3,000 for each employee who receives the premium tax credit and purchases insurance through the exchange (healthcare.gov).

In the SBA presentation I viewed, they stated specifically that they were attempting to incentivize employers into offering coverage because the medical expenses incurred were deductible on their annual Federal tax return, but the penalties are not.

Aside from the penalty amounts, do you notice anything else "odd" about the mandate descriptions above? Well, what does "minimum essential coverage" mean? What constitutes it? What is "minimum value"? How is it calculated? If you have a background in algorithms or enjoy Soduko, then I encourage you to check it out and let me know. My brain just couldn't process it all today.



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Affordable Care Act Topics

- Individuals and Families
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Minimum Value and Affordability

Basic Information

- In general, under the employer shared responsibility provisions, an applicable large employer (ALE) member may either offer affordable minimum essential coverage that provides minimum value to its full-time employees (and their dependents) or potentially owe an employer shared responsibility payment to the IRS.

- There are two potential employer shared responsibility payments. Whether the minimum essential coverage offered by an employer to its full-time employees is affordable and provides minimum value is relevant for the second type of employer shared responsibility payment. That payment applies if an ALE member offers minimum essential coverage to its full-time employees and their dependents but, despite that, at least one full-time employee receives the premium tax credit for purchasing coverage through the Health Insurance Marketplace. A full-time employee could receive the premium tax credit if the employee was offered minimum essential coverage that either was not affordable for that employee or did not provide minimum value.

Minimum Value

An employer-sponsored plan provides minimum value if it covers at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan. See Notice 2014-69 for additional guidance regarding whether an employer-sponsored plan provides minimum value coverage if the plan fails to substantially cover in-patient hospitalization services or physician services. Under proposed regulations upon which taxpayers may rely, employers generally must use a minimum value calculator developed by HHS to determine if a plan with standard features provides minimum value. Plans with nonstandard features are required to obtain an actuarial certification for the nonstandard features. The proposed regulations also describe certain safe harbor plan designs that will satisfy minimum value.

Affordability

Because employers are not likely to know the household income of their employees, there are three safe harbors that an employer may use to determine affordability for purposes of the employer shared responsibility provisions. (These safe harbors do not affect whether an employee's coverage is affordable for purposes of determining the employee's eligibility for the premium tax credit.) In general, under these employer shared responsibility affordability safe harbors, employers are allowed to use Form W-2 wages, an employee's rate of pay, or the federal poverty line, instead of household income in making the affordability determination. For more information about the safe harbors, see our Question and Answer page and section 54.4980H-5 of the ESRP regulations.

More Information

More information about the employer shared responsibility provisions is available in our Questions and Answers. The Department of the Treasury and the IRS have also issued the following legal guidance related to the employer shared responsibility provisions:

- Regulations on the employer shared responsibility provisions
- Notice 2013-45, announcing transition relief for 2014
- Notice 2014-49, regarding a proposed approach to the application of the look-back measurement method in situations in which the measurement period applicable to an employee changes.

More information is also available in this fact sheet issued by the U.S. Department of the Treasury.

HealthCare.gov

Get more information about the Affordable Care Act from the Department of Health & Human Services.

Go to HealthCare.gov

Employer Topics

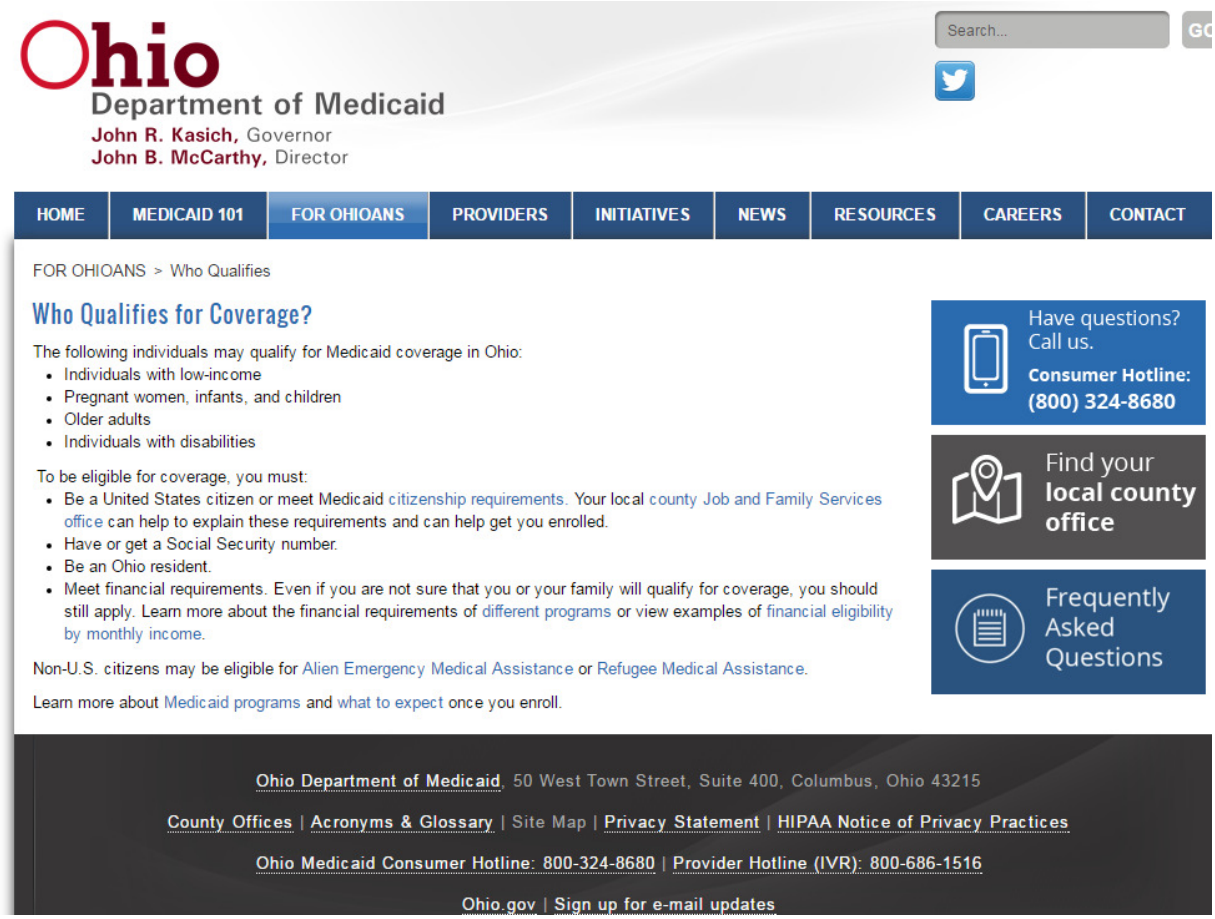
- Small Business Health Care Tax Credit
- Employer Shared Responsibility Provision
- Information Reporting by Applicable Large Employers
- Information Reporting by Coverage Providers

Related Links

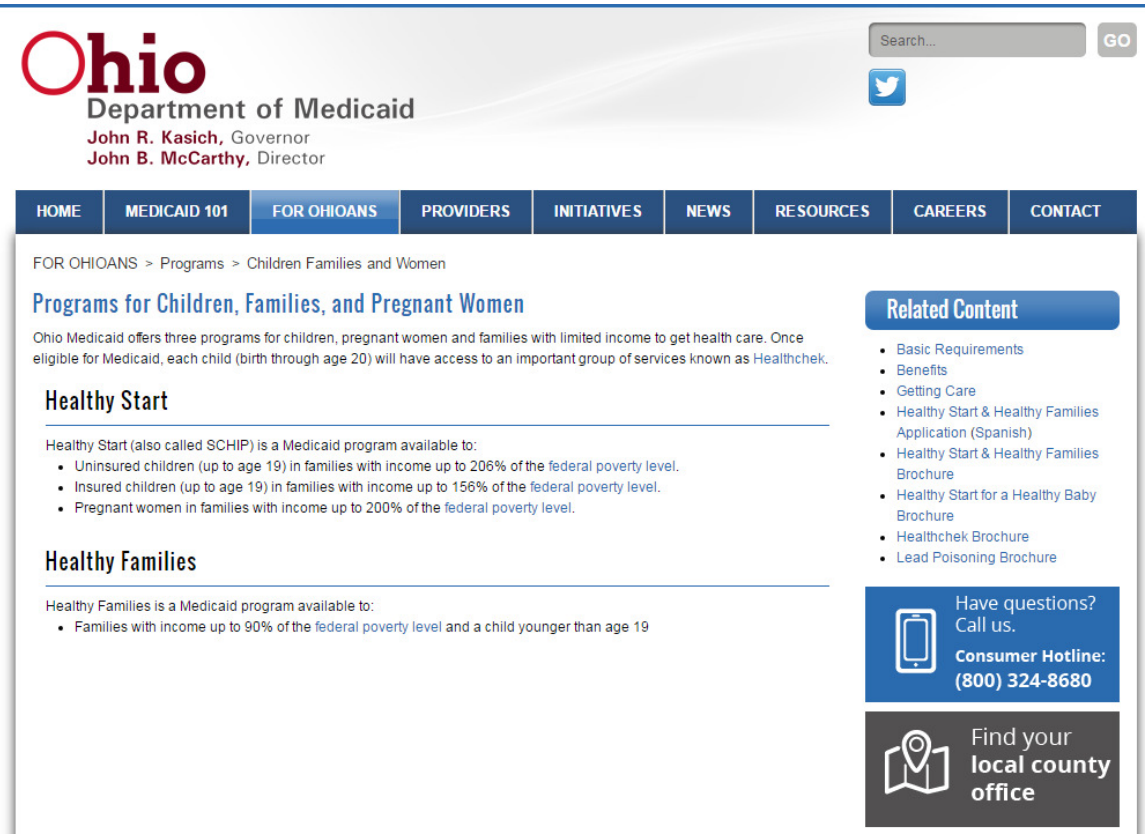
- Small Business Administration
- Department of Labor
- BusinessUSA

I'm not going to go into all the reporting requirements employers are subject to comply, but I am linking to a Fact Sheet issued by the Department of the Treasury in March 2014 if you would like to read it for yourself. I found it to be very long, confusing and depressing. Reporting requirements get more complicated if you do business in a State that offers its own healthcare exchange. Another confusing aspect is whether independent contractors and temporary employees are considered FTEs. The IRS has a "20 Factor Test".

Let's talk about who may be subject to the Individual Shared Responsibility Payment (ISRP). So, what we were told over and over again was that the poor could not afford coverage, so children and the elderly were dying in the streets. In the State of Ohio, the current Medicaid program offers coverage to:



Here are the financial requirements:



And here are the Federal poverty guidelines for 2016:

HHS POVERTY GUIDELINES FOR 2016

See also the Federal Register notice of the 2016 poverty guidelines, published January 25, 2016

2016 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $4,160 for each additional person.	
1	$11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890

If you are a family of four and have uninsured children, you can obtain coverage for your children through the SCHIP Medicaid program if your income is below 206% of the federal poverty level. For 2016, this would be $50,058.

This chart is for 2015 poverty levels and shows the monthly income limits by covered category:

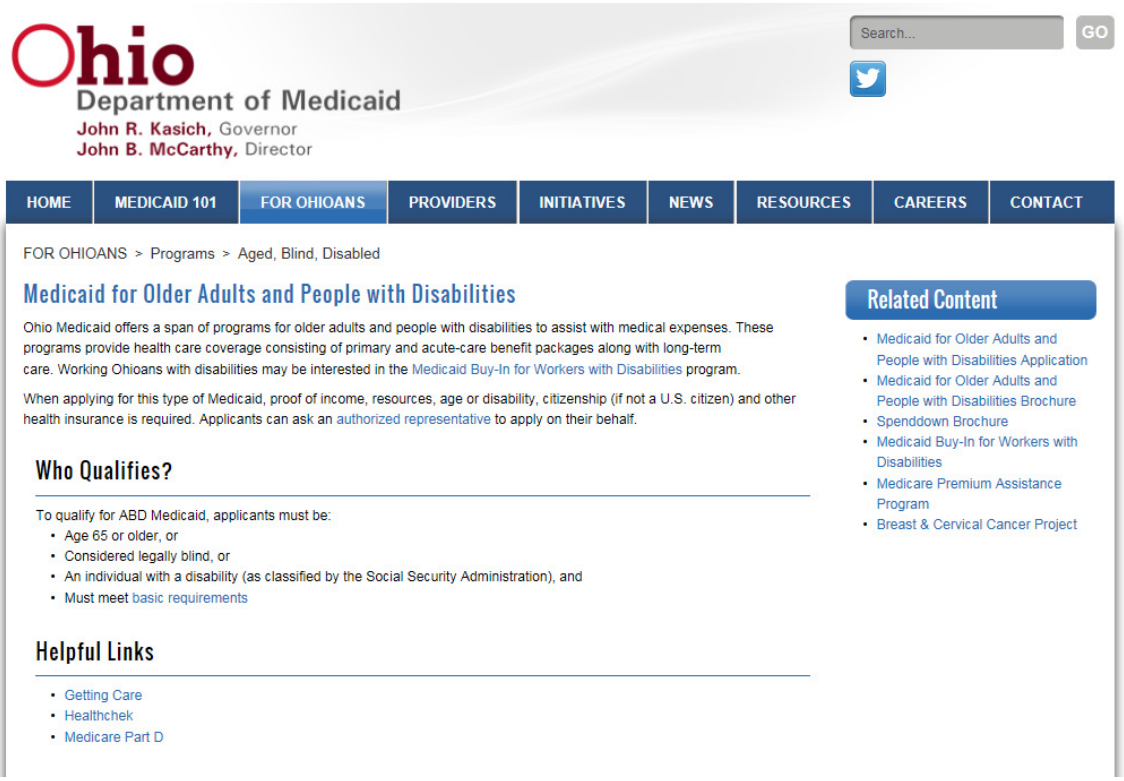
Ohio Medicaid

2015 Financial Eligibility - Monthly Income

Family Size	Federal Poverty Level	Adults [age 19-64]	Children with Insurance	Pregnant Women	Children without Insurance
	100%	138%	156%	200%	206%
1	$981	$1,354	$1,531	$1,962	$2,021
2	$1,328	$1,833	$2,071	$2,655	$2,735
3	$1,675	$2,312	$2,612	$3,349	$3,449
4	$2,021	$2,789	$3,153	$4,042	$4,163
5	$2,368	$3,268	$3,694	$4,735	$4,878
6	$2,715	$3,747	$4,235	$5,429	$5,592
7	$3,061	$4,224	$4,775	$6,122	$6,306
8	$3,408	$4,703	$5,316	$6,815	$7,020
9	$3,755	$5,182	$5,857	$7,509	$7,734
10	$4,101	$5,659	$6,398	$8,202	$8,448
11	$4,448	$6,138	$6,939	$8,895	$9,162
12	$4,795	$6,617	$7,479	$9,589	$9,876

These figures are updated annually.

This screen shot shows that there are no income limitations for the elderly or disabled:



So, just to recap, we have children from families earning below 206% (uninsured) or 156% (insured) of the poverty level covered. We have pregnant women below 200% of the poverty level and the elderly and disabled covered. This leaves individuals between the ages of 19 and 64 that are not disabled which earn above poverty level incomes.

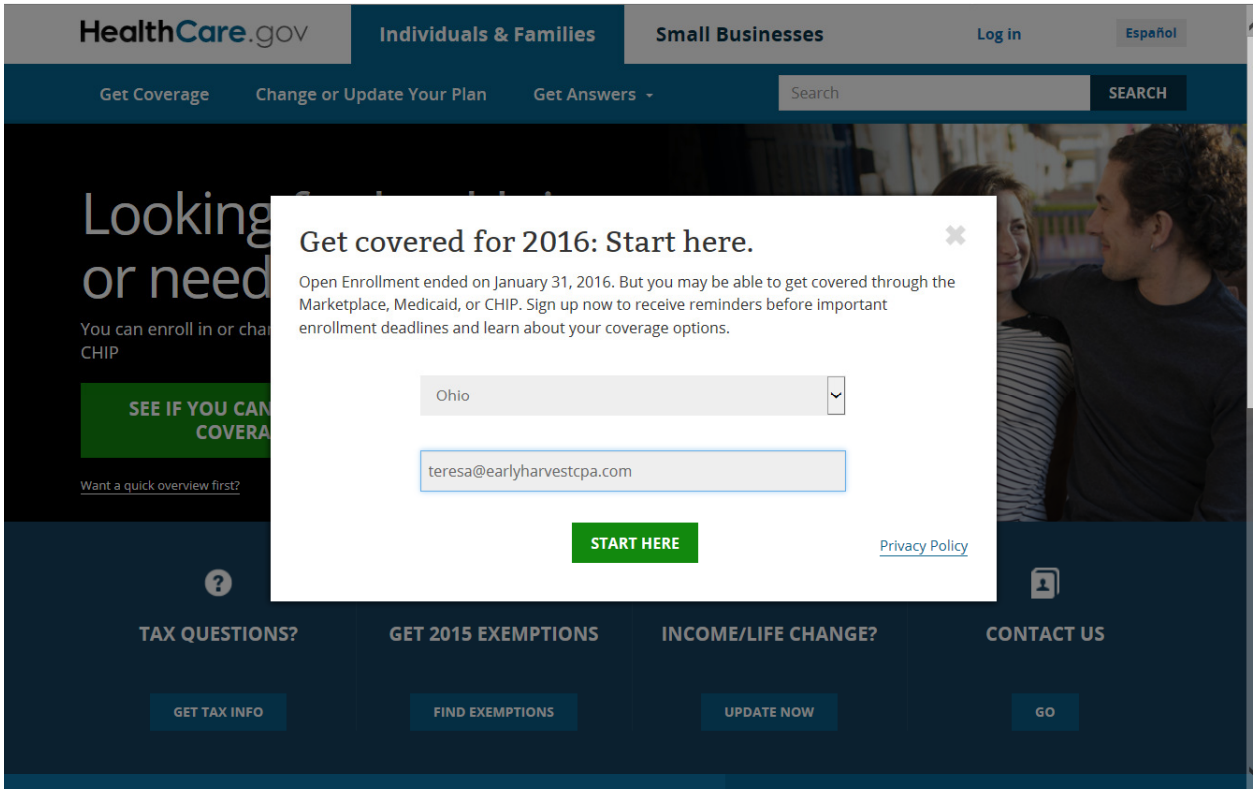
Within this group, we have individuals who:

- Work full-time for an ALE - COVERED
- Work full-time for a small employer – If income is low enough, may qualify for Medicaid. Otherwise, NOT COVERED
- Work part-time for an ALE – If income is low enough, may qualify for Medicaid. Otherwise, NOT COVERED
- Work part-time for a small employer – If income is low enough, may qualify for Medicaid. Otherwise, NOT COVERED
- Are self-employed – NOT COVERED
- Go to school – if under 26, can still be covered on parent's plan. If not and their income is low, they may qualify for Medicaid. Otherwise, NOT COVERED

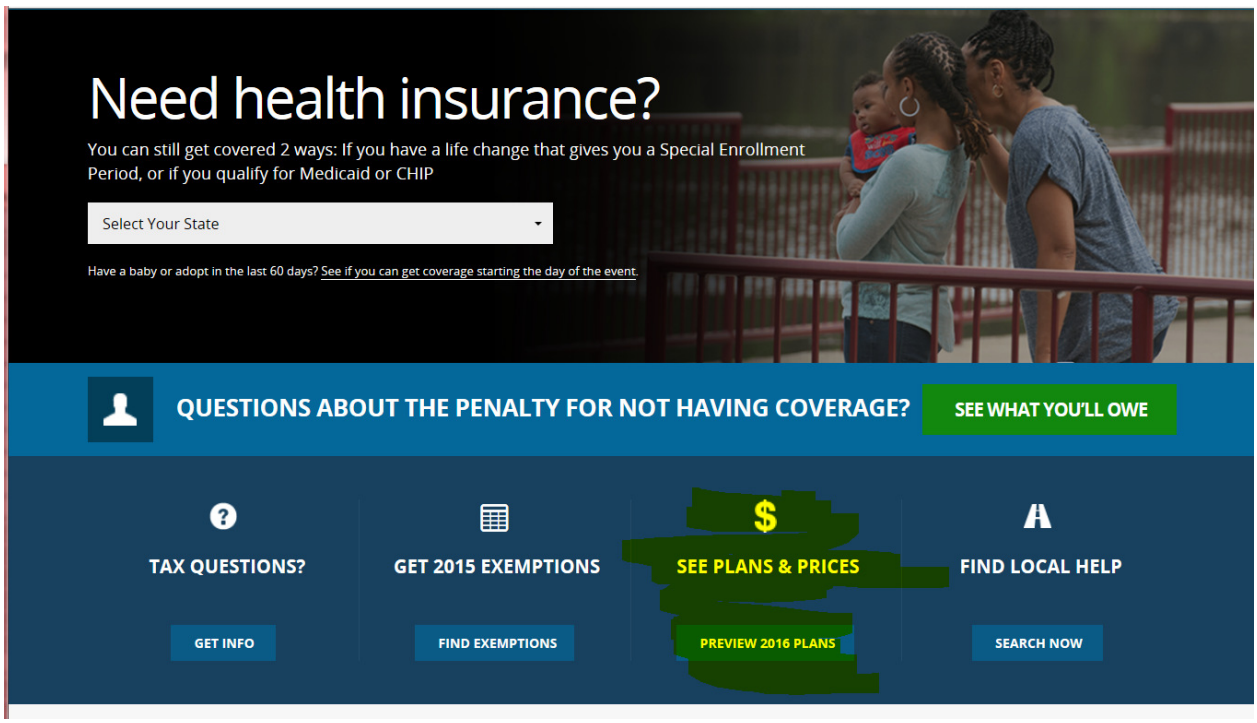
Hmmm, unless you work for a large Corporation who is going to make sure their plan complies to avoid potential penalty amounts that can be in the millions of dollars, it appears that you will need to go to the government (or State) exchange to obtain coverage.

This is where things get hairy for me. We've all heard the stories of people who could not obtain coverage any other way except through the exchange. They report astronomical premium and deductible increases. One case in particular stated that their monthly premiums were $3,200 and their annual deductible was $10,000. This would mean that they would have to spend $48,400 out of pocket (their premiums and deductible combined) before the insurance would pay one single penny! Then, they would only pay 80%. How is this "affordable"? Are these stories true?

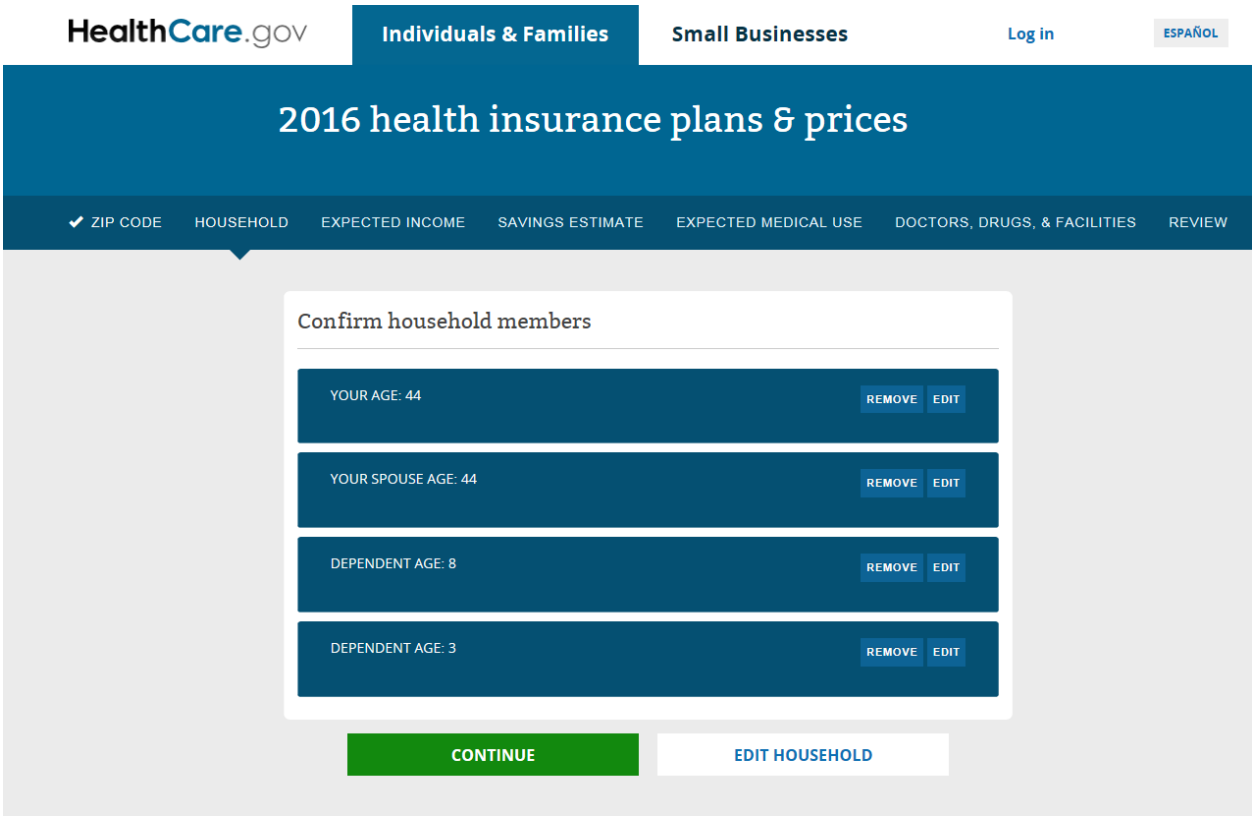
So I embarked on my own journey into the mysterious realm of HealthCare.gov. You are required to enter an email address just to enter the site, which I find personally annoying. Why can't I just look at your numbers anonymously? Big Brother has to know who's snooping around I guess . . . but that's just me being cynical.



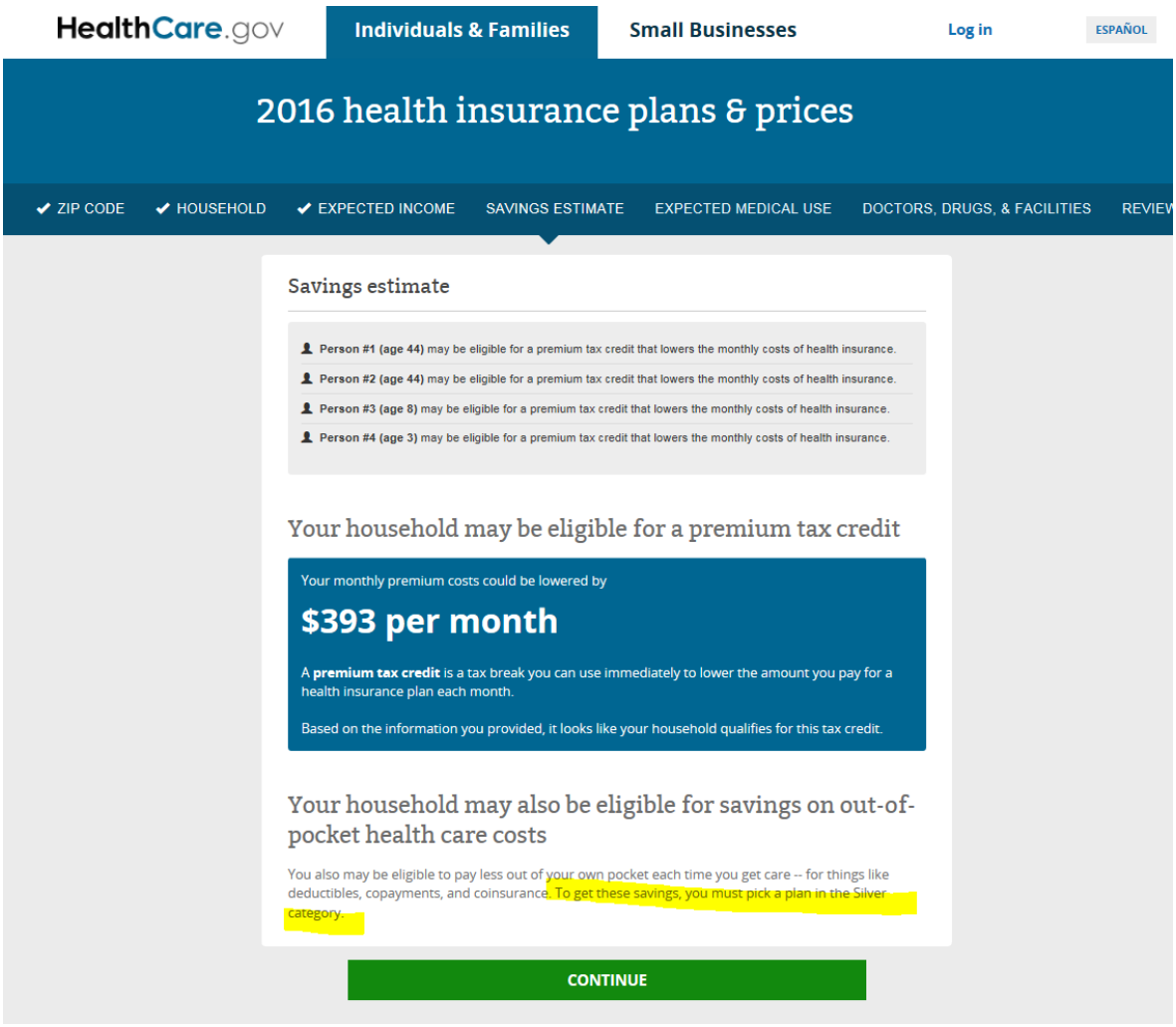
Once in, I chose the “see plans and prices”:



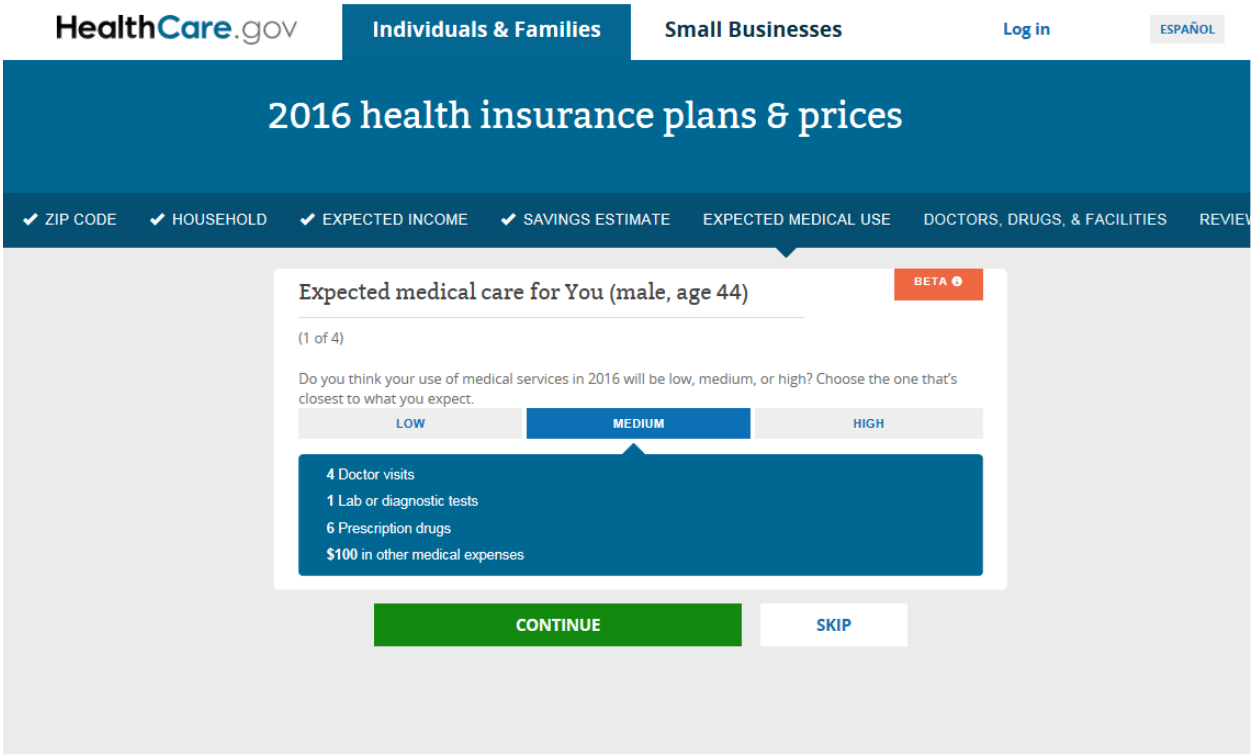
Next, they ask for my zip code, how many people in my household, am I married, will I claim dependents and how many, then they ask for age, gender and if you are eligible for other insurance or are a tobacco user. For this exercise, I decided to search plans for a fictional family of four with two children under the age of 19 who are above the 206% poverty level and cannot obtain coverage for their children under Medicaid in Ohio. The parents are both 44 and non-smokers and their annual income is $52,000 which is slightly above the 206% poverty level for 2016 of $50,058.



After entering the annual expected income of $52,000, it shows me what my expected premium tax credit may be. Just to be clear, this is the EXPECTED calculated amount. Personally, I immediately know I have a problem when the CREDIT is $393 per month. If that's the credit, how much is the insurance??

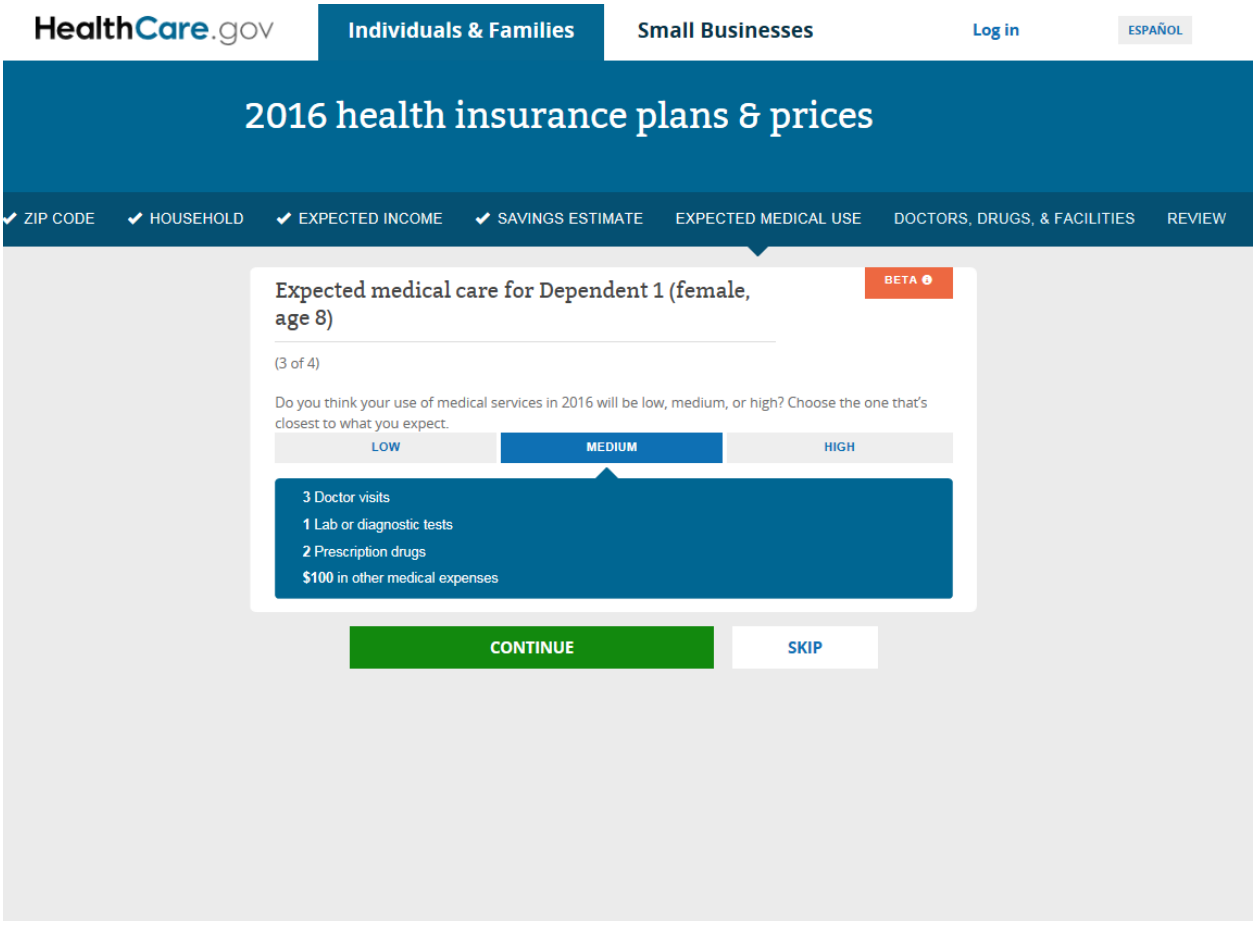


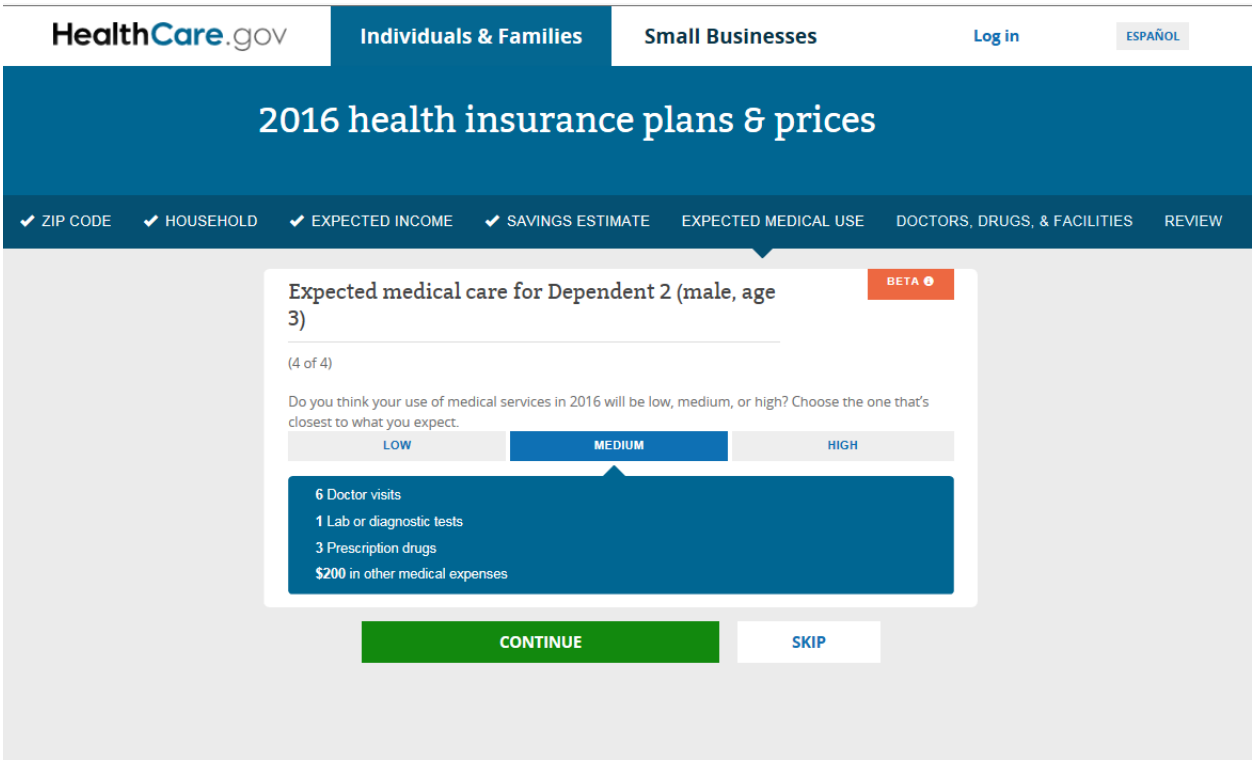
Next it asks if you want an estimate of your annual costs and it asks you to determine your expected level of care for the year:



That seemed excessive, so I chose the “low” for both parents:

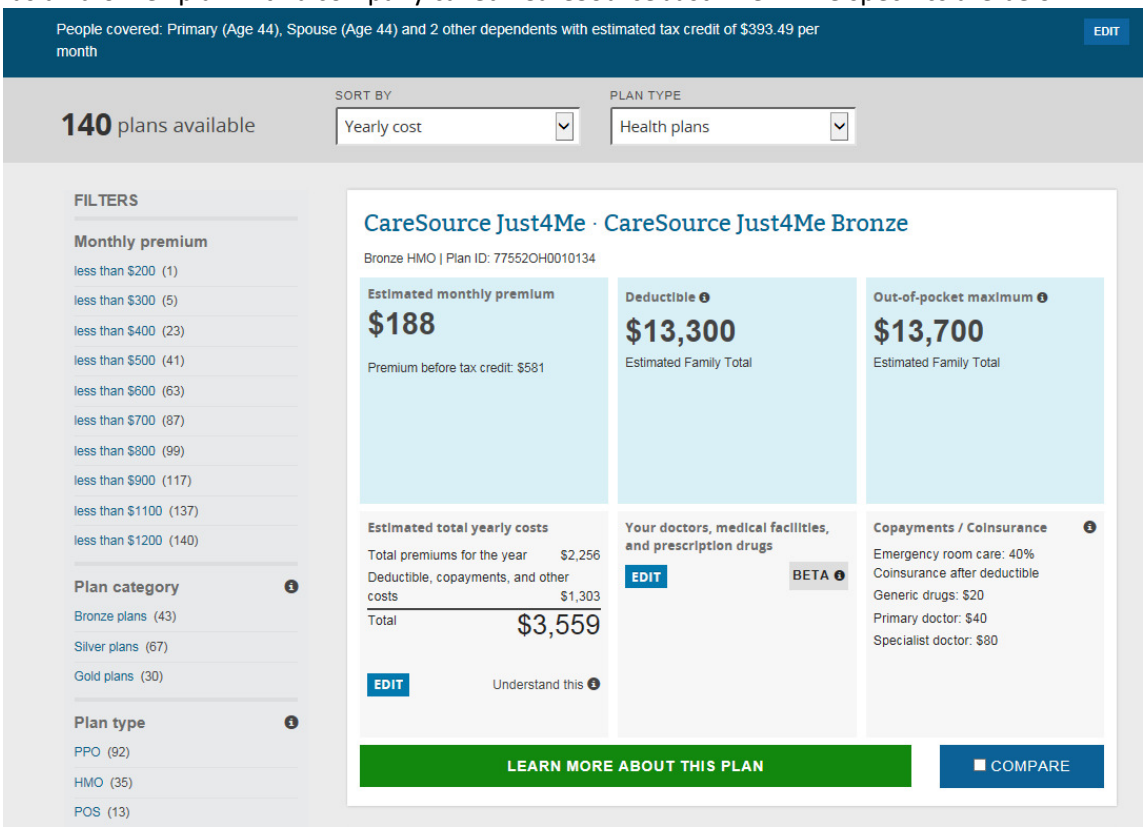
And “medium” for the two children:





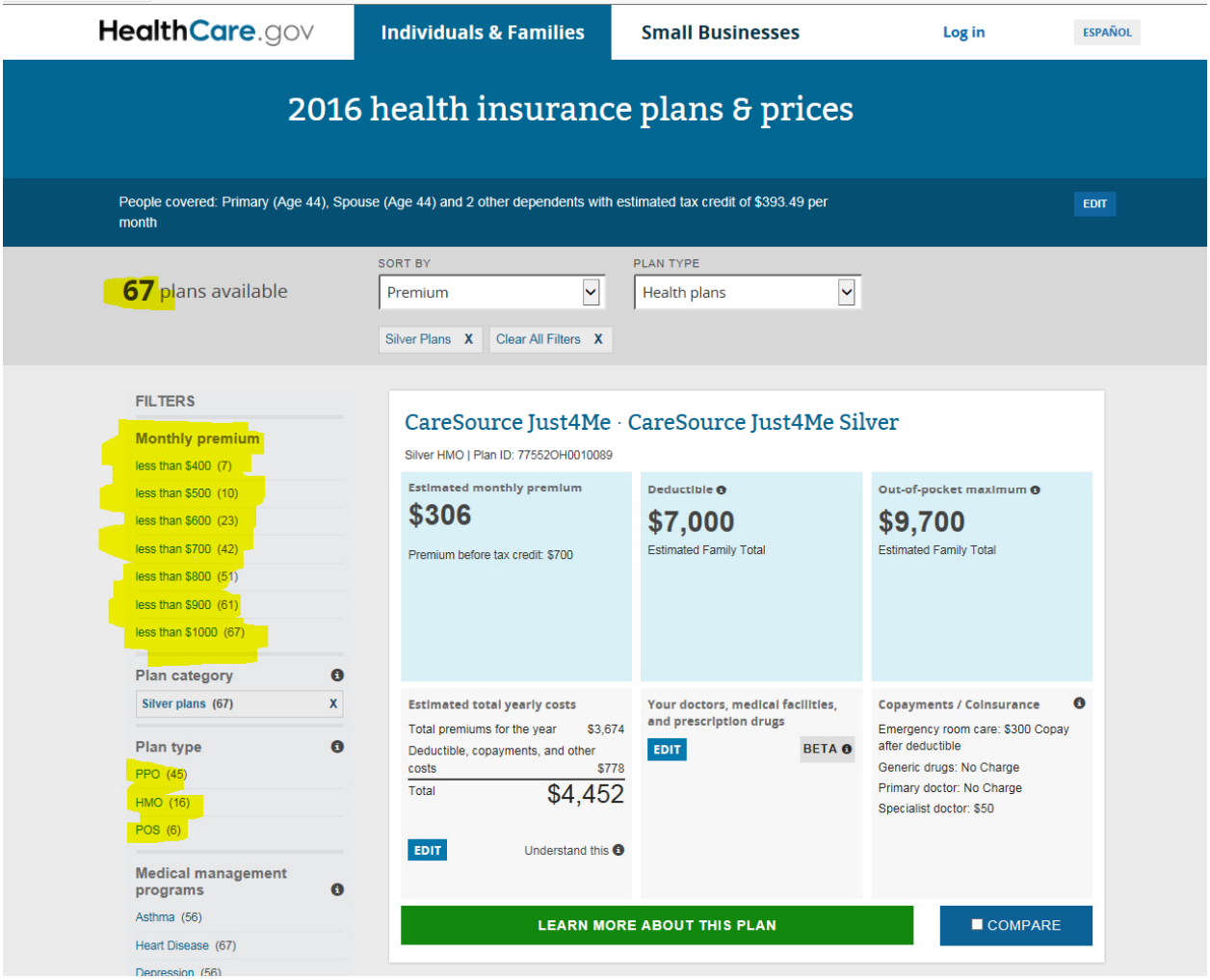
Next it asks if you want to search insurance companies for information about which doctors, hospitals and drugs they cover. This family doesn't take any prescriptions currently and is not tied to their doctor, so I chose "skip". It then gives a recap of your information before it takes you to the plans.

The results were staggering. There were 140 plans available. You can filter by insurance company or medical "management" programs or if you want a PPO, HMO or POS which frankly I have no idea what the differences between these plans are. I sorted by Yearly Cost and if I understand correctly what it was showing me, the least expensive plan was a "bronze" plan with a company called "CareSource Just4Me". The specifics are below:



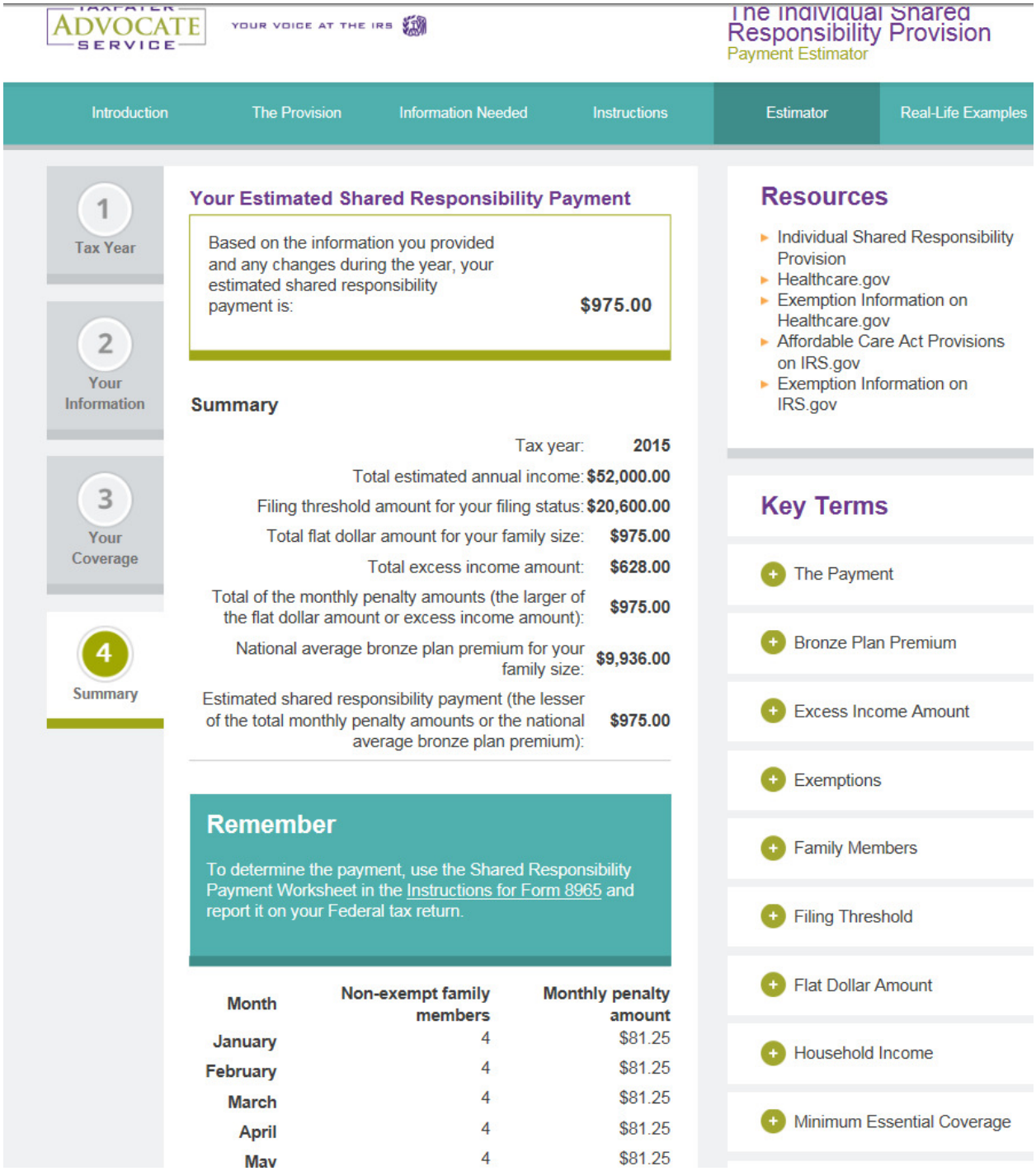
I did not understand how the “estimated total yearly costs” could only be $3,559 when the deductible is $13,300 so I clicked on the “understand this” icon. Unfortunately, it’s a popup and I couldn’t take a screen shot of it, but suffice it to say that it’s legal jargon for this is just our best guess. It should be noted that the monthly premium of $188 is less the premium tax credit calculated by the system of $393.49, the actual monthly premium for this plan is $581, so the higher your income, the less your credit and the higher your premium.

You should be aware that the website times out after seemingly 15 minutes. I kept getting error messages that said “sorry there was an error. Please try this again”. Everytime I tried it again, it did not work so I had to start over and re-enter all my choices. My biggest issue with the listing, being a spreadsheet person, is that you cannot download or print the entire list. The silver choices alone had 67 plans that covered 7 pages. There was no way to get this all on one page or print to .pdf. I highlighted a few of the filters on the left to show that the monthly premiums range from Less than $400 to Less than $1000.



Now, remember one of the stipulations for the ALEs is that their plans have to be AFFORDABLE. The concern for employers was they had no way to know their employees’ total household income, so the Safe Harbor test to determine affordability is 9.5% of wages. If we follow the same math for our fictional family, monthly wages would be $4,333.33 ($52,000/12). 9.5% of this is $411.67. So, it would appear from the “monthly premiums” section I have highlighted above the vast majority of plans in the Silver range are NOT affordable according to the government’s own calculations. From the filter above, only 10 plans are less than $500 per month. What gives? Why are there different “standards”? Who is really being hurt here? Let’s say our fictional family has one parent employed by a small business with less than 50 employees who makes $25 an hour and the other parent runs the household and cares for the children. Is increasing their income the answer? Nope. This just decreases their “premium tax credit”. Are you beginning to see the issue here?

Call me crazy, but it appears to me that the real people being "left behind" in regards to affordable health care are those that are trying to better themselves. If you work for a small company or are self employed, or if you are unable to get full time work (which this legislature has encouraged and rewarded), you are being detrimentally affected. If you make too much money, your family suffers. In our example above, the family could cover their two children for free under Medicaid with no co-pays or deductibles if the employed parent only made $24 an hour. Not only is this family detrimentally affected financially, but if they say, "well, we just can't afford it, we'll have to go without and pray nothing happens", so sorry, but that option is not open to you because now you're going to lose the refund for child tax credit or earned income credit or any overpayments made because, you guessed it, now you're on the hook for the ISRP (Individual Shared Responsibility Payment). They have an estimator on the website. Since I'm a "worst case scenario" type of gal, I entered the data for our fictional family having no insurance at all for 2015. The penalty is $975 which is scheduled to increase each year.



TAXPAYER ADVOCATE SERVICE — YOUR VOICE AT THE IRS

The Individual Shared Responsibility Provision
Payment Estimator

Introduction | The Provision | Information Needed | Instructions | Estimator | Real-Life Examples

1 Tax Year
2 Your Information
3 Your Coverage
4 Summary

Your Estimated Shared Responsibility Payment

Based on the information you provided and any changes during the year, your estimated shared responsibility payment is: **$975.00**

Summary

Tax year:	**2015**
Total estimated annual income:	**$52,000.00**
Filing threshold amount for your filing status:	**$20,600.00**
Total flat dollar amount for your family size:	**$975.00**
Total excess income amount:	**$628.00**
Total of the monthly penalty amounts (the larger of the flat dollar amount or excess income amount):	**$975.00**
National average bronze plan premium for your family size:	**$9,936.00**
Estimated shared responsibility payment (the lesser of the total monthly penalty amounts or the national average bronze plan premium):	**$975.00**

Remember

To determine the payment, use the Shared Responsibility Payment Worksheet in the Instructions for Form 8965 and report it on your Federal tax return.

Month	Non-exempt family members	Monthly penalty amount
January	4	$81.25
February	4	$81.25
March	4	$81.25
April	4	$81.25
May	4	$81.25

Resources

- Individual Shared Responsibility Provision
- Healthcare.gov
- Exemption Information on Healthcare.gov
- Affordable Care Act Provisions on IRS.gov
- Exemption Information on IRS.gov

Key Terms

- The Payment
- Bronze Plan Premium
- Excess Income Amount
- Exemptions
- Family Members
- Filing Threshold
- Flat Dollar Amount
- Household Income
- Minimum Essential Coverage

There are some “real life examples” (note the far right tab above) on the website. The calculations are laughable. First, both of them are for 2014 when the max penalty was only $95. The second example shows a family of four with partial year coverage. Again, the max penalty for 2014 was $95, so the penalty was only $37.25.

Look, you don’t need to take my word for it – check out the website yourself. Pretend that you (and your spouse) become unemployed tomorrow and enter your data. Now, imagine how you would incorporate this expense into a now non-existent budget.

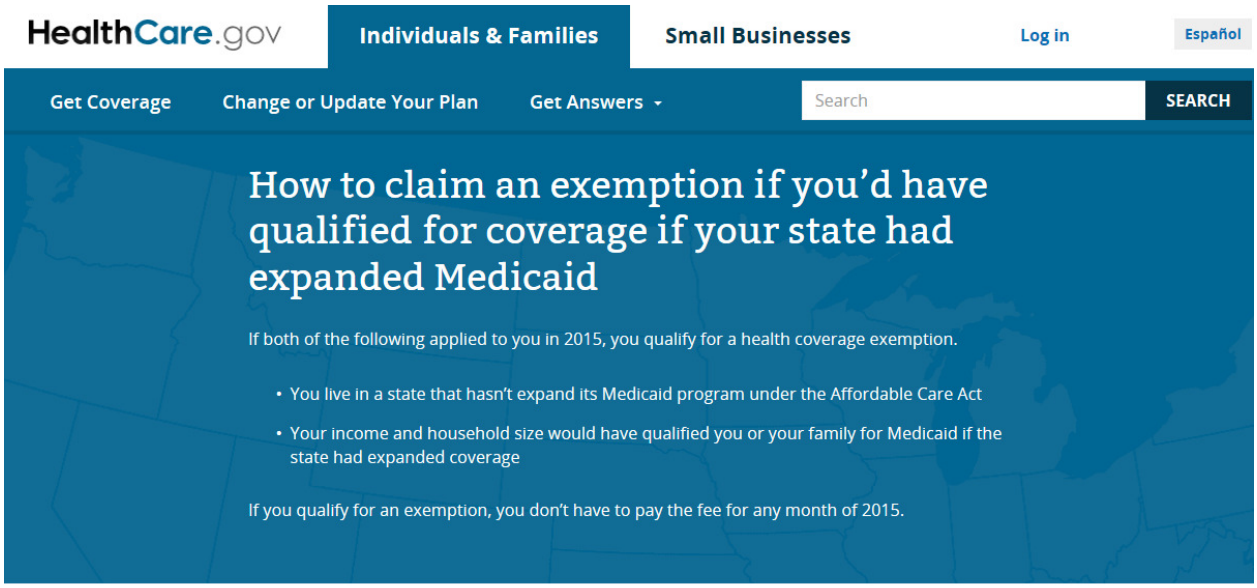
There are exemptions which I will not cover in detail but I did print the page to .pdf and you can link to it here, and one of them does state that if the lowest coverage available to you is more than 8.05% of your household income you are exempt. Our family would NOT qualify for this exemption because 8.05% of their monthly income is $348.83 and the lowest priced plan was $306. Below are the “hardship” exemptions:

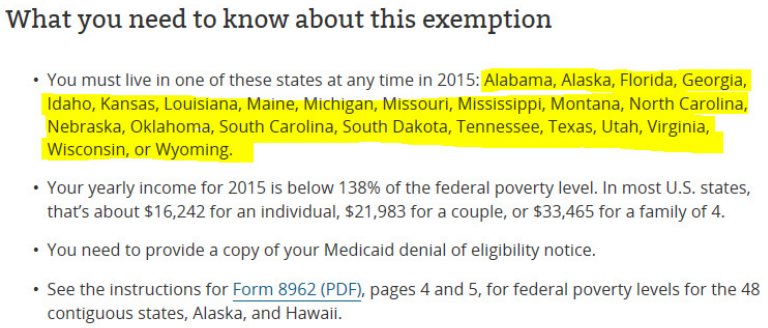
Hardship exemptions from the requirement to have health coverage: Forms & how to apply

Following are all health coverage exemptions based on hardships. The links below take you to a page with details about each exemption, forms, and instructions.

1. You were homeless
2. You were evicted or were facing eviction or foreclosure
3. You received a shut-off notice from a utility company
4. You experienced domestic violence
5. You experienced the death of a family member
6. You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property
7. You filed for bankruptcy
8. You had medical expenses you couldn’t pay that resulted in substantial debt
9. You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member
10. You expect to claim a child as a tax dependent who’s been denied coverage for Medicaid and CHIP for 2015, and another person is required by court order to give medical support to the child. In this case you don’t have to pay the penalty for the child.
11. As a result of an eligibility appeals decision, you’re eligible for enrollment in a qualified health plan (QHP) through the Marketplace, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you weren’t enrolled in a QHP through the Marketplace in 2015
12. You were determined ineligible for Medicaid because your state didn’t expand eligibility for Medicaid in 2015 under the Affordable Care Act
13. Your individual insurance plan was cancelled after June 30, 2013 and you believe other Marketplace plans are unaffordable
14. If you experienced another hardship obtaining health insurance, use this form to apply for an exemption with the Marketplace (PDF)

This is the list of States that did not expand Medicaid under #12 above. Sorry, Ohio is NOT on the list . . .





I know I've bombarded you with a lot of information and it's very overwhelming, but this is only the tip of the iceburg. If you are self employed or a small business (with more than 50 employees), the reporting requirements and calculations needed are excessive and burdensome. Honestly, you would need to hire an outside company that specializes in the ACA to be compliant and avoid penalties. So ask yourself, who is better off under this plan? Who developed it? Who do you NOT hear complaining about it? Has there been one insurance company reporting negative earnings since these changes? Who do lobbyists work for – the taxpayers or the conglomerates that hire them? Why is Congress exempt? Why has our Republican Congress and Senate done NOTHING to relieve us of this mess? Who do they work for – you or themselves? Why are the Great Unwashed not marching on the Capitol with torches and pitchforks?

I do not have any answers to these questions, but we all need to be educating ourselves and holding our "representatives" feet to the fire. They've received a "pass" from us for way too long. Did we all need it to hit our own pocketbooks to motivate us? Or do we just need a leader, someone who gives us hope that they will actually address this for once and for all and repeal it? Someone who is not personally benefitting from it and actually has been subjected to it from an ALE perspective?

Think for yourself. Use logic. Decide what's important to you before it's too late.