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The Impact of the Patient Protection and Affordable Care Act on Middle-sized Businesses

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Abstract

The Patient Protection and Affordable Care Act (PPACA), also known as Obamacare, introduces many complications and headaches for business owners, leaders and managers. Such people have not the time or the patience to read through the legislation itself to discover what it requires of them, why they should care and what they can do about it. By writing a summary of its impact on business, along with a few suggestions to help, I seek to solve this problem. The majority of information within this document comes directly from Public Law 111-148, with some supplementary articles written by qualified professionals. I have included some of my own opinions with references to create ideas and solutions, as well as assumptions about the future. Further research regarding alternative solutions would be especially beneficial, as well as an update following the deliberation of the Supreme Court on the constitutionality of the bill.

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Introduction

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. Admittedly, the purpose of the bill was to bring about massive reform in the healthcare sector of the United States. When those outside the sphere of politics began to examine the bill for themselves, it became clear that effects of this legislation would be much farther-reaching than previously imagined.

As a business professional, you are certainly aware that this legislation will have some impact on your company policies and operations over the coming years. As a manager, you no doubt have little time to spend pouring over 1,024 pages of legal jargon so complicatedly written as to deter comprehensive knowledge of its contents. This is where the research contained here is meant to help. Upon analyzing the bill itself, along with its companion document, the Health Care and Education Reconciliation Act (HCERA), I have found that some sections are more pertinent to employers and business managers than others. Admittedly, I have not read the bill cover to cover. With this in mind, I still believe my efforts may assist you in better understanding what the law now requires of you and your company so that you can avoid any unnecessary conflicts, difficulties and punitive action.

If you were looking for a specific topic about which you have heard, I would direct you to the table of contents, where each topic is listed according to headings within the document. I would recommend, however, that you read through this document from beginning to end so as to not miss any previously unknown or unmentioned requirements. With that being said, let's dive right in.

Why Size Matters

For the purposes of this paper, a middle-sized business is one that hires at least 50 employees but fewer than 500 employees at any one time during a calendar year. Employers with fewer than 50 employees are, according to Public Law 111-148, not required to offer a group health insurance plan. Also, should a qualifying small employer desire to offer health insurance for employees, the government offers various tax benefits to help make that ambition a reality (See PPACA, Title I, Sec. 1421). Large businesses also have less concern for the PPACA. According to Blumberg in a 2010 article, 98% of companies with 100 or more employees provided health insurance options in 2009. While some of the legislation still affects larger businesses, the universal coverage portion and its threatened penalties are of little consequence to them.

Specifications for Health Insurance Plans

No lifetime maximum benefit or annual dollar limit

As of September 23, 2010, no health insurance plan, whether it is a group or individual plan, is permitted to exercise a "lifetime maximum benefit." Annual dollar limits for benefits are also prohibited. (See PPACA, Title I, Sec. 2711)

Annual Limit Waivers

Although annual limits were intended to be eliminated by the PPACA, some exemptions were granted that will last until January 1, 2014. As of June 2011, over 1,400 waivers were granted to companies and organizations that would experience significant cost increases and difficulties as a result of annual benefit limits taking effect. While these waivers are currently active, the Department of Health and Human Services (HHS)

stopped issuing new waivers on September 22, 2011. All waivers will expire on January 1, 2014, at which time annual limits will be prohibited. (Riggs 2011)

No rescission of coverage, with exception

No insurer is permitted to rescind coverage from an enrollee that has been enrolled on a particular health plan, with the exception of fraud or intentional misrepresentation by the enrollee. (See PPACA, Title I, Sec. 2712)

Dependent age extension

A dependent that is covered by a health insurance plan is now allowed to stay on his or her parent's/guardian's insurance plan until the age of 26. A stipulation for this rule is that the dependent maintains an unmarried status. (See PPACA, Title I, Sec. 2714)

No discrimination based on salary

With the exception of employers who operate with a self-insured health insurance plan, employers are not allowed to discriminate which coverage plans are available for certain employees based on hourly or annual salary. (See PPACA, Title I, Sec. 2716)

No discrimination for pre-existing conditions

Health insurance plans are now restricted from discriminating enrollment based on pre-existing conditions. (See PPACA, Title I, Sec. 2704)

Brief Summary of Benefits

According to the initial legislation, health insurance issuers (including those providing group plans) and self-insured employers were required to create and provide a document summarizing available health care benefits for enrollees by March 2012. The Department of Labor (DOL) would provide a template for the summary. However, due to delays by the DOL in publishing the finalized template, implementation has been

postponed. Once the DOL releases the completed template, they will also announce a deadline for insurers and employers to comply (Agile 2011). According to the general description, the summary cannot be longer than four (4) double-sided pages. Summaries must include a glossary of insurance and plan terms. Illustrations and examples of how a plan pays for claims such as cancer treatment, pregnancy and diabetes management. If an issuer does not provide this summary by the appointed date, which has at this time not yet been determined, a $1,000 fine will be enforceable per enrollee. (See PPACA, Title I, Sec. 2715)

W-2 reporting

Employers are required to specify the aggregate cost for their health insurance plan on their W-2 form as a part of their tax reporting. (See PPACA Title I, Sec. 1514)

Limit on Employee Annual Contribution for FSAs

For companies that maintain a Section 125 health flexible spending account (FSA) for their "cafeteria" plan, an employee's annual contribution is limited to $2,500. This requirement takes effect January 1, 2013. (See PPACA Title IX, Sec. 9005)

Excise tax increase for high-income individuals

For an employer that is a sole proprietor or who earns over $200,000 annually or whose household income is over $250,000, be aware of the new excise tax. This tax, which comes into effect for the 2013 tax year, charges said individuals or households an additional 0.9% in Medicare Part A taxes (FICA and SECA), raising the rate to 2.35%. (See PPACA, Title IX, Sec. 9015 and PPACA, Title X, Sec. 10906)

New tax on unearned income for high-income individuals

For an employer that is a sole proprietor or who earns over $200,000 in a year or whose household income is over $250,000, be aware of a new tax on unearned income. An individual or household above the income threshold will be liable to pay 3.8% of the lesser of these two:

1) Net investment income* for the taxable year, or
2) Amount of modified adjusted gross income in excess of the threshold for the taxable year

(See HCERA Title I, Sec. 1402)

Example: An individual earns $280,000 in a year; therefore, the individual has $80,000 in excess of the threshold. The individual has $100,000 in net investment income for the same year. Since the $80,000 is less than the $100,000 net investment income, the 3.8% tax would be applied only to the $80,000 excess.

*For a clarification of "net investment income" and specifics on the tax, see "National Association of Realtors" source

Health Insurance Exchanges

As of January 1, 2014, Health Insurance Exchanges (HIXs) will be established in every state and operated either by that state or by the federal government, depending on the timeliness and appropriateness to which the particular state has completed the necessary steps to establishing their HIX by January 1, 2013. HIXs will provide a centralized location from which individuals (and eventually employers) may purchase private health insurance. All previously mentioned criteria placed on health insurance plans will also be placed on these plans. Each health insurance plan will be placed into

one of four tiered groups: bronze, silver, gold or platinum. Out-of-pocket maximums will be set at the HIXs for individuals and families. Large employers will be allowed to purchase a group plan from the HIX beginning in 2017. Certain individuals may be qualified for federal subsidies when purchasing a health insurance plan from an HIX. If an employee is offered group health insurance from their employer, they may still choose to purchase health insurance through the HIX in their state. Should an employee choose a HIX plan over their employer's group plan, the employer will be liable for a penalty. (See PPACA, Title I, beginning with Sec. 1311 and continuing to other sections pertaining to "health benefit exchanges")

Penalty for employee alternative choice

An employee that meets at least one of two possible criteria and foregoes an employer's insurance option to purchase from the HIX will bring a penalty on the employer. The two criteria are as follows:

1) If the employer's group plan premium costs more than 8-9.8% of the household income of the employee.
2) If the employee's income is less than or equal to 400% of the Federal Poverty Level

(See PPACA, Title I, Sec. 1401)

If an employee meeting one of these specifications chooses an HIX health insurance plan over the employer's option, a $3,000 annual penalty is assessed to the employer per instance (See HCERA, Title I, Sec. 1003). The example below will illustrate the effects of both criteria.

Example: An employer of 100 employees offers a suitable group health insurance plan to all employees. Five employees, each earning $20,000 in annual salary (less than 400% of the Federal Poverty Level), choose to get health insurance from the state HIX. The employer is assessed the penalty for these five employees. Another 3 employees each earn $50,000 in annual salary. The premium for the group plan offered by the employer is $6,000. The three employees each decide to purchase health insurance from the HIX rather than the employer. Because the premium is higher than 9.8% of the employee's annual income ($6000/$50000 = 12%), the employer is assessed the penalty. By combining the penalties for the first five employees and the other three, the employer is required to pay a fine of $24,000 for the year ($3000 X 8 employees) or $2,000 per month. Do not forget that these penalties are assessed on a POST-TAX BASIS, so the costs are coming directly out of net income.

"Cadillac" health plan tax

A "Cadillac" health plan is defined by the total cost of the premiums of the employer and employee combined. The threshold for a health plan is $10,200 for an individual and $27,500 for a family. These amounts are also applicable to FSAs and HSAs. A 40% excise tax will be applied to any amount exceeding the defined threshold. Stand-alone dental and vision plans are not considered part of the threshold. This tax becomes effective on January 1, 2018. (See PPACA, Title IX, Sec. 9001 in conjunction with HCERA, Title I, Sec. 1401)

Universal health coverage

Many business owners and managers are of the understanding that all companies with 50 or more employees will be required to offer health insurance by January 1, 2014.

Technically, this is not the case. The legislation states that IF an employer does not offer a suitable* health insurance package to all full-time employees and IF a full-time employee of that employer goes to the Health Exchange to purchase insurance and IF said employee is eligible for a subsidy for this coverage, THEN the employer will be assessed a fine. Full-time employees are defined as working 30+ hours a week. Part-time employees, while not covered by the employer's group health insurance plan, are considered when determining the number of full-time equivalent employees. In order to calculate the number of FTEs that a company's part-time employees represent, divide the aggregate number of hours of service part-time employees complete in a month by 120. This quotient is then added to the number of full-time employees to determine if a company is "large" or "small". Again, employers are NOT required to provide health insurance opportunities for part-time employees. (See PPACA, Title I, Sec. 1513 and Title X, Sec. 10106 and also HCERA, Title I, Sec. 1003)

* suitable – defined by the state Health Insurance Exchange (HIX)

Penalty for non-compliance

If a large business does not provide a suitable medical insurance plan available to all full-time employees, the business will be assessed a fine. This fine will be determined by multiplying $2,000 times the number of full-time employees currently employed by the business minus the first 30 FTEs. Note: This penalty is NOT applied based on the number of employees that are not offered an adequate medical insurance option from their employer. It stipulates that if one employee is not allowed on an employer plan, the penalty will be enforced for all full-time employees of the business. (See HCERA, Title I, Sec. 1003)

Example: Company A currently employs 150 full-time employees. The employer does not offer medical insurance to ten of those employees. The employer is assessed the following fine for the year: $2,000 * (150-30) = $240,000 or $240,000/12 = $20,000 each month. These fees are enforced on a POST-TAX BASIS. Consider this additional example:

Company A is assessed the same fine of $240,000 as above. The company is in a 35% federal tax bracket. For the year, the company achieved $1,000,000 in profits. Rather than paying taxes on $760,000 ($1,000,000 - $240,000), Company A will pay taxes on the original $1,000,000 and THEN pay the $240,000 fine. So, Company A pays $350,000 in federal taxes ($1,000,000 * 0.35) and $240,000 in fines, leaving $410,000 in after-tax profits. So, in a sense, Company is paying 35% taxes on the fine. Therefore, the total financial loss from the fine is $324,000 ($240,000 fine + $84,000 tax).

Automatic Enrollment

Companies that employ more than 200 employees are required to automatically enroll all new full-time employee hires in a suitable group health insurance plan. The employer must also notify the employee of this enrollment, the option to select an insurance policy from the HIX, and the employee's potential eligibility for a federal subsidy for an HIX plan. Employers must allow the employee to opt out of this enrollment in lieu of an Exchange health plan if he or she so chooses. (See PPACA, Title I, Sec. 1511)

Reporting Standards

Beginning in 2014, employers are required to report a number of items to the Secretary of the Treasury every year. These items include:

1) Whether or not health insurance coverage is offered to all full-time employees
2) The waiting period to enroll in the coverage*
3) The total number of full-time employees during each month
4) The name, address and Tax ID Number of each full-time employee and the months in which they were covered by the employer's insurance plan

(See PPACA, Title I, Sec. 1514)

*In the initial legislation, employers were to be assessed fines based on extended waiting periods to enroll their employees. These requirements and fines have since been eliminated. (See HCERA, Title I, Sec. 1003)

Alternative Strategies

The following suggestions are based on a combination of research and my own personal conclusions.

Self-insurance

One way to handle some of the added costs from the PPACA is to become self-insured. While this is a riskier move in some cases, for certain employers this can provide significant cost savings. It is, of course, much more sensible for a large employer to self-insure. In 2009, 88% of insured employees of ultra-large companies (companies with 5000 or more employees) were on self-insured plans. Compare this with only 15% of covered employees of small firms (3-199 employees) whose companies used the self-insured model. Clearly, spreading the risk over larger numbers of enrollees helps to reduce costs per employee and make the model more affordable. Becoming self-insured is not the answer for everyone, but it is worth a look. (Brien and Panis 2012)

SHOP Exchange

Small Business Health Options Program (or SHOP) Exchanges offer an interesting alternative for small employers. The way your state handles its inception is critical. States, if they so choose, may consider employers with up to 100 employees as "small businesses," thus allowing them to buy group insurance plans on the SHOP Exchange. Large employers will be permitted to shop the SHOP in 2017. A couple of different scenarios may then play out, depending on how much control the employer wishes to exert in the process over the employees. Tax benefits will be available to qualifying businesses (less than 25 employees and a average wages below $50,000). If the qualified employer contributes 50% of the costs for premiums when purchasing from the SHOP Exchange, they will be afforded a tax credit of 35% of their contribution for the first two years (Corlette). Considering this will not even be an option for larger employers until 2017, it is certainly not a solution for the short-term.

Reorganization

Some business professionals are considering a somewhat "edgy" solution. With the government giving a stiff advantage to businesses with fewer than 50 employees, why not reorganize the business into small units of employees and avoid the problem altogether? While I cannot vouch for the IRS and their opinions, I cannot see auditors looking on this with much understanding or leniency. I do not recommend or condone openly avoiding giving the government their due.

Reduce Salaries, Other Expenses/Benefits

Of course, one obvious solution would be for businesses to reduce their other costs after calculating the burden the PPACA will bring. Since an employee health

insurance plan is part of employee benefits and compensation, a company may need to reduce other benefits or even salary. In most cases, the PPACA limits the contribution percentage of a plan that an employer can require an employee to pay; however, if an employer already offers insurance to some employees and contributes more than 60%, they may shift some of the expense to the employees. Also, if employees are working at a salary or hourly wage above minimum wage, it may be possible to reduce the base salary or hourly wage in order to satisfy health insurance requirements. Employers that do not currently offer health insurance to employees and have many people working minimum wage jobs will find little solace in these suggestions.

Pay the fines

And finally, we come to the elephant in the room. If you analyze the situation and the costs seem too great, it very well could make the most business sense to just pay the fines. The government actually intends to raise a fair amount of the revenue to fund the health reform by collecting fines from employers and individuals. Consider that in 2011 the average cost for employer-sponsored individual coverage was $5,429. Family coverage premiums averaged at $15,073, with employers contributing almost $11,000 of that. Now consider that the average premiums for family coverage increased by 113% from 2001 to 2011 (Kaiser 2011). If we assume that premiums will continue to rise at the same average rate until 2014, that would mean the average premium for family coverage in 2014 would be just over $20,000. Using the same contribution percentages as before, this would mean that employers would contribute over $14,000 towards each family premium. Even the minimum employer contribution percentage of 60% would still require employers to pay at least $12,000 per family enrollee. That $2,000 penalty is

starting to sound pretty good! In a talk held recently at the University of Tennessee, Knox County Commissioner Dr. Richard Briggs suggested that, in light of the disparity between the cost of healthcare to employers and the fine for not providing it, it will be in the best interest of many businesses to not offer healthcare coverage or even eliminate existing options to take advantage of cost savings. Where will the government get the money to subsidize health insurance for all these people? Beats me. But don't forget: the proponents of the PPACA claim this will actually reduce the federal deficit. But I digress.

Conclusion

So here's the good news: you made it! The bad news: all of this really does have to be implemented. Yes, one could say some of the requirements are difficult. In fact, you might make the argument that some are downright ridiculous. It might not even be such a stretch to say that a few companies will no longer be operational due to the effects of these regulations. However, we aren't here to argue its validity. You're reading this because you have to know these things.

Despite the challenges raised, a light remains at the end of the tunnel. On March 26-28, 2012, the Supreme Court heard arguments from lawyers arguing the constitutionality of an individual mandate to purchase health insurance and the bill as a whole. Following their deliberations, the justices will release their determinations about these considerations. The final decision will likely be announced before the end of June 2012. The deliberations could take a number of forms. The Supreme Court could decide to uphold the bill as law, after which companies will no doubt scramble to decide if they are capable of continuing operations in their current state and how they might best adapt.

Another possible decision is that the individual mandate will be ruled unconstitutional, but the remainder of the bill will be enforced. This is the most unlikely of the scenarios, but must be considered a possibility. Finally, the Supreme Court could determine that an individual mandate is unconstitutional, and without the mandate, the PPACA as a whole cannot stand. In all honesty, I do hope this is the case. Granted, that decision would nullify the need for my research, but I will accept that end if it means the continued existence of numerous middle-sized (or any-sized!) companies throughout the United States.

I sincerely hope this document has been of some help to you. The final result ended up being longer than I had intended, and for this I apologize to you. If in doubt, be sure to find the specific section of the PPACA or HCERA as cited and careful dissect it.

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**Special Recognition: Although no specifics citations were made in the paper from this source, the Powerpoint presentation from this talk gave significant guidance while I researched Public Laws 111-148 and 111-152.

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