The Patient Protection and Affordable Care Act (PPACA)

The Patient Protection and Affordable Care Act is known by many names, including the ACA, Obama Care, PPACA and health care reform. The law seeks to ensure health coverage for as many Americans as possible, by expanding employer and individual coverage requirements. It provides for the new Health Insurance Marketplace, through which people may buy subsidized health insurance. It expands Medicaid and improves Medicare, and includes both tax breaks and tax penalties.

Although people may continue to purchase insurance on their own and employers may continue to offer health insurance to employees, the ACA provides new ways to purchase insurance and different criteria for evaluating the coverage. Individuals who fail to purchase insurance must pay a penalty. Companies that fail to provide coverage that is affordable and that provides minimum value must also pay penalties.

Consisting of more than 2,000 pages, the ACA is difficult to boil down into a short document. Still, employers need to understand what the ACA requires of them. Because of the law's complexities, they need resources and guidance to help them stay in compliance.

What Does the ACA Do?

The first wave of rules under the ACA took effect in 2010 – 26 of them. These included rules about Medicare, dependent coverage for adults to age 26, and the coverage of preventative benefits. Between 2011 and 2016, 64 more provisions were slated to be implemented. In total, 82 provisions have taken effect as of February 2016, with more expected until 2018.[1] These range from updated requirements for COBRA notifications to waiting period limits to the creation of health care exchanges. The Kaiser Family Foundation's website presents an informative Implementation Timeline detailing the ACA's provisions.

Are We Subject to the ACA?

School districts and municipalities are not exempt from the ACA. One provision of the ACA you need to understand is the Employer Mandate. This provision requires any employer classified as an Applicable Large Employer (ALE) to provide affordable health coverage, or pay a per-employee fine. The implementation date for this provision was moved to January 1, 2015 for employers with at least 100 full-time employees, and January 1, 2016 for employers with 50-99 full-time employees. Failure to provide affordable coverage will result in fines of $2,000 per full-time employee (excluding the first 30 employees) or $3,000 for each employee receiving a premium tax credit. You can find details on the Department of Health and Human Services' website.[2]

To determine whether or not your district is an ALE, first figure out the number of full-time employees you have. A full-time employee for this purpose is anyone who works, on average, 30 hours or more per week or 130 hours or more per month.

Next, you need to figure out how many full-time equivalent (FTE) employees you have. This is a little more tricky. Count the number of your part-time employees, and figure out their average weekly hours by adding up the total number of hours they work in a week and dividing by the number of part-timers. Multiply the number of part-time employees by the average hours worked by this group, then divide the total by 30. When you add the result to the number of your full-time employees, you will get the number of your FTEs for purposes of the Employer Mandate.

1 http://kff.org/interactive/implementation-timeline/

2 http://www.hhs.gov/healthcare/about-the-law/read-the-law/index.html

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Fewer than 50 FTEs? Your district is not subject to the Employer Mandate. But if you count more than 50 FTEs, you are an ALE — although you may qualify for transition relief.[3]

How Do We Prove Our Coverage is Affordable?

There are two new reporting forms required under the ACA. Form 1095 provides information to the IRS about your health insurance coverage, its affordability and whether or not it provides minimum essential coverage and minimum value. Form 1094 is the transmittal form for Form 1095.

In 2016, ALEs must provide health coverage to at least 95% of their full-time employees and dependents up to age 26. The coverage must be affordable, and it must provide minimum value, as defined in the ACA. Affordability for employee-only coverage is based upon 9.5% of an employee's household income. You are unlikely to know the household income of your employees; that's why the law provides three safe harbor tests.

Your coverage meets the affordability standard if self-only coverage for your lowest cost plan does not exceed 9.5% of

- The employee's W-2 wages from working for you for the calendar year;
- The federal poverty level for a single individual; or
- An actual pay amount based on the employee's actual pay or salary.[4]

Does Our Coverage Provide Minimum Value?

In order to meet the minimum value standard, your plan must cover at least 60% of the total allowed cost of benefits that are expected. This will depend upon the plan's features, like co-pays and deductibles. A qualified consultant can help you determine the affordability and value of your health plans.

As you might expect, the ACA rules are very complex and contain exceptions and conditions. It includes many opportunities to find yourself facing penalties and fines from non-compliance – intentional or not.

To keep you on the right path as you navigate this new territory, we urge you to contact a qualified guide, like the consultants at USEBSG. We consider it a privilege to help you get (and stay) on the right path. Contact us for more information. We can be reached at info@usebsg.com.

3 https://www.irs.gov/Affordable-Care-Act/Employers/Transition-Relief

4 https://www.irs.gov/Affordable-Care-Act/Employers/Minimum-Value-and-Affordability