Oregon Educators Benefit Board
Affordable Care Act (ACA) Bulletin #8-D

Spotlight on Health Care Reform
Prepared for Entities Participating in the OEBB Benefits Program

APPLICABLE TO EMPLOYEE GROUPS THAT RECEIVE A BENEFIT CONTRIBUTION WHICH MAY ONLY BE USED FOR ONE OR MORE OF THE FOLLOWING OPTIONS: TO PURCHASE MEDICAL, DENTAL, AND/OR VISION BENEFIT PLANS; HAVE A PORTION OF THE CONTRIBUTION GO INTO A HEALTHCARE FLEXIBLE SPENDING ACCOUNT (HCFSA); AND EMPLOYEES IN THE GROUP HAVE THE OPTION TO RECEIVE A CASH INCENTIVE (TAXABLE INCOME) OR A CONTRIBUTION TO A HEALTH REIMBURSEMENT ARRANGEMENT (HRA/VEBA) FROM THE ENTITY WHEN CHOOSING NOT TO ENROLL IN AN OEBB MEDICAL PLAN.

This bulletin will review the ACA Affordability safe harbor calculation as well as the impact of opt-out credits on the safe harbor calculations when the employee's options are to: (1) use the benefit contribution toward the purchase of medical, dental and/or vision coverages through OEBB, (2) allocate any excess employer contribution into a HCFSA, or (3) receive additional taxable income if the employee elects to opt out of the OEBB medical coverage or receive a contribution to an HRA/VEBA. Affordability safe harbors are related to the Pay or Play penalties of the Shared Responsibility provisions of the ACA.

Overview of ACA Requirements and the Play Penalty

The Affordable Care Act requires large employers to provide minimum essential coverage to full-time employees or face penalties (the Pay penalty). The coverage offered to employees must also qualify as "affordable" or the Play penalty may be triggered. The Play penalty assessed against an entity is prorated to $250 per month ($3,000 annually) for each employee who secures subsidized medical coverage from a public exchange AND for whom the coverage offered by the entity was deemed unaffordable. In this bulletin, we will review the three methods that entities may use to determine whether the coverage offered is deemed "affordable" according to the ACA. Additionally, we will review the impact of offering opt-out credits to the affordability calculations.

Definitions for this bulletin and the ACA affordability calculation purposes relevant in this bulletin

- **Opt-out Credit**: This term means a taxable benefit, such as cash, provided to an employee for electing not to enroll in the OEBB medical coverage available through the employing entity. If an employee receives a contribution into a health reimbursement arrangement (HRA/VEBA) when electing not to enroll in an OEBB medical plan because they are covered on another OEBB medical plan as a spouse or domestic partner, this is not considered an opt-out credit for purposes of the affordability calculations.

- **Employee Contribution**: For this bulletin, the term **employee contribution** means the amount of premium the employee is required to pay (usually through payroll deduction) for medical coverage ***and conservatively includes*** the value of any opt-out credit as defined above (more on this below). For purposes of the affordability calculations, the **Employee Contribution** is calculated based on the cost to cover the employee only on lowest-cost plan available to the employee — even if the employee chooses a higher cost plan and/or enrolls family members — plus the value of the opt-out incentive available to an employee in the same employee group. For example, if Employee-Only coverage for the lowest-cost plan available has a total premium amount of $353 and the Entity pays $300 towards the coverage, the Employee Contribution is $53. If the entity also offers to pay the employee $250 per month in taxable income when the employee elects to "opt out" of medical coverage, the Employee Contribution is $303 ($53 + $250) per month.

- **Flex Credits:** A flex-credit system is one in which the entity provides a lump sum or cap to the employee for purchasing a variety of benefit plans. In this bulletin, flex credits are used to purchase medical, dental and/or vision coverage only and the employee is limited to electing to have unused employer contribution dollars go into a healthcare flexible spending account (HCFSA); therefore, the flex credits do not negatively affect an entity's affordability calculation. **See OEBB Bulletin 8-C for employee groups that can use the entity benefit contribution to purchase coverages other than medical, dental and/or vision or as a contribution into a healthcare flexible spending account.**

Background

On February 10, 2014, the Internal Revenue Service (IRS) issued final regulations implementing the employer-shared responsibility provisions (otherwise known as the pay-or-play mandate) under the Patient Protection and Affordable Care Act (ACA). Additional guidance followed in the form of Internal Revenue Code Notices and FAQs. On November 26, 2014, the Minimum Essential Coverage and Other Rules Regarding the Shared Responsibility Payment for Individuals were issued. This guidance clarified a number of ACA key topics, including how minimum essential coverage is determined, the application of the play and pay penalties in 2015 and 2016, and affordability of coverage for the purposes of the ACA's individual mandate penalty. The individual mandate penalty is the ACA penalty generally requiring all individuals have medical coverage unless they qualify for an exemption such as having no affordable coverage options available to them (whether employer-provided coverage or through other sources).

The IRS has issued formal guidance on the affordability safe harbors applicable to the employer mandate penalty (also referred to as the Pay or Play penalties), which can be found here: http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act%20-%20.

During the last six months, the IRS has also provided verbal comments and clarifications in ACA-related conference calls which continue to impact the interpretation of these regulations. Written guidance on the treatment of flex credits and opt-out credits in the employer safe harbor affordability calculations have not been issued. The IRS has provided verbal guidance on several occasions regarding the treatment of both flex credits and opt-out credits. This bulletin will outline and describe the treatment of flex credits and opt-out credits as verbally interpreted by the IRS and as understood by Towers Watson when performing safe harbor affordability calculations.

OEBB hosted a webinar on March 19, 2015 for entities to review the specifics of the affordability safe harbors. A recording o of this webinar can found on OEBB's website: www.oregon.gov/oha/OEBB/Pages/ACA-Healthcare-Reform.aspx.

How are flex credits treated in the affordability calculations?

The November 26, 2014 regulations indicated that a flex credit applies toward the affordable coverage calculation for individual mandate penalty purposes if <u>all</u> the following are true:

(1) The employee does not have the option to take the flex credit as a taxable benefit (e.g., cash payment);

(2) The flex credit may be used to purchase minimum essential coverage; <u>and</u>

(3) The flex credit may only be used to pay for benefits providing medical care under IRC § 213.

Senior IRS officials have verbally indicated on several occasions that <u>the IRS believes this definition should also apply to employers</u> when determining whether an employer has met an employer affordability safe harbor for the purposes of avoiding the Play penalty, although it has yet to issue written guidance incorporating this position into the employer affordability safe harbor rules.

How are opt-out credits treated in the affordability calculations?

The IRS has verbally indicated that the value of an opt-out credit should be *added* to the cost of medical coverage for the purposes of the employer affordable coverage calculation. The IRS' view is based on the lost opportunity cost of the opt-out credit by an employee who actually elects coverage, because the employee will pay for the cost of their coverage <u>and</u> surrender the value of their opt-out credit. The IRS has not issued written guidance on this subject.

Why should an entity consider dealing with the potential flex credit and/or opt-out credit issues now?

An entity might be willing to conclude that the IRS' verbal position is unenforceable in the absence of any written guidance from the IRS which has not indicated when this guidance may appear. Conservatively, we are concerned that this guidance may appear at any time with an explicit effective date and no special exception for collective bargaining. Entities who are engaged in collective bargaining or who will be in the near future may wish to address the opt-out credit and its impact on affordability issue during this round of collective bargaining rather than having to re-open collective bargaining at an unplanned time.

<u>Affordability Determinations</u>

How does an entity determine whether it offers affordable coverage?

An entity may avoid a potential Play penalty if it offers affordable coverage to its <u>full-time employees (FTE) as defined under the ACA</u>. Please see earlier OEBB bulletins for details about who qualifies as an FTE for ACA purposes.

Note: The play penalty can only be assessed with respect to an FTE. As a result, affordability is only applicable to Full-time Employees as defined by the ACA.

Affordability at the Individual Level

An individual's eligibility for a subsidy in the public insurance marketplace depends on certain criteria including whether the individual was offered affordable coverage through another source. Qualifying for a federal subsidy in the marketplace is generally based upon an individual's household income.

Affordability at the Employer Level

The IRS recognized that determining affordability based upon household income would be very difficult for employers and issued three affordability safe harbor methods for determining whether an entity has offered affordable coverage to a Full - time Employee. As a result, affordability is determined based on what an employee would pay per month for employee-only coverage for the lowest-cost plan option offered by an entity, even if the employee elects a more expensive plan option. If offered by an entity, OEBB's Plan H would be the lowest-cost plan offered to its employees. For entities using composite rates, there are no special rules or exceptions for entities that would permit an entity to reflect only a portion of the composite rate as attributable to employee-only coverage when performing affordability calculations. The entire monthly composite rate for the lowest-cost plan option offered would have to be used. Employees who are at the lower end of the pay scale are more likely to present affordability issues if the entity uses a composite premium rate structure. For entities using tiered rates, affordability is determined on the employee-only rate tier.

Many entities will elect to use the same safe harbor method for all of its employees. However, an entity may choose to use more than one of the following safe harbors for its employees. An entity may vary the use of safe harbors for any "reasonable category of employees." These categories include specific job category (e.g., classified, administrators, etc.), hourly/salaried status or other similar bona fide business criteria. For example, it would be reasonable for an entity to use one approach for hourly employees and another approach for salaried employees, if necessary. The three affordability safe harbor methods are as follows:

1. Federal Poverty Level (FPL) Safe Harbor

An entity satisfies the FPL safe harbor if the employee is offered a plan for which the monthly premium for employee-only coverage is less than 9.5% of the Federal Poverty Level for a single individual, divided by 12. Entities are permitted to use the most recently published poverty guidelines as of the first day of the plan year of the applicable large employer's health plan. The final regulations clarified that with the FPL safe harbor, entities can use the guidelines in effect six months prior to the beginning of the plan year in order to give entities enough time to establish premium amounts in advance of the plan's open enrollment period. For 2015, a plan option will be affordable under the FPL safe harbor if the Employee Contribution is less than $93.18 per month. The FPL is increased annually but typically by a small amount, and the safe harbor value shouldn't change by more than $2 – $3 from one year to the next. This safe harbor method is the easiest to use administratively since it does not rely on determining the employee's compensation.

2. Form W-2 Safe Harbor

An entity satisfies the W-2 safe harbor if the employee is offered a plan for which the required annual premium contribution by the employee for employee-only coverage is less than 9.5 percent of that employee's wages for that calendar year, as reported in Box 1 of Form W-2. Note that Box 1 of the Form W–2 excludes elective deferrals that an employee makes into an Internal Revenue Code (IRC) § 401(k) plan or § 403(b) plan, and also excludes amounts that an employee elects to contribute on a pre-tax basis for qualified benefits under a cafeteria plan or a commuter benefits plan. An entity will not know the true Box 1 value until the end of the calendar year, but an entity should be able to reasonably estimate these values when running internal affordability calculations. Note: This method understates an employee's income in comparison to the method used to calculate income the third safe harbor described below.

3. Rate of Pay Safe Harbor

An entity satisfies the rate-of-pay safe harbor if the employee is offered a plan for which the monthly premium contribution by an employee for employee-only coverage is less than 9.5% of his or her monthly rate of pay.

a. For *hourly* employees, coverage is affordable if it is less than 9.5% of the employee's hourly rate of pay multiplied by 130 hours. The hourly rate of pay used for a given calendar month is the lower of the employee's hourly rate as of the first day of the plan year (October 1st for most entities) or during the calendar month. In other words, the hourly rate can decrease for calculation purposes throughout the year, but it cannot increase from the hourly rate as of the first day of the plan year.

b. For *salaried* employees, coverage is affordable if it is less than 9.5% of the employee's monthly salary. The rate of pay safe harbor is not available if an employee's monthly salary is reduced during the plan year. Solely for this purpose, an entity may use any reasonable method for converting payroll periods to monthly salary.

The rate of pay safe harbor doesn't exclude elective deferrals and should produce the highest compensation values for affordability calculation purposes. However, it is more administratively complex than either the Federal Poverty Level or W-2 safe harbors.

Examples

Below are some examples that illustrate how employer contributions that are limited to being used to purchase medical, dental and/or vision coverages and/or being contributed to a Healthcare Flexible Spending Account (HCFSA) and the employee can receive an opt-out credit may impact an entity's affordable coverage calculations. Again, these examples assume that the IRS' informal remarks are formalized and the value of any opt-out credit must be included in the affordability calculation:

Example 1: Employee Group with tiered rates. Excess flex credits can be directed into an HCFSA (with no opt-out credits available).

Entity A offers all OEBB medical plans. Plan H is the lowest-cost plan option available to the employee. The total premium amount for Employee-Only coverage for Plan H is $353 per month. The entity contributes $800 per month which can be applied toward medical, dental, and vision coverage ONLY. (For examples in which employees can use their employer contribution toward life/disability insurance, see OEBB Bulletin 8C). Any remaining employer contribution (i.e., flex credit) after the employee makes his/her medical, dental and/or vision benefit choices are placed in an HCFSA. The employee's premium share for selecting Plan H is $0 per month since the entity contribution (or flex credit) fully covers the cost for employee-only coverage for Plan H.

Affordability Calculation

The employee's premium share for Plan H (Employee-Only coverage) is $0 per month because the entity contribution fully covers this election amount.

- FPL safe harbor is satisfied because the $0 per month employee contribution less than $93.18.

Example 1A: Same as above but employees who opt out of OEBB coverage receive an opt-out credit of $100 per month.

Entity A offers all OEBB medical plans. Plan H is the lowest-cost plan option available to the employee. The total premium amount for Employee-Only coverage for Plan H is $353 per month. The entity contributes $800 per month which can be applied toward medical, dental and vision coverage ONLY. Any remaining employer contribution (i.e., flex credit) after the employee makes his/her medical, dental and/or vision benefit choices are placed in the employee's HCFSA. Additionally, if the employee elects to opt out of OEBB medical coverage, Entity A provides a $100 per month cash incentive (benefit stipend, opt-out credit).

Affordability Calculation

According to the affordability calculation rules, the employee's premium share for Plan H (Employee-Only coverage) is $100 ($0 + $100) per month.

- FPL safe harbor cannot be satisfied because $100 is greater than $93.18.
- Using the W-2 safe harbor, the coverage is affordable for an individual with approximately $12,632 or higher in annual compensation as reported in Box 2 of the W2 (($100/0.095) x 12 = $12,632).
- Using the Rate of Pay safe harbor (hourly employees), the coverage is affordable for an individual with a rate of pay of $8.10 per hour or higher (($100/0.095)/130 hours = $8.10).

Example 1B: Same as above but the employee group uses a composite rate structure.

Entity A offers all OEBB medical plans. Plan H is the lowest-cost plan and total premium amount for Employee-Only coverage for Plan H is $860 per month. The Entity contributes up to $1,300 per month which can be used to purchase medical, dental and/or vision coverage ONLY. Any remaining employer contribution (i.e., flex credit) that is left after the employee makes his/her medical, dental and/or vision benefit choices are placed in the employee's HCFSA. If an employee elects to opt out of OEBB medical coverage, Entity A provides a $100 per month cash incentive (benefit stipend, opt-out credit).

Affordability Calculation

According to the affordability calculation rules, the employee's premium share for Plan H (Employee-Only coverage) is $100 ($0 + $100) per month.

- FPL safe harbor cannot be satisfied because $100 is greater than $93.18.
- Using the W-2 safe harbor, the coverage is affordable for an individual with approximately $12,632 or higher in annual compensation as reported in Box 2 of the W2 (($100/0.095) x 12 = $12,632).
- Using the Rate of Pay safe harbor (hourly employees), the coverage is affordable for an individual with a rate of pay of $8.10 per hour or higher (($100/0.095)/130 hours = $8.10).

Example 2: Employee Group with tiered rates; if the employee opts out of coverage, the entity will provide funds into an HRA which the employee can use to pay for medical expenses (only allowed if covered as a spouse or dependent by another OEBB plan).

Entity B offers all OEBB medical plans. Plan H is the lowest-cost plan and total premium amount for Employee-Only coverage for Plan H is $353 per month. The Entity contributes $800 per month which can be used to purchase medical, dental and/or vision coverage ONLY. (For examples in which employees can use their employer contribution for life, AD&D or disability insurance, see OEBB Bulletin 8C). If an employee is covered by another OEBB plan and elects to opt out of OEBB medical coverage, Entity B puts $300 per month into an HRA/VEBA which the employee can use to pay for IRC 213 medical expenses.

Affordability Calculation

The employee's premium share for Plan H (single only coverage) is $0 per month because the entity contribution fully covers this election amount. The entity contribution to an HRA/VEBA is not considered an opt-out credit for purposes of ACA affordability calculations

- FPL safe harbor is satisfied because $0 is less than $93.18.

Example 2B: Same as above but the employee group uses a composite rate structure.

Entity B offers all OEBB medical plans. Plan H is the lowest-cost plan and total premium amount for Employee-Only coverage for Plan H is $860 per month. The Entity contributes up to $1,300 per month which can be used to purchase medical, dental and/or vision coverage ONLY. Any remaining employer contribution (i.e., flex credit) that is left after the employee makes his/her medical, dental and/or vision benefit choices are placed in the employee's HCFSA. If an employee is covered by another OEBB plan and elects to opt out of OEBB medical coverage, Entity B puts $300 per month into an HRA/VEBA which the employee can use to pay for IRC 213 medical expenses.

Affordability Calculation

The employee's premium share for Plan H (Employee-Only coverage) is $0 per month because the entity contribution fully covers this election amount. The entity contribution to an HRA/VEBA is not considered an opt-out credit for purposes of ACA affordability calculations.

- FPL safe harbor is satisfied because $0 is less than $93.18.

- For employee groups who can apply the Entity's benefit contribution toward only the cost of medical, dental and/or vision coverages or a contribution to an HCFSA and who are eligible for a cash incentive for opting out of OEBB medical coverage, see OEBB Bulletins 8-A and 8-B.

- For employee groups who can apply the Entity's benefit contribution toward the cost of life, disability, AD&D, long term care and/or a health savings account (HSA), please refer to OEBB Bulletins 8-C and 8-E which focuses on "flex credits" with these types of benefits and the impact on affordability calculations. If the flex credit system includes options to purchase benefits such as life or disability coverage or health savings account elections, this presents additional challenges.

- For employee groups who can only apply the Entity's benefit contribution toward the cost of medical, dental and/or vision plans and are NOT able to use any remaining contribution for ANY purpose (including purchasing life, disability, or AD&D or contributing to a health savings account (HSA)) and are NOT eligible to receive a cash or other monetary benefit or contribution to an HRA or FSA for choosing not to take OEBB medical coverage (i.e., waiving medical coverage), see OEBB Bulletin 8-F.

Frequently Asked Questions

1. *Does the affordable coverage calculation issue apply to all employees?*

   No. An entity cannot be assessed a penalty for a failure to offer affordable coverage to an individual who does not meet the definition of a full-time employee under the ACA. An entity is welcome to run the calculation on all employees, and the FPL safe harbor accomplishes this automatically if applicable. The potential for a “play” penalty under the ACA (this is the $3,000 per year per affected individual penalty) can occur if an entity does not offer affordable coverage to an FTE (as defined by the ACA) who applies for and qualifies for subsidized coverage in the public insurance marketplace. The issue of affordable coverage is not relevant for the ACA’s “pay” penalty (this is the $2,000 per year per all FTEs penalty).

Please note: If an entity offers affordable coverage to an employee (whether full-time or part-time), the employee will lose the ability to qualify for subsidized coverage in the public insurance marketplace.

2. *Do we need to be concerned with affordability issues for employees who waive coverage?*

   Maybe. If an employee chooses not to enroll in an OEBB medical plan (either through waiving or opting out of coverage) and enrolls in the marketplace, this does not remove an FTE from an entity’s potential penalty risk pool. The coverage offered to the employee who waived or opted out must have been deemed affordable in order for penalties to be avoided.

   Many entities only permit an FTE to waive coverage if they are enrolled in another group medical plan and the OEBB rules require the employee to be covered on another employer-sponsored medical plan to opt out of coverage (e.g., through a spouse’s employer). An individual actually enrolled in other affordable medical coverage (including Medicare and Medicaid) cannot qualify for subsidized coverage in the marketplace and cannot trigger the “play” penalty against the entity. Due to the potential penalty risk, the entities may consider requiring substantiation of other coverage (if you do not already). An individual employed by more than one employer may also have access to affordable coverage elsewhere preventing subsidy eligibility.

3. *Can you provide an example where the FPL safe harbor will not work?*

   Yes. The FPL safe harbor will not work if the monthly cost of employee-only coverage for the lowest-cost medical plan available to the employee is greater than 9.5% of the FPL for that year. In 2015, the FPL safe harbor will not work if the employee contribution for the lowest-cost medical plan available is greater than $93.18 per month for employee-only coverage. If an entity does not offer an OEBB medical plan option with a contribution level below this amount, the FPL safe harbor will not be satisfied. Remember that the FPL itself increases a little each year, so the safe harbor value will also increase a little each year.

4. *If an employee chooses plan G, we will divert excess entity contributions into an HRA/VEBA for the employee to use to reimburse their medical expenses. How does that affect affordability calculations?*

   HRA rules do not allow for funding — either directly or indirectly — through a Section 125 Cafeteria plan. Typically, the arrangement in which an employing entity provides an employee with Flex Credits (as defined in this bulletin) is done through a Cafeteria Plan. HRA funding by the employer should be provided outside of a Cafeteria plan and would be provided independent of other employee plan elections. In this case, the employer funding is not considered in affordability calculations.

5. *Is affordable coverage based only on medical insurance, or does other coverage such as vision and dental insurance count?*

   For the entities, the affordable coverage rules apply solely to the cost of medical coverage. If medical, dental and vision were bundled under a single insurance policy at a single employee contribution rate without the ability to separately elect or waive them, they would all count together for affordability purposes. In that instance, they would also already be treated as a single employee contribution.

6. *Does the use of an opt-out credit impact all employees for affordable coverage calculation purposes or just those who waive coverage and receive an opt-out credit?*

   It will impact all employees in the employee group that have the ability to receive a cash incentive (opt-out credit) for opting out of OEBB medical coverage whether the individual employee receives the cash incentive or not.

7. *When an employee declines coverage, we contribute the unused entity contributions we would have spent on their coverage toward a pool that is used to reduce the contributions of our participating employees. Can we use this reduced contribution amount for affordable coverage calculation purposes?*

   We believe an entity can use the reduced contribution amount (after the funding in the pool is distributed) for affordability calculation purposes. The use of a pool may mean that the cost of coverage provided to the FTEs and reported to the IRS on IRS Form 1095-C can fluctuate from month-to-month which may present an administrative challenge.

8. *How will the IRS know that we are providing an opt-out credit?*

It may be some time before the IRS can meaningfully police these rules or the measurement, penalty and reporting rules themselves, but we do recommend operating as if the IRS could detect and address a compliance failure at any time.

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