The Patient Protection and Affordable Care Act (“ACA”) and Your Facility

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President Obama signed the Patient Protection and Affordable Care Act (“Health Care Law”) into law on March 23, 2010. Next to the introduction of Medicare decades ago, the new Health Care law is the most sweeping legislation in the health service field that has been enacted in American history. The law will modify health coverage for virtually every American that is not currently eligible for Medicare or Medicaid benefits. The law will cost the government approximately $940 billion over ten years and includes a variety of additional taxes, penalties and Medicare/Medicaid changes that are designed to pay for the cost.

The intent of the legislation was to do five things:

1. Cover the uninsured.
2. Improve the quality of health care.
3. Reduce the cost of health care.
4. Promote the prevention of poor health.
5. Prevent waste/fraud of a government run system.

It is clear that the Health Care Law will introduce the opportunity for coverage for those that are currently uninsured. However, some practical challenges in increased administrative reporting, higher employer costs and oversight by the government may make achievement of the remaining four goals difficult. The plan also includes a variety of changes to the tax code that will have an adverse effect on certain employees and businesses. A number of changes will have a rather significant impact on company Human Resource and tax departments reporting requirements that will be time challenging and difficult to meet compliance with the law.

It is important to note that the Health Care Law does not require changes for those enrolled in group health plans in effect currently. However, there were some changes that affected employer health care plans that were effective on June 23, 2010. Those changes required all group plans to continue dependent coverage to children up to age 26, even if they are married, and must not exclude participants under age 19 with pre-existing conditions. The Health Care Law also eliminated lifetime or annual limits on the dollar value of benefits and will preclude the ability for insurers to rescind participant coverage unless fraud or intentional misrepresentation was involved. New plans must cover preventative care services without co-payments.

The most sweeping portions of the Health Care Law will become effective starting in calendar year 2014. The 2014 requirements will have the most effect on U.S. employers. Starting in 2014, the American Health Benefit Exchanges will be introduced in every state. The exchanges will be the prime tool to provide coverage for those that do not have coverage currently. These exchanges will include Small Business Health Options that will assist small group market employers to provide qualified health plans to their employees. The benefit of the exchanges should be to provide affordable coverage for self-employed individuals and other small employers that are challenged by health care coverage costs for themselves and for their employees. This portion of the law will provide assistance to the majority of PGA Professionals.
that are self-employed as well as for those that work for a small employer that doesn’t offer health coverage.

The law is scheduled to go into effect over a course of stages with some provisions due for almost immediate implementation. The following timeline shows the schedule for the most important target dates related to the new law in the areas that affect individuals and businesses:

**Tax Changes in 2013**

- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.
- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8% assessment on unearned income for higher income taxpayers.
- Limit the amount of contributions for a FSA for medical expenses to $2,500 per year increased annually by the cost of living adjustment.
- Impose an excise tax of 2.3% on the sale of any taxable medical devices.
- Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments.

**Tax Changes in 2015 and Later**

- Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage effective on January 1, 2018.

**Insurance Changes in 2013**

- Create the Consumer Operated and Oriented Plan to foster the creation of non-profit, member run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans.
- Adopt a single set of operating rules for eligibility verification and claims status, electronic funds transfers and health care payment and remittance, and health claims or equivalent counter information, enrollment in a health plan, health plan premium payments, and referral certification and authorization. Health plans must document compliance with these standards or face penalties.

**Insurance Changes in 2014**

- Create state based American Health Benefit Exchanges and Small Business Health Options Program Exchanges, administered by a government agency or non-profit organization where individuals and small businesses with up to 100 employees can purchase qualified coverage.
• Require guarantee issue and renewability and allow rating variation based only on age, premium rating area, family composition and tobacco use in the individual and small group market and the exchanges.
• Reduce the out of pocket limits for those with incomes up to 400% of the Federal Poverty Level (“FPL”) to the following levels:
  • 100 – 200% FPL – 1/3 of the HSA limits ($1,983/individual and $3,967/family)
  • 200 – 300% FPL – ½ of the HSA limits ($2,975/individual and $5,950/family)
  • 300 – 400% FPL – 2/3 of the HSA limits ($3,987/individual and $7,973/family).
• Limit the deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits.
• Limit any waiting periods for coverage not to exceed 90 days.
• Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost sharing to the current law HSA limits (were $5,950/individual and $11,900/family in 2010 and for 2013 have been changed to $3,250/individual and $6,450/ family), and is not more extensive than the typical employer plan.
• The Office of Personnel Management will contract with insurers to offer at least two multi-state plans in each exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.
• Allow states the ability to create a Basic Health Plan for uninsured individuals with incomes between 133 – 200% FPL who would otherwise be eligible to receive premium subsidies in the exchange.
• Allow states the option of merging the individual and small group markets.
• Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high risk individuals.
• Require qualified health plans to meet new operating standards and reporting requirements.

**Insurance Premium Subsidies Changes in 2014**

• Provide refundable premium credits and cost sharing subsidies to eligible individuals and families with income between 133 – 400% FPL to purchase insurance through the exchanges.

**Insurance Changes in 2015 and Later**

• Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Compacts will not take effect until 2016.

**Individual and Employer Changes in 2014**

• Require all U.S. citizens and legal residents to have qualifying health coverage.
• Phase in a tax penalty for those without coverage.
• Require all employers with 50 or more full-time employees that do not offer coverage under an eligible employer sponsored plan and have at least one full time employee who receives a premium tax credit to pay a fee of $2,000 per full time employee, excluding the first 30 employees from the assessment. This requirement is variously known as “Employer Shared Responsibility”, the “Employer Mandate” or “Pay or Play”. For purposes of determining whether an employer is covered by this requirement, an employer must include not only full-time employees but also a full-time equivalent for employees who work part-time. The law defines “Full Time Employee” as those working an average of at least 30 hours per week. Full-time equivalent employees (“FTE’s”) are determined by aggregating on a monthly basis all hours worked by non-full-time employees and dividing by 120. An eligible employer sponsored plan must provide coverage that is “affordable” and provide coverage of medical expenses with an actuarial value of 60 percent. “Affordable” coverage is defined as that costing no more than 9.5% of the employee’s modified household income. Note that the percentage is based on “household income” and not on the wage that the employee earns from the employer. However, the IRS has taken a realistic approach to this requirement and described in Notice 2011-73, that the Department of the Treasury and the IRS intend to issue proposed regulations or other guidance permitting employers to use an employee’s Form W-2 wages (as reported in Box 1) as a safe harbor in determining the affordability of employer coverage due to the burden of supposition in having an employer determine what an employee’s household income is.

There are multiple scenarios where the employer may elect to pay the employee penalty (less the first 30 employees) and enable all of the employees to purchase their own coverage through the health exchanges or through federal programs where the employer would save a material annual outlay. Assuming that employee benefits package costs considerably more than $2,000 or $3,000 (for employers with 50 or more employees) per employee and being allowed to exempt the first 30 employees from the calculation may present a material cost savings for employers.

• Employers with 50 or more employees that offer coverage but have at least one full time employee receiving a premium tax credit will pay the lesser of $3,000 for each employee receiving a premium credit up to a maximum of $2,000 for each full time employee, excluding the first 30 employees from the assessment.

• Require employers with more than 200 employees offering more than one health plan to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage. The opt out written notice must contain clear language describing employee options in state created health care exchanges as well as eligibility for a premium tax credit.

Prevention/Wellness Opportunities in 2014

• Permit employers to offer employees rewards of up to 30% increasing to 50% of the cost of coverage for participating in a wellness program and meeting certain health-related standards.

• Establish a 10 state pilot program to permit participating states to apply similar rewards for participating in wellness programs in the individual market.
Frequently Asked Questions Relative to PGA Member, Apprentice & Intern Employment:

1. **Which employers must comply with the Health Care Law “Employer Shared Responsibility” or “Pay or Play” requirements?**
   a. Starting in calendar year 2014, all employers who have 50 or more full-time employees on business days in the preceding calendar year are required to comply with the Employer Shared Responsibility or Pay or Play requirements of the Health Care Law. Both full and full-time-equivalent employees are counted in the 50 employee number. Full-time employees are defined as a worker averaging at least 30 hours per week.

2. **What are covered employers required to do under the law regarding providing health insurance coverage?**
   a. Covered employers are required to offer their full-time employees and their eligible dependents health coverage that is “affordable” and provides “minimum essential coverage.” If the employer fails to provide “qualifying health insurance”, then the employer will remit a penalty to the federal government in the amount of $2,000 per employee ($3,000 if an employee receives coverage through a Health Insurance Exchange). If an employer has a waiting period for new employees to be eligible for health insurance benefits, there is an additional tax of $400 - $600.

3. **Are seasonal employees covered under the Health Care Law?**
   a. The term “seasonal employees” is used in the Health Care Law only in the context of determining whether an employer is covered by the Shared Responsibility requirement. Seasonal employees are not required to be counted for that purpose that is for determining whether or not the 50 full-time employee threshold is met. A seasonal employee is defined as any worker who works less than 120 days per calendar year. Most PGM University interns and many seasonal golf professionals may fall under the “seasonal” definition and the employer would not be required to count them in determining whether it is subject to the Shared Responsibility requirement.
   b. The question of whether an employer is otherwise subject to the Shared Responsibility mandate and would need to provide health care coverage to seasonal employees is more complex. This would depend on whether the seasonal employee is classified as full-time. The IRS has provided initial and very complex guidance on determining full-time status for coverage purposes. The IRS published a notice on August 31, 2012 (Notice 2012-58) [http://www.irs.gov/pub/irs-drop/n-12-58.pdf](http://www.irs.gov/pub/irs-drop/n-12-58.pdf) that may be welcome relief for employers that hire many temporary or seasonal employees. The employers may not be required to offer health benefits to many of the temporary or seasonal employees if the employer elects to choose a 12-month measurement period to determine whether an employee’s hours meet the definition of full-time under the Health Care Law. The potential issue with this is that employers will be required
to keep any employees deemed full-time in their health plans for a period of time equal to the measurement period chosen, which could be as long as a year for employers that select a 12-month retrospective measurement period.

c. The IRS guidance also gives employers the flexibility to use different measurement periods for different classifications of workers (i.e. hourly, salaried, collective bargaining). The types of employers that will benefit the most from this flexibility are those that have mostly seasonal employees, such as seasonal golf facilities. This rule also is beneficial for employers that lay off workers after those peak seasons and rehire them the following year. There is nothing in the guidance that indicates that an employer must treat a rehired employee as if they have never been gone. It is strongly recommended that employers work with their legal counsel and insurance providers to review their workforce and determine the best way to classify their employees pursuant to the Health Care Law and the IRS guidelines.

d. Here is an example of how an employer may classify a worker as a seasonal worker under the Health Care Law and not be required to offer that person health coverage using the 12-month initial measurement period; 1+Partial Month Administrative Period:

i. The ABC Golf Resort uses a 12-month initial measurement period for new variable hour employees and seasonal employees that begins on the start date and applies an administrative period from the end of the initial measurement period through the end of the first calendar month beginning after the end of the initial measurement period. ABC hires a golf instructor on June 15, 2014 with an anticipated season during which the golf instructor will work through October 15, 2014. ABC determines that the golf instructor is a seasonal employee based upon a reasonable good faith interpretation of that term. The golf instructor’s initial measurement period runs from June 15, 2014 – May 31, 2015 (1-year). The golf instructor works 40 hours per week from June 1, 2014 – September 30, 2014 and is not reasonably expected to average 30-hours per week for the 12-month initial measurement period. Accordingly, ABC does not treat the seasonal golf instructor as a full-time employee and ABC does not offer the golf instructor coverage.

ii. How did the employer accomplish this objective? The employer used (i) an initial measurement period that does not exceed 12 months; (ii) an administrative period totaling not more than 90 days; and (iii) a combined initial measurement period and administrative period that does not extend beyond the final day of the first calendar month that begins on or after the one-year anniversary of the employee’s start date. In the above example, the employer is not subject to any payment under Section 4980H of the
Internal Revenue Code because the employer complies with the standards for the initial measurement period and stability periods for a new seasonal employee. Also, Public Health Service Act Section 2708 does not apply to the employee during this period because, pursuant to the plan’s eligibility conditions, the employee does not become eligible during this period for coverage under the plan.

4. **Are employers required to provide health insurance coverage or pay the penalty if a worker may fulfill the full-time definition under the Health Care Law but is age 26-years or younger and covered under his/her parents’ health insurance plan?**
   a. Beginning in 2014, children up to age 26 may remain on their parent’s employer plan even if they have an offer of coverage through their employer (Source: answers.healthcare.gov/categories/1704). Both married and unmarried adults age 26 and under may remain on their parents’ health insurance plan. The only exclusion to this rule is if the parent is covered by Medicare. The dependent age 26 and under is eligible to remain on the parents’ health insurance regardless of whether the child lives under the same roof, is married or whether or not the child is financially dependent on the parent. Depending on your state, plans may or may not include stepchildren.
   b. Therefore, if a PGM University intern working on a full-time schedule is covered under the intern’s parents’ health insurance coverage, then the employer would not be required to offer health coverage to the intern (with the exception if the parental coverage is Medicare).

5. **Are independent contractors factored into the 50 employee number?**
   a. Bona fide independent contractors are not factored into the 50 employee number to determine if an employer is covered under the ACA. Independent Contractors must be true independent contractors that are vendors providing services and fulfill independent contractor status requirements. Merely re-classifying employees to independent contractor status may subject the employer to misclassification penalties, back taxes and reclassification to meet the 50 person rule.

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