**SECTION: BENEFITS**

**POLICY:** Affordable Care Act (ACA) **EFFECTIVE DATE:** insert date adopted

**STATEMENT OF PURPOSE:**

The City is required to comply with the Affordable Care Act (ACA). The health care reform legislation enacted in March 2010 was designed to expand the availability of health insurance, reform the regulation of health coverage and restructure its delivery. Among the law's various mechanisms for increasing coverage are:

* Expansion of Medicaid.
* A mandate that employers with 50 or more full-time employees offer affordable, essential coverage to at least 95 percent of full-time employees and their dependents.
* Provisions for insurance premium subsidies for certain low- and middle-income households.
* A mandate that individuals without health insurance through an employer or other source, such as Medicare, purchase it on their own. However, the penalties under this mandate were repealed in 2017.
* Establishment of state-based health insurance exchanges—marketplaces where individuals can shop for and purchase health insurance.

The law also prohibits lifetime limits on coverage and arbitrary cancellations of coverage, and it requires that [children up to age 26](https://www.shrm.org/topics-tools/tools/hr-answers/affordable-care-act-aca-employer-to-pay-penalty-tax-fails-to-offer-group-health-plan-coverage-to-employees-dependents) be permitted to stay on a parent's health policy.

The ACA includes penalties for noncompliance with several aspects of the law.

The City may not retaliate against an employee who reports a violation of the ACA.

Reference: <https://www.hhs.gov/healthcare/about-the-aca>

**DEFINITIONS:**

1. **Expand Coverage:** The ACA aims to make health insurance more affordable and accessible to more people, including those who are uninsured.
2. **Prohibit Discrimination:** It prohibits insurance companies from denying coverage or charging higher premiums based on pre-existing conditions.
3. **Essential Health Benefits:** The ACA requires non-grandfathered health insurance plans to cover essential health benefits, which include a range of services.
4. **Marketplace:** The ACA established a marketplace (Healthcare.gov) where individuals and small businesses can compare and purchase health insurance plans.
5. **Tax Credits and Subsidies:** The ACA provides tax credits and subsidies to help individuals and families afford health insurance premiums.
6. **Employer Mandate:** The ACA requires most employers to offer health insurance to their employees, or face penalties.
7. ALE: An ALE is an employer who, on average, employed at least 50 full-time employees (including full-time equivalent employees, or FTEs) during the preceding calendar year.
8. **Preventative care:** The ACA requires that all health insurance plans must cover preventative care services without cost sharing.

**APLICABILITY:**

This policy applies to all employers of 50 or more employees, and is applicable to all full-time employees working at least 30 hours per week.

This policy does not apply to part-time employees working less than 30 hours.

**PROCEDURES:**

1. The City is required to report to full-time employees the Internal Revenue Service (IRS) information regarding the coverage (summary plans) they offer.
2. Calculating whether the City is subject to the employer mandate should be done monthly, and a record of such calculations should be maintained. Here are the steps:
   1. First, calculate the number of full-time employees—those who are regularly scheduled to work an average of 30 or more hours per week.
   2. Next, calculate the total number of hours worked during the month by employees who are not full-time, and divide the total by 120. The result (rounded down) is the number of FTE employees represented by the hours worked by the City's non-full-time employees.
   3. Last, add the number of full-time employees and the number of FTE employees represented by non-full-time employees. The result is the City's total FTE employees.
3. Determine if the Plan is "Grandfathered"
4. An employer-sponsored health plan in effect on March 23, 2010—the date that the ACA was signed into law—was "grandfathered," which, with certain exceptions, permits the plan to avoid or delay compliance with some of the law's administrative requirements and coverage mandates.
5. The items most affected by having or not having grandfathered status are the insured non-discrimination rules (currently delayed) and the small-employer minimum design requirements. However, many plans are already likely to be in compliance with the nondiscrimination rules, and many insured health plans have already implemented the minimum design and preventive-benefits provisions across health plan options—regardless of grandfathered status.
6. Under the grandfather provision and the Obama administration's final interim regulations, issued in June 2010, employers can maintain many of their current health care coverage provisions if, among other things, they do not change insurance carriers, reduce benefits, or significantly raise co-payment charges or deductibles.
7. As health care costs continue to rise, however, employers that sponsor grandfathered health plans may conclude that they have to offset at least some of the increases by significantly raising employees' co-payments or deductibles or by reducing benefits; such actions would cause their plans to lose grandfathered status.
8. Determine Whether to 'Play or Pay'
   1. By performing the calculations—on a regular and defined basis—to determine if the City has 50 or more FTEs, an employer determines if it is required to offer full-time employees health insurance that meets the ACA's standards for affordability and essential coverage.
   2. If the City has fewer than 50 FTEs, there is no obligation under the ACA to offer health coverage of any kind to any employees. Nonetheless, many small cities that are not obliged to offer health coverage may do so anyway, perhaps as a recruiting and retention strategy. Employers should bear in mind that other aspects of the health care reform law may apply to the coverage they offer. Employers that choose to participate in the Small Business Health Options Program (SHOP) may qualify for the Small Business Health Care Tax Credit and state premium assistance programs.
   3. If the employer has 50 or more FTEs, the employer is an ALE and must decide whether to offer full-time employees and their dependents affordable, essential coverage (the "play" option) or to decline to offer such coverage and thereby incur federal penalties (the "pay" option).
   4. Such decisions by an employer should be aligned with the City's total rewards strategy. The decisions should be considered, for example, in terms of how they would help advance the employer's recruitment and retention efforts—its means of getting the right employees in the door and keeping them there. Enforcement of this employer mandate for large employers took effect Jan. 1, 2015.
9. Decision to "play."
   1. If the City subject to the employer mandate decides to "play"—to offer health coverage to full-time employees—the coverage must meet the health care law's standards of affordability and minimums of essential coverage; otherwise, the employer could be liable for federal penalties. The subjects of affordability and essential coverage are discussed in separate sections below.
10. Decision to "pay."
    1. If the City that is subject to the employer mandate decides to "pay"—that is, to not offer coverage and thereby incur federal penalties—the employer will be subject in the given year to a penalty of $2,970 (for 2024) multiplied by the total number of the City's full-time employees, minus the first 30 full-time employees, even if one full-time employee receives a tax credit to purchase coverage through a state health insurance exchange.
    2. If, in a given year, a large employer does offer health coverage to full-time employees, but the coverage is deemed unaffordable or does not meet the standards of minimum essential health coverage or minimum actuarial value, then the employer is subject to the lesser of two potential penalties: $2,970 multiplied by the total number of full-time employees, minus the first 30 employees, or $4,460 (for 2024) multiplied by the number of full-time employees who receive a premium tax credit at a state insurance exchange.
    3. An employer's decision about whether to offer health coverage or instead pay penalties might seem to be a simple weighing of the costs of each option. Paying penalties could be less costly than subsidizing health coverage. But the decision is more complicated than a comparison of dollar outlays. The employer's calculations should include an analysis of the effects that not offering coverage could or would have on the City's total rewards and HR strategies and on its overall goals.
11. Determine if the Coverage Offered is Affordable
    1. As noted above, an employer that is required to offer health coverage and wants to avoid penalties must offer all full-time employees’ coverage that meets the health care reform law's standards for affordability. The concept of affordability is based on the cost of the employee's premium contribution for employee-only coverage under the lowest-cost eligible health plan offered by the employer.
    2. The calculation is based on the employee-only rate regardless of whether the employee chooses family coverage or any other tier of coverage. To avoid penalties for offering unaffordable coverage, the employer should make certain that affordability is based on the City's lowest applicable wage. *See* [IRS Annual Health Plan Affordability Threshold](https://www.shrm.org/ResourcesAndTools/hr-topics/benefits/Pages/IRS-announces-2024-health-plan-affordability-threshold.aspx).
    3. In general, affordability is calculated to ensure that the employees' cost of employee-only coverage offered by the lowest-cost eligible health plan does not exceed a certain percentage of the employees' household income. Because employers often do not know their employees' household incomes, there are [three affordability safe harbors](https://www.federalregister.gov/d/2014-03082/p-161) ALEs can use to determine if the annual affordability threshold is being met. The safe harbors are based on information the employer does have, and any of the three can be used:
       1. The employee's W-2 wages, as reported in Box 1, generally as of the first day of the plan year.
       2. The employee's rate of pay, which is the hourly wage rate multiplied by 130 hours per month as of the first day of the plan year or, for salaried employees, 8.39 percent (for 2024) of the monthly salary as of the first day of the coverage period.
       3. The individual federal poverty level (FPL), as [published](https://aspe.hhs.gov/poverty-guidelines) by the U.S. Department of Health and Human Services (HHS) each January. Using the FPL safe harbor simplifies ACA reporting and coding of Form 1095-C, which plan sponsors file with the IRS for each employee who is offered ACA-compliant health coverage.
    4. Employers are using various strategies to achieve the affordability level. Some are implementing high-deductible health plans (which offer lower premiums) as an option for all employees. Some employers have designed employee premium contributions based on employees' wages or level in the City (the more they make, the more they pay in premium contributions).
12. Determine if the Plans Offered Meet Standards of Essential Health Coverage and Minimum Value Employers that have 50 or more FTEs must offer all full-time employees health coverage that not only is affordable but also provides essential care. The requirements for affordability were outlined in the previous section; in this section, the focus is on essential health coverage and related concepts such as actuarial value.
13. Essential Health Coverage
    1. Essential health coverage under the health care reform law includes the following items:
       1. Ambulatory patient services.
       2. Emergency services.
       3. Hospitalization.
       4. Maternity and newborn care.
       5. Mental health and substance use disorder services, including behavioral health treatment.
       6. Prescription drugs.
       7. Rehabilitative and habilitative services and devices.
       8. Laboratory services.
       9. Preventive and wellness services and chronic-disease management.
       10. Pediatric services, including oral and vision care.
14. Actuarial Value
    1. Actuarial value refers to a health plan's average reimbursement level, that is, the percentage of covered expenses that the plan is expected to pay. The minimum permissible value for an eligible employer-sponsored health plan is 60 percent. To avoid penalties for the employer, the plan must pay at least 60 percent of the total expected covered expenses for the year, and thus no more than 40 percent would be paid by the participant in the form of deductibles, co-payments, and co-insurance (but not the participant's premium contribution).
    2. A tool for determining minimum actuarial value is the [minimum value calculator](https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/mv-calculator-final-4-11-2013.xlsm) provided by the HHS. Employer contributions to a health reimbursement account or a health savings account (HSA) will affect the minimum actuarial value of the health plan.

The ACA created four benefit-level tiers of coverage for health plans available in state exchanges. The tiers, defined by the assigned actuarial value based on expected reimbursement levels, are commonly referred to as the "metals" because of the descriptions provided in the law; each of the percentages below is to be read as plus or minus 2 percent:

* + 1. A platinum health plan has an actuarial value of 90 percent.
    2. A gold plan, 80 percent.
    3. A silver plan, 70 percent.
    4. A bronze plan, 60 percent.

1. Annual Deductibles and Out-of-Pocket Maximums
   1. The annual deductible is the amount a covered individual pays for health services before any insurance coverage is applied. Once the deductible is met, the individual shares the cost of health services (co-insurance) with the insurance plan until the out-of-pocket maximum is met.

For example, an employee has a surgery that costs $20,000. The insurance plan has a $3,500 deductible, a 40 percent co-insurance, and a maximum out-of-pocket limit of $8,000. The employee would pay the $3,500 deductible and then 40 percent of the balance, up to $8,000. After the out-of-pocket maximum is met, the insurance plan will cover all costs of covered health services for the remainder of the plan year.

* 1. HHS sets out-of-pocket maximums for ACA-compliant plans annually.
  2. In addition to the ACA requirements, employers offering high-deductible health plans with an HSA are subject to additional IRS rules.

1. Determine who must be offered coverage
   1. Under the ACA's employer mandate, employers that decide to offer affordable essential health coverage to full-time employees must do so for all employees who are regularly scheduled to work an average of 30 or more hours per week and for their dependents. Employers are not required to offer coverage to employees' spouses, but it is common for employers to do so.
   2. The determination to offer coverage is straightforward regarding employees who are hired with the expectation that they will work 30 or more hours per week.
   3. The calculation is more complicated, however, regarding current employees who work "variable hours" or for new employees whose expected hours per week have not been determined or are variable. The final regulations under the employer shared responsibility provisions provide employers with two options for identifying a full-time employee when an employee's hours vary or when it cannot be reasonably determined if an employee will average full-time hours (30 hours per week):
      1. Monthly measurement method: The employer determines each employee's status as a full-time employee by counting the employee's hours of service at the end of each calendar month. Under this method, any employee with at least 130 hours of service during the calendar month will be considered a full-time employee for that month.
      2. Look-back measurement method
         1. This method is an optional alternative approach in which an employer may determine the full-time status of an employee during a future period (referred to as the stability period), based on the employee's hours of service in a prior period (referred to as the measurement period). Under this method, an employer looks back over a defined period of time (measurement period) to determine if the employee averaged at least 30 hours per week.
         2. This option is available only when it cannot be determined that the employee will be employed on average at least 30 hours per week; an employer may not use the look-back method for employees who are hired to work full-time and who are reasonably expected to work full-time (30 or more hours per week).
         3. The look-back measurement method involves the following three periods, which are defined in [guidance from the IRS](https://www.irs.gov/irb/2012-41_IRB#NOT-2012-58):
            * In the measurement period, the actual hours worked by a variable-hour employee are recorded. This period is at least three but not more than 12 consecutive calendar months, as chosen by the employer.
            * In the administrative period—not to exceed 90 days—the average of the employee's actual hours worked during the measurement period is calculated.
            * In the stability period, if the employee has worked an average of 30 or more hours a week during the measurement period, the person becomes and remains eligible for benefits, that is, is considered a full-time employee. The stability period can be six to 12 months, but not longer than the measurement period.
         4. Measurement Period for Ongoing Employees

Most employers will likely choose a 12-month measurement period for ongoing employees and will coordinate it with their benefits plan year. This provides a relatively straightforward administrative process for the employer, and it provides an accurate picture of hours worked over a longer period of time. The longer measurement period also provides the employer with the flexibility to avoid providing coverage to variable-hour employees who may leave the employer within the year.

* + - 1. Initial Measurement Period for Variable-Hour and New Employees

For an ongoing variable-hour employee, the process described above is repeated year after year, following the same measurement, administrative and stability periods. New employees who work variable hours are also subject to a measurement period, administrative period, and stability period, but the initial periods are based on the employees' dates of hire before transitioning to the standard periods.

***Example:***

Emilio's hire date at XYZ Corp. is May 23, 2018. The employer has a calendar-year benefits plan, and the company's standard measurement and stability periods are based on that 12-month calendar year and plan year. Emilio's initial measurement period is 12 months from his date of hire. His hours during that period are recorded. On May 22, 2019, Emilio's 12-month measurement period expires; his actual hours are averaged, and on May 23, 2019, Emilio's administrative period begins. Emilio is found to have worked 30 or more hours per week during the initial measurement period.

Emilio now begins the 90-calendar-day eligibility period called for in the plan, and on Aug. 20, 2019, Emilio becomes eligible for benefits. He remains eligible for benefits for the remainder of XYZ's stability period—until the end of 2019.

If it had not been determined that Emilio worked 30 or more hours per week during the initial measurement period, he would enter the standard measurement period, counting the hours going back to Jan. 1, 2019.

* + - 1. Standard Measurement Period

Once a new employee has completed an initial measurement period, he or she must be tested for full-time status under the ongoing employee rules for the employer's standard measurement period, regardless of whether the employee was full time during the initial measurement period.

During the measurement periods, the employer captures and records the actual hours worked by each variable-hour employee. This can be accomplished through timesheets, time and attendance systems, or a payroll system. For salaried employees, it can be accomplished by choosing a standard number of hours for each day worked.

* + - 1. Administrative Period

Once the actual hours worked have been captured and recorded during the measurement period, the administrative period allows an employer up to 90 days to calculate the average hours worked during the measurement period. For most employers, however, this period will probably be much shorter—from one day to one week. It may be coordinated with the employer's open enrollment period as well.

For employees found to be full-time (averaged 30 or more hours per week during the measurement period), the standard eligibility period begins. After the eligibility period, the employee is eligible for coverage for the remainder of the stability period.

If it is determined that the employee was not full time during the measurement period, then the process begins again. (See below for more details on initial and ongoing variable-hour employees.)

* + - 1. Stability Period

In the stability period, employees found to be full-time must remain eligible for health coverage. This period cannot be less than six months and not more than 12, and it cannot be longer than the measurement period. For many employers, the stability period will be the standard annual benefits plan year.

In practice, this means that an employer will measure hours in one plan year, calculate the hours to determine full-time eligibility during open enrollment and then offer coverage during the following plan year. There are myriad variations on the balance of these periods, but many employers choose this combination for administrative ease.

* + - 1. Waiting Periods

Under a 2014 [final rule](https://www.federalregister.gov/articles/2014/06/25/2014-14795/ninety-day-waiting-period-limitation), after an employee is determined to be otherwise eligible for coverage under the terms of the group health plan, any waiting period may not extend beyond 90 days, and all calendar days are counted beginning on the enrollment date, including weekends and holidays.

1. Reporting Requirements
   1. Employee notification. Employees must be informed about the employer's health coverage (or lack of it) and about the exchanges—the marketplaces in each state where individuals can buy health insurance. Such notification must also include information on how individuals can use the exchanges.
   2. Summary of benefits and coverage. City’s must provide a summary of benefits and coverage (SBC) to participants each year. The purpose of the SBC, not to be confused with a summary plan description, is to make it easy for employees and their family members to compare plans so they can choose among them.
   3. W-2 reporting. There is also a requirement that W-2 forms include the cost of coverage for employees. Although such reporting is optional for employers that filed fewer than 250 W-2 forms in the previous year, the IRS notes that such optional status could be changed in the future.
   4. IRS reporting. Employers must submit informational reports to the IRS (these reports are named for revenue requirement sections in the Internal Revenue Code (Title 26)—§6055 and §6056). Covered employers must file [Form 1095-C](https://www.irs.gov/forms-pubs/about-form-1095-c), Employer-Provided Health Insurance Offer and Coverage, and [Form 1094-C](https://www.irs.gov/forms-pubs/about-form-1094-c), Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns, with the IRS annually. The regulations under §6055provide further guidance on the [information reporting requirements for health coverage providers](https://www.irs.gov/affordable-care-act/employers/information-reporting-by-providers-of-minimum-essential-coverage), including self-insured employers.