Health Care Reform and Idaho Businesses

A summary compiled from the New York Times and other sources

From a business perspective, the legislation enacted in March 2010 dramatically revamping the way health care costs are paid for in the United States. The effect on businesses depends on their size, the kind of work force they have and what they have done about worker health coverage in the past.

Effective six months from the date of enactment of the bills:

- Group health plans or insurance companies providing group or individual market coverage are prohibited from rescinding coverage once an enrollee is covered under a plan, except in the case of an individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact.

- Group health plans or insurance companies providing group or individual market coverage are prohibited from setting lifetime limits on the dollar value of benefits and from setting unreasonable annual limits on the dollar value of benefits. Annual limits will be banned completely in 2014.

- Any group health plan or plan in the individual market that provides dependent coverage for children must make that coverage available until the child turns 26 years of age.

All waiting periods for coverage to go into effect will be limited to 90 days beginning in 2014.

In general, the new law does not require an employer to provide insurance for any employee. If an employer does provide coverage, beginning in 2011 the employer is required to disclose the value of the benefits provided on each employee’s W-2 form.

Beginning in 2014, however, businesses with 50 or more full-time employees will pay a penalty if a full-time worker gets a public subsidy to buy insurance individually. A full-time employee for purposes of this law is one who works 30 hours a week or more.

The subsidy, provided on a sliding scale based on age of the primary insured and household income, offsets a portion of the premium paid for insurance obtained outside work. It is provided to households with incomes less than 400 percent of the federal poverty level. That would be $88,200 for a family of four in Idaho.

Considering Idaho as an area of median health care costs, a 35-year-old worker with a spouse and two children earning the Idaho average wage of $33,000 a year who is not offered health insurance by his employer would receive a subsidy of $7,323. The household income in this case is 150 percent of the federal poverty guideline.
The chart above, prepared by the Kaiser Family Foundation, shows the annual subsidy for a household of four without access to employer-provided health insurance based on the age of the primary insured in an area of medium health care costs. Specific calculations of health care subsidies based on specific family, income and age circumstances can be found online at


The subsidies are based on a household spending a percentage of its income for health insurance. That percentage is on a sliding scale based on the level of income compared to federal poverty guidelines:

- 133% to 150% of the federal poverty level: 3% to 4% should be spent in health insurance.
- 150% to 200%: 4% to 6.3%
- 200% to 250%: 6.3% to 8.05%
- 250% to 300%: 8.05% to 9.5%
- 300% to 400%: 9.5%

The penalty on businesses not offering health coverage generally will be imposed if at least one full-time employee requires a public subsidy for insurance because the employer offers none. In that case, the employer, who has the equivalent of at least 50 full-time employees, must pay $2,000 for each actual full-time employee the company has above 30 full-time employees. Again, only employees who work 30 hours a week or more are counted in this calculation. Should a business have 29 full-time employees and 100 employees who work less than 30 hours a week, it would not reach the threshold subjecting it to the penalty even though it would have the equivalent of 50 full-time employees when the aggregated hours of the part-timers are converted to full-time equivalents and combined with the full-timers.
Once that penalty threshold has been met, however, part-time employees – but not seasonal employees – are used to determine the total employee count subject to penalty. This calculation is made monthly. The hours of the part-time employees are aggregated and then divided by 120 – the hours in a month for 30-hour-a-week full-time workers – and that product is added to the number of full-time workers to determine the number of full-time equivalents subject to penalty. In other words, 40 people working 30 hours a week and 20 people working 15 hours a week creates a full-time equivalent of 50, which meets the initial threshold for imposition of penalties, and because there are more than 30 actual full-time workers penalties would be assessed on the 10 full-time workers over 30. Had the number of full-time employees been just 25 and the number of part-timers 50, the full-time equivalent would again be 50, meeting the initial penalty threshold, but because the actual number of full-timers is under 31, the penalty would not be imposed.

There is also a penalty for businesses who offer health coverage to employees but at a cost to the employee that is determined to be unaffordable, again based on the ratio of the wage to the federal poverty level as follows:

- 133% to 150% of the federal poverty level: 3% to 4% should be spent in health insurance.
- 150% to 200%: 4% to 6.3%
- 200% to 250%: 6.3% to 8.05%
- 250% to 300%: 8.05% to 9.5%
- 300% to 400%: 9.5%

In the case of unaffordable coverage from an employer, the employer must pay a penalty of $3,000 per employee who receives a subsidy or $2,000 for every full-time employee, whichever is less. From 2010 through 2013 – before health insurance exchanges are established – very small businesses will receive tax credits to offset 35 percent of their health insurance costs if they cover at least half of the premium. In 2014 and beyond when the insurance exchanges offer coverage, the credit increases to 50 percent and is available for any two consecutive years. The full credit is available to businesses with the equivalent of 10 or fewer full-time workers earning on average less than $25,000 a year. It phases out as the payroll, excluding seasonal workers, grows to 25 and wages rise to an average of $50,000.

The tax credit is neither refundable nor salable, but it can be carried back one year or forward 20 years so a company that pays no taxes in a bad year may still be able to take advantage of it. A tax-exempt employer, by contrast, can take a refundable tax credit against 25 percent of its health insurance costs in the years before the exchange kicks in and 35 percent beginning in 2014.

For the purposes of the tax credit, owners and their close relatives are not counted as employees for meeting eligibility requirements, and their health care expenses cannot be offset by the credit.


Beginning in 2014, states must set up a so-called “small-business health options programs” through which small employers can purchase insurance.
Plans offered on the exchange will have to be standardized for easy comparison and offer minimum levels of benefits established by federal law. Beginning in 2017, a state may allow large employers (with at least 101 employees) to take part in the exchange.

The standard for the minimum benefit level called the "essential benefits package" require coverage of:

- Hospitalization;
- Outpatient hospital and clinic services, including emergency room services;
- Services of physicians and other health professionals;
- Services, equipment and supplies necessary to the services of a physician or health professional in appropriate settings;
- Prescription drugs;
- Rehabilitative and "habilitative" services to maintain the physical, intellectual, emotional and social functioning of developmentally delayed individuals;
- Mental health and substance use disorder services;
- Certain preventive services with no-cost-sharing permitted and vaccines;
- Maternity care;
- Well-baby, well-childcare, oral health, vision, hearing services, equipment and supplies for those under age 21.

The plan must cover at least 60 percent of the full value of benefits in the essential benefits package, and employers must contribute a minimum of 72.5 percent of the premium for the lowest cost qualified plan offered by the employer for individual coverage and at least 65 percent for families. This contribution would be prorated for part-time employees, based on the employee's weekly hours worked. Out-of-pocket maximums will be capped at $5,000 for individuals and $10,000 for families.

For employers who currently provide health insurance to their employees, there is a five-year grace period beginning 2013, for which employment-based plans could keep their existing coverage and not have to comply with the minimum requirements of the new law. Upon expiration of the grace period, the plan would have to meet the minimum essential benefits requirements or face all required penalties. The only exception is for health plans that are subject to collective bargaining agreements, which are exempted from providing the minimum essential benefits through the expiration of the agreement or one year after enactment of the law, whichever is later.


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1The information provided in this summary is for general educational purposes only and not for the purpose of providing legal advice. If legal advice is required, an attorney should be contacted.

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