Updated 10/3/2016

In The Spotlight: ACA Employer Impacts

Employer sponsored health insurance coverage got its start during World War II. To combat inflation, strict controls were placed on worker compensation in 1942. Without the freedom to offer high wages to compete for the fewer available workers, employers began to expand their benefits package, including health insurance coverage. The Internal Revenue Service (IRS) made employer contributions to health insurance coverage not taxable in 1954, leading to a rapid expansion in employers who offered health insurance. Not only were more people covered by an employer sponsored policy, the benefits became richer.

Today, employers face many issues when deciding whether or not to offer health insurance coverage. The costs of health care continue to rise, which can make it difficult for both employers and employees to keep pace with changes. Between 2000 and 2014, the total spending on health services (as a percent of GDP), increased from 13.3% to 17.5%.[1] As spending on care increases, health care coverage is becoming an even larger component of employers' budgets.

For small businesses with smaller overall budgets, offering health insurance coverage is often a larger burden. Cost is often the single biggest factor affecting small employers' decisions to buy insurance. As medical costs continue to rise, so do insurance premiums, and it can be a struggle for small employers to continue to offer coverage. Some employers may choose to switch to a defined contribution arrangement, where employers offer a specified dollar amount toward health care coverage and employees may choose how to best spend that money. Employees generally see these plans as favorable since they may be portable, meaning that if the employee leaves a company, he or she may take the plan (or Health Savings Account) with them since it is an account tied directly to the employee, not the employer.

The Affordable Care Act (ACA) made several changes to encourage employers to offer meaningful health insurance coverage. These policies, described below, create "carrots" and "sticks" to encourage employers to offer, but do little to address costs of coverage and may even increase the financial burden on employers.

SHOP Exchange

Beginning in 2014, small businesses were able to shop for health insurance coverage through the Small Business Health Options Program (SHOP). Through the SHOP Exchanges, eligible employers can access available tax credits, described below, to help alleviate the costs of employee health insurance coverage. To qualify for SHOP, small businesses must have no more than 50 full-time equivalent employees, pay an average wage of less than $50,000 yearly, and cover at least half of employee health insurance premiums.

For plan years beginning on or after January 1, 2017, a new "vertical choice" model for Federally-facilitated SHOPs will be an option for employers. The vertical choice model allows employers to offer qualified employees a choice of all plans across all available actuarial value levels of coverage from a single issuer (in addition to the existing employee choice within a platinum, gold, silver or bronze metal level). However, the state of North Carolina did not opt to offer vertical choice. Blue Cross and Blue Shield of North Carolina (BCBSNC), has been the only medical issuer offering coverage on SHOP in North Carolina.

[1] "U.S. Health Expenditures 2000 Compared with 2014". Peterson-Kaiser Health System Tracker. September 2016.

Tax Credits for Small Businesses

To encourage smaller employers to provide health insurance coverage, the federal government created tax credits for employers with fewer than 25 full-time equivalent employees. In 2010, prior to SHOP Exchange operations, certain small businesses were eligible for tax credits of up to 35% of the employer-paid portion of the health insurance premium. After 2014, when the SHOP Exchanges were implemented, these tax credits increased to up to 50%. Blue Cross and Blue Shield of North Carolina provides an online calculator to help small businesses determine their eligibility for the tax credits.

Pay or Play

The ACA does not mandate that employers provide health benefits to their employees, but Applicable Large Employers (ALEs) may face tax penalties for failing to offer affordable minimum essential health insurance coverage. Employers with 50 or more full-time employees or full-time equivalents must offer coverage that is (1) affordable and (2) covers at least 60% of benefit costs ("minimum value") to their full-time employees and their dependents. If ALE's do not meet these requirements, they are charged a penalty, as described below.

For purposes of the employer mandate, full-time employees are those who average 30 or more hours a week. To identify the accurate number of full-time equivalents (FTEs), employers use a formula to calculate the total hours worked (part-time employees included). So far, the implementation of the mandate has proven to be successful in encouraging employers to offer coverage. A recent survey on employer sponsored health offerings reports that 97% of firms with at least 50 FTEs offer a health plan to at least 95% of their employees.[2]

For 2016, the ACA defines affordable coverage as consuming no more than 9.66% of an employees' household income. As employers are largely unaware of an employee's total 'household income', the IRS provides several methods (called safe harbors) that employers may use to determine if the offered coverage satisfies the affordability requirements.

ALE's will be subject to a tax penalty for any month that they fail to offer full-time employees and their dependents the opportunity to enroll in minimum essential coverage and at least one full time employee receives an Advanced Premium Tax Credit, or tax credit, through a Health Insurance Exchange. This penalty is equal to $2,000 times the number of individuals employed by the ALE, minus 30.

Even if an ALE provides coverage to full-time employees and their dependents, it may still be liable for a penalty if the coverage is not affordable or fails to meet minimum value requirements. If the employer offers coverage but at least one employee receives a tax credit and the coverage does not meet the definition of affordable, the penalty is the lesser of $2,000 times the total number of employees or $3,000 times the number of employees receiving a credit.

[2] Employer Health Benefits Survey 2016. Kaiser Family Foundation and Health Research and Educational Trust. September 2016.

Reporting Requirements

Starting with the 2015 tax year, certain large employers[3] are required by the ACA to report information about whether they offered coverage, and costs of that coverage to the federal government and covered individuals. This reporting serves two main purposes. First, it allows the federal government to enforce the individual shared responsibility requirements ("individual mandate") because it helps the government piece together whether individuals carried minimum essential coverage during the year. Also, reporting allows the government to enforce the employer shared responsibility requirements (employer mandate or "pay or play") to determine whether certain employers owe the government penalties.

Future Outlook

Future regulations are also expected to impact what employer coverage looks like.

The ACA's "Cadillac Tax" is a 40% tax on high cost benefit plans. The tax was originally planned to go into effect in 2018 for plans valued over $10,200 for single coverage and $27,500 for a family. Recently, the federal government delayed implementation of the tax until 2020. When the tax is finally implemented, the benefit cost to trigger the tax will be higher than those proposed for 2018. This tax is meant to encourage employers to be more cost conscious and identify ways to reduce spending, rather than offering expensive health plans to employees. In response to the tax, some employers have already taken strides to reduce costs, which could result in greater out-of-pocket costs for employees.

The newly implemented nondiscrimination rule implementing Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities of covered entities. Covered entities include health care insurers and providers, which receive federal financial assistance that includes some Medicare payments and subsidies available through the health insurance exchanges. The rule prohibits categorical exclusion for gender transition services in these health programs or activities, and prohibits coverage limitation or imposing additional cost sharing based on the protected classes. Most group insurance coverage and many self-funded plans are impacted by Section 1557 by virtue of their relationship with an insurer or third party administrator that is subject to the law.

Today, more than half (56%) of all employers offer health insurance coverage. This is compared with 61% of employers in 2006, showing a small overall decline since implementation of the ACA.[4] Based on a recent employer survey, 98% of larger employers offer health coverage, compared with 55% of smaller employers. The survey finds that the smallest employers (3-9 employees) as a group are the most impactful to the overall offer rate, or percent of employers that offer coverage, since most employers are small. The primary driver for small employers' decision not to offer coverage is cost.[5]

[3] If employers offer a fully-insured health benefit coverage, then the health insurer that offers their coverage will provide portions of the reporting.
[4] Employer Health Benefits Survey 2016. Kaiser Family Foundation and Health Research and Educational Trust. September 2016.
[5] Employer Health Benefits Survey 2016. Kaiser Family Foundation and Health Research and Educational Trust. September 2016.

Despite the current decline in overall offers of health insurance, the number of consumers with employer coverage is expected to level out by 2019, according to recent studies.[6] Even if employers do not drop coverage completely, some employers may turn to self-funded plans since there are fewer requirements on benefit protections, or they may alter their benefit designs to manage rising costs, to the extent allowable by law.

BCBSNC Views

BCBSNC supports efforts to maintain the viability of the employer-based health insurance system. We recognize the strong contributions that employers make, and how this system aids stability in the marketplace while creating greater access to coverage for many individuals and families. As medical costs continue to rise, we are concerned that smaller employers will not be able to afford to enter the market and some larger employers may consider dropping coverage. The administrative requirements facing employers (and BCBSNC as we try to support our employer customers) continue to add costs to the system.

For More Information:

Kaiser Family Foundation: 2016 Employer Health Benefits Survey: http://kff.org/report-section/ehbs-2016-section-one-cost-of-health-insurance/

Healthcare.gov: https://www.healthcare.gov/small-businesses/employers/

[6] "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026." Congressional Budget Office. March 2016.