Part I: The Obamacare Challenge for Employers – Employers with 50 or More Full-time Employees

The Affordable Care Act — or Obamacare — is dramatically changing how small- and mid-sized businesses must handle health care benefits. What's more, many rules governing employers' duties in 2014 and 2015 have been changing, creating more complexity. To sort through the key issues, Knowledge@Wharton spoke with two experts for this podcast: Jeff Englander, a senior vice president and senior research analyst at GE Capital, and Lawrence Gelburd, a Wharton instructor. An edited transcript of the conversation appears below.

Knowledge@Wharton: We are meeting today to discuss the Affordable Care Act — or Obamacare — and how it's affecting small- and mid-sized companies, which face a lot of shifting rules and confusing information over implementation. To help us gain some clarity about these topics, we're going to speak with Jeff Englander, a senior vice president and a senior research analyst at GE Capital, and Lawrence Gelburd, an instructor here at Wharton. He is also on the Huffington Post's small business board of directors as well as being an entrepreneur himself. Thanks to both of you for joining us today.

Jeff Englander: Thank you.

Lawrence Gelburd: Pleasure to be here.

Knowledge@Wharton: The first two questions that I want to ask probably apply both to larger employers and smaller employers. As you know, there is a split in how these rules affect employers with more than, or less than, 50 employees. So let's get started. There have been a lot of changes to health care act deadlines for employers and individuals recently. Which are most important to employers?

Englander: First and foremost, the biggest one was the employer mandate, which requires employers with 50 or more full-time employees — the so-called applicable large employers — to offer insurance to their employees has been delayed until January 1, 2015. In addition, the so-called employer and insurer reporting obligations, which required employers to report who is eligible for coverage, who has been offered coverage and which employees are enrolled in coverage have also been delayed until January 1, 2015. That happened back in July.

Knowledge@Wharton: So it is not that they don't have to be thinking and preparing. It is just that they have got a bit of a reprieve in figuring out the best way to go about what it is they have to do. Is that right?

Englander: That is correct. I think that that's actually a perfect way to put it. To use this year to think and to prepare and to understand what their obligations are going to be and to figure out what they are going to have to do in the coming year. That really is what you want to use this delayed year for.

Knowledge@Wharton: Along those same lines, certain things have not changed. So which deadlines do employers need to still be aware of for 2014? Which rules did not get delayed?

Englander: A number of them and significant important ones — W-2 reporting of employer-sponsored insurance is effective January 1, 2014. Employers are required to provide their

employees with what is called the Summary of Benefits and Coverage Notice, which is a standardized eight-page form in what is called a linguistically appropriate format — meaning the language of the majority of their employees as well as others who have special language requirements. That must indicate in 2014 whether their plan provides minimum value, which we will define later.

There is also the so-called comparative effectiveness fee, which went into effect in July of this year. There is the so-called reinsurance fee, which will be based on the enrollment counts in November of this year and will be paid in January 2015. And last but not least, the so-called exchange or marketplace notice where employees had to be notified about state and federally funded health insurance marketplaces, which was due in October and now all employers are required to inform all of their new employees of this when they are hired.

Knowledge@Wharton: You mentioned something about minimal value. I know that you have noted elsewhere that coverage must be "affordable" and offer "minimal value," which is what you were talking about just a moment ago. Could you discuss how those are defined in the law?

Englander: Under the law, in order for an employer's coverage to be deemed to meet what they call "their shared responsibility obligation," it must meet two requirements — affordability and minimum value. Under affordability, this means that employers — for self-only coverage for the employee — must cost no more than 9.5% of that employee's W-2 wages with that employer for the previous year. This is what is called the "safe harbor" and this is basically a proxy for the employer to use for household income to determine affordability of coverage. So basically the coverage for a single employee for self-only coverage cannot be more than 9.5% of their W-2 wages.

In addition, the so-called minimum value says that 60% of the actuarial value of the benefits that the plan is going to pay out must be covered by the plan. And there are so-called minimum value calculators available at different websites [to calculate whether your plan meets this requirement]. There are also what they call "safe harbor methods" or you can also hire an actuary to look at your plan and determine whether it is covering 60% of the costs of the benefits of the plan.

Knowledge@Wharton: You mentioned that an employee's cost for self coverage can be no more than 9.5% of their wages. What if they want to get their family in the program? What happens then?

Englander: There are different requirements for a family and the employer can charge different rates. You need to look at that as well as the fact that there are certain instances where people can be covered under their spouse's plan so there are different rules that you need to look at. But those 9.5% requirements apply only, once again, for the mandate purposes only for self-only coverage.

Knowledge@Wharton: Lawrence, do you want to add to that?

Gelburd: I think that, from a small business perspective, a lot of small business owners have a lot of questions about these issues and they haven't really gone into them in depth. In some ways, having that extra year is a good thing as long as you take it and make something useful out of it. So one of the things that I think all small business owners can do to help them meet all their requirements but also make the best use of the time of the professionals that they have in their network — whether those are part-time people, whether they are on an advisory board or board of directors, or full-time or part-time employees who might be employed in legal or accounting or banking — is to get with those people and talk with them about what should be measured beforehand.

As Jeffrey pointed out, there is opportunity here to see what is going to be effective from a financial standpoint. I also know, as an entrepreneur myself and as someone who works with a lot of small businesses, sometimes things

get put off until the last minute and the best way to use your assets is to get online and do some research yourself. Find out some of these factors and get as far along as you can before you engage those professionals so that you can get the most use out of them.

Knowledge@Wharton: So this is probably good advice for small- and mid-sized companies.

Gelburd: I would say so.

Knowledge@Wharton: What are some of the considerations that larger employers have to weigh as they look at extending healthcare coverage to their employees?

Englander: The considerations that they will want to weigh as they look at this are to make sure that they do not just look at the economic factors of the cost of the coverage and the cost of the penalty. First of all, they have to look at the after-tax cost of the coverage, which is tax deductible, versus the after-tax cost of the penalty, which is not deductible. They also want to look at whether they are currently providing insurance. If they decide to no longer provide insurance, they will have to compensate employees for that loss of coverage because they are taking away a tax-sheltered income, which was paying for that coverage. They are going to have to look at how much they will have to compensate those employees.

In addition, you will want to look at the employment situation, the competitiveness of the labor market. You want to be able to use insurance possibly as a hiring, recruitment, and retention tool. Also, one thing that people have had to consider as you have looked at a number of people who have elected to drop insurance, or considered dropping insurance, is the impact that this has on your brand and reputation. A lot of people spend a great deal of time and effort carefully cultivating their brand and their reputation and you want to consider what this is going to do to your brand both compared with other employers and within the community and your marketplace. And lastly you have to consider the relative age and income levels of the employer and labor force.

Because of the way insurance is structured under the exchanges, younger employees, because of the rating bands, will actually be paying a little bit more than they would be otherwise. Younger employees are going to be demanding more compensation if you choose not to offer insurance. And higher income level employees who were getting tax sheltered income via insurance are now going to be demanding higher incomes — particularly older employees who tend to have higher incomes — to replace the insurance they no longer have.

Gelburd: When you have a larger organization, it is not just the cost of the coverage. There are also brand issues and this is very relevant when you have to decide who the stakeholders are. Identify those stakeholders. Identify the effect on them. So, for a large company, that may be different than for a medium or small-sized company. It is easy to measure the financial payments. It is obviously good to do that. But then you have the fuzzy and very important decision about deciding what the impact is going to be on your stakeholders. So I think that is a good thing to keep in mind.

Knowledge@Wharton: We can all imagine certain big companies that have been in the news and it has been pointed out that they are pretty skimpy with their benefits. But if you are a medium-sized company, or let's say a regional firm, you are not going to get that national play. So what are the branding considerations for these mid-sized companies versus the very large companies?

Gelburd: I would say for the mid-sized companies they are going to have a somewhat easier time in finding comparable-sized companies and to see what is offered out there and get a sense of what the marketplace is. So this gives you a year to survey, directly and indirectly, what those other companies are doing and give yourself a sense as a company of where you fall in that hierarchy.

Englander: The one thing that I would like to add is, even though you probably do not spend as much maybe in advertising on a national scale as a smaller or mid-sized company, you need to look at some of the things you will do maybe in terms of the community efforts even through sponsoring Little Leagues and the like. Those are all branding efforts that you want to consider as you look at whether or not to offer insurance. You also have to look at how is this going to position you competitively. Is this going to give you a competitive advantage or place you at a competitive disadvantage versus other people in the marketplace?

Gelburd: I know here at the University of Pennsylvania they have had a lot of these drives that Jeffrey mentioned to get people to be aware of their health numbers and what their health is. And, in fact, they found a couple of employees who were in very serious, had very serious conditions and did not become aware of it until they came in. So that is something that the University can show that it is good not only for the employees, but it can actually be really directly related not just to the dollars but directly to their health.

Knowledge@Wharton: Also for larger employers, there are questions about whether or not employers must offer coverage for variable hour employees. Apparently this is determined in part by some IRS rules that are obscure to some — maybe known well to accountants — but many people just do not understand them. So, first of all, what is the definition of a variable hour employee? And, second, what do the rules require of large employers?

Englander: The rules require that any employee who works 30 hours or more, on average, per week for the previous year must be offered insurance. Now the rules for determining that are a little bit complicated in the sense that the IRS defines three time periods for the so-called employee status for whether or not an employer has to offer insurance under the mandate. They define what is called a measurement period, a stability period, and an administrative period.

The measurement period is a period of between three and 12 months, selected by the employer, where the employer basically looks back and will track the employee's hours during this measurement period. If the employee works 30 hours or more per week during that period, and they have 50 or more full-time employees or full-time equivalent employees, they are the so-called applicable large employer; they must offer insurance during what is called the stability period, which is the period subsequent to the measurement period.

The stability period is a period of at least six months and no less than that initial measurement period. It begins after that standard measurement period and after what is called an administrative period. The last period defined is this administrative period.

It is very similar to what you would go through now in an open enrollment period. It is up to approximately 90 days. It is generally the period between the measurement period and the stability period when they are offered the insurance. It is the period the company would use to determine eligibility, notify the employee that they are eligible for coverage and enroll the employee if they choose to get the coverage. This administrative period would cover the entire period between the date when the employee becomes eligible for coverage and the date the employee is offered coverage. This is an extremely complicated calculation. It is highly recommended that you look at this in a very detailed fashion and even get help from a professional advisor on calculating this.

Gelburd: It sounds like the devil is in the details there.

Englander: Absolutely.