

Nevada Employer's Guide to the Affordable Care Act

Nevada Division of Insurance





State of Nevada
Department of Business and Industry
Division of Insurance

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This is a publication of the Nevada Division of Insurance. It was published on February 13, 2014. Due to the complexity of the Affordable Care Act and the new rules and guidance issued daily from the federal government, it is recommended that you consult with an insurance professional and attorney for final guidance on what is best for your business.

Note: Note: The enforcement of the assessment for not providing coverage was originally scheduled to begin in 2014. However, a U.S. Department of Treasury announcement on July 2, 2013 delayed enforcement of this aspect of the law to 2015. Final rules issued jointly by the Internal Revenue Service and U.S. Department of Treasury on February 10, 2014 delayed enforcement for employers with fewer than 100 full-time employees or full-time equivalent employees to 2016 and introduced 'transitional relief' for employers with 100 or more full-time or equivalent employees under certain conditions.



Nevada Employer's Guide to the Affordable Care Act

On March 23, 2010, President Obama signed the Affordable Care Act (health care reform) into law. The law puts in place a significant number of health insurance reforms; many have rolled out over the last three years while some of the final, and most significant, changes of the law will take effect on January 1, 2014. The remainder will take effect in the following years.

It is likely that some of these new laws and regulations will affect your business in some way. This guide is intended to help you navigate these challenges and opportunities so that you can make the best decisions for your business as the health insurance landscape continues to change in 2014 and beyond.

Will I have to provide coverage to my employees?

The law does not require you to provide health insurance but there may be financial penalties for not doing so. **Starting in 2015, if you employ 100 or more full-time employees or full-time equivalent employees**, and you do not provide **affordable minimum essential coverage** to at least 70% of your full-time employees (and their dependents), **you will be required to pay an assessment to the Internal Revenue Service (IRS)**. In 2016 and later you will be required to pay an assessment to the IRS if you employ 50 or more full-time or equivalent employees and do not provide affordable minimum essential coverage to at least 95% of your full-time employees (and their dependents).

Note: The enforcement of the assessment for not providing coverage was originally scheduled to begin in 2014. However, a U.S. Department of Treasury announcement on July 2, 2013 delayed enforcement of this aspect of the law to 2015. Final rules issued jointly by the IRS and U.S. Department of Treasury on February 10, 2014 delayed enforcement for employers with fewer than 100 full-time employees or full-time equivalent employees to 2016 and introduced 'transitional relief' for employers with 100 or more full-time or equivalent employees under certain conditions.

Should I provide coverage to my employees?

EMPLOYEE COUNT

For your employee count, your full-time employees and the number of full-time equivalent employees is used. This includes:

Employees who work
an average of
30+ HOURS A WEEK

Employees who worked
130+ HOURS A MONTH

**SEASONAL
EMPLOYEES**

For more information please contact the Nevada Division of Insurance

HOW TO CALCULATE YOUR FULL TIME EMPLOYEE EQUIVALENT



Number of hours worked
by all **part-time** employees



120



**Full-time equivalent
employee count**

(Round down to the
nearest whole number)

NOTE: This calculation takes into account all employees employed by the same person, entity, or group. For example, one individual owning two unrelated businesses, each with 40 full-time employees and equivalents, may be considered a large employer with 80 employees.

SHOULD I PROVIDE COVERAGE?



The law specifically exempts all businesses that have fewer than 50 full-time employees or full-time equivalent employees from this assessment.

For employers who have 50 or more full-time or full-time equivalent employees and who **do not** offer affordable minimum essential coverage, the assessment will be calculated in one of three ways:

1. If you do not provide insurance at all, and if at least one full-time employee receives advance premium tax credits to purchase coverage through the Silver State Health Insurance Exchange, also known as Nevada Health Link, the assessment will be \$2,000 for each full-time employee you employ after the first 30 employees.
2. If you provide insurance but it does not qualify as “minimum essential coverage,” the assessment will be \$3,000 for each full-time employee you employ that is not offered minimal essential coverage.
3. If you provide insurance that does qualify as “minimum essential coverage” but that insurance does not meet the “minimum value” or is unaffordable, meaning that an employee’s contribution exceeds 9.5 percent of their modified adjusted gross income, the assessment will be \$3,000 for each full-time employee that fails the 9.5 percent affordability test.

What is a full-time employee?

For the sake of your employee count, your full-time employees and the number of full-time equivalent employees is used. This includes:

- Employees who work an average of 30 hours or more a week.
- Employees who worked 130 hours or more per month.
- The number of hours worked by all part-time employees divided by 120 (rounded **down** to the nearest whole number). This is your full-time equivalent employee count.
- Seasonal employees are included in your count. For more information please see the “Questions for Large Employers” section.

Calculating Your Monthly Employee Count						
Company Name	Number of full-time employees	Number of part-time employees	Hours worked by part-time employees	Number of full-time equivalent employees (divide total hours by 120)	Total count	Pay Assessment?
ABC Roofing	40	10	1,150	9	49	No
XYZ Flooring	5	60	6,000	50	55	Yes

Your employee count is the annual average of your monthly full-time and full-time equivalent count rounded down to the nearest whole number.

Calculating Your Annual Average Employee Count														
Full-Time and Full-Time Equivalent Employees	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total	Avg
	40	40	56	49	49	64	71	45	45	48	46	41	594	49

To calculate your annual average, add the monthly totals of full-time and full-time equivalent employees from the last calendar year, and divide the total by 12. Round **down** to the nearest whole number.

It is important to note that this calculation takes into account all employees employed by the same person, entity, or group. For example, one individual owning two unrelated businesses, each with 40 full-time employees and equivalents, may be considered a large employer with 80 employees. If you have questions specific to your situation or use an employee leasing or temp company, please consult an attorney.

For more information about determining whether or not your employees are full-time, visit <http://www.dol.gov/ebsa/newsroom/tr12-01.html>.

What is minimum essential coverage?

In order to qualify as minimum essential coverage, a plan must be an employer-sponsored plan defined as, with respect to an employee, a group health plan (including both fully insured and self-insured plans) or group health plan insurance coverage offered by an employer to an employee that is (1) any plan or coverage offered in the small or large group market within Nevada; or (2) a health plan treated as being grandfathered under the Affordable Care Act that is offered in the group market.

What is minimum value?

Minimum value is defined by the U.S. Department of Health and Human Services as coverage of at least 60 percent of the total allowed cost of benefits provided under the plan—it is a measure of benefits, not a measure of premium.

A minimum value calculator will be made available to employers by the IRS and Department of Health and Human Services. Employers can input certain information about the plan, such as deductibles and copay, into the calculator and get a determination as to whether the plan provides minimum value. If the plan covers at least 60 percent of the estimated total allowed cost, the plan will meet the “minimum value” test.

How do I know whether the coverage that I provide is “affordable”?

If an employee’s share of the premium for employer-provided coverage would cost the employee more than 9.5 percent of that employee’s annual household modified adjusted gross income, then the coverage is considered “unaffordable” for that employee. If you offer multiple healthcare coverage options, the affordability test applies to the lowest-cost option available to the employee that also meets the minimum value requirement.

Because employers generally will not know their employee’s household incomes, employers can take advantage of one of the “affordability safe harbors” set forth in the federal regulations. Under the safe harbors, an employer can avoid a payment if the cost of the coverage to the employee would not exceed 9.5 percent of the wages the employer pays the employee that year, as reported in Box 1 of Form W-2, or if the coverage satisfies either of two other design-based affordability safe harbors.

For more information about safe harbors see Federal Register Vol. 78 n. 1 at p. 218 (Jan. 2, 2013) at <http://www.gpo.gov/fdsys/pkg/FR-2013-01-02/pdf/2012-31269.pdf>.



Will my part time and seasonal employees be counted for the purpose of the assessment?

To be subject to the assessment, you must employ at least 50 full-time employees or a combination of full-time and part-time employees that equals at least 50.

For example, 40 full-time employees employed at least 30 hours per week on average plus 20 half-time employees working 15 hours per week on average would be the equivalent of 50 full-time employees. As an employer, you must determine each year, based on your current number of employees, whether or not you will be required to pay an assessment.

For example, if you have at least 50 full-time employees (including full-time equivalents) in the prior calendar year, then you will be required to pay an assessment.

If you have seasonal employees, then you must average the number of employees across the months in the year to see whether you have 50 or more employees. The averaging may be able to take into account fluctuations throughout the year. If you are close to the 50 full-time employees (including equivalents) and want to know what to do for 2015, a special transition relief program has been proposed. The regulations issued by the IRS provide additional information about determining the average number of employees for a year and information about how to take account of salaried employees who may not clock their hours and additional information on seasonal workers.

Additional information is available at: <http://www.healthcare.gov> or www.dol.gov/ebsa/healthreform.

Employers will not have to pay an assessment if two conditions are met: The employer averages 50 or more full-time employees (including equivalents) for 120 days or less, and the employees who bring the employer over the 50-employee threshold are seasonal workers. If these two conditions are met, the employer is not subject to the assessments that would apply for failing to provide coverage to full-time employees.

I have 50 or more employees; can I supplement my employees' income instead of offering insurance?

There is no provision for a monetary payment to the employee to avoid the assessment. According to Section 4980H of the Internal Revenue Code, an employer with 50 or more employees could be subject to assessment if any full-time employee is certified to receive an advance premium tax credit or cost-sharing reduction. Generally this may occur where either: (1) the employer does not offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan; or (2) the employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an employer-sponsored plan that is either unaffordable relative to the employee's household income or does not provide minimum value.



Other changes that affect Employers

Health Care Reform will affect Small Employers and Large Employers differently. Therefore it is important to know how your business will be classified when considering how you will be impacted.

An employer with anywhere from one to 50 full-time and full-time equivalent employees is considered a Small Employer.

An employer with 51 or more full-time and full-time equivalent employees is defined as a Large Employer.

A sole proprietor with no employees must purchase insurance as an individual.

Note: Beginning in 2016, employers with anywhere from one to 100 full-time and full-time equivalent employees will be considered a Small Employer.

Questions for Small Employers

**I am a Small Employer who offers health insurance to my employees.
How do I know if I am eligible for a tax credit?**

To reduce the cost of providing coverage, you may qualify for a small business tax credit that could be as high as 35 percent (up to 25 percent for non-profit employers) to help offset the cost of the insurance for tax years 2010 through 2013. The amount of the credit is on a sliding scale based off the size of your business. The fewer employees you have the larger the tax credit you may potentially be eligible for. If you did not owe tax during the year, you can carry the credit back or forward to other tax years. Non-profit employers who do not owe taxes can be refunded the amount of the credit.

To be eligible for this credit, you must:

- Have less than 25 full-time equivalent employees;
- Pay average annual wages below \$50,000;
- Provide health insurance;
- Pay for at least 50 percent of the employee's (not spouse or dependents) health insurance premium; and
- Purchase the insurance through the Exchange.

Starting in 2014, the small business tax credit increases to a potential of up to 50 percent (35 percent for non-profit employers).

For more information about the tax credit visit <http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers>.

What do I need to know when purchasing Small Group Health Insurance?

Guaranteed Coverage

If you are a small employer with 50 or fewer employees, your business has a right to purchase health insurance from any insurer regardless of the health status of your employees or their dependents. This rule applies when you initially apply for small employer coverage and also if you decide to change plans. Health insurers must make available to you any small employer health plan that they market to other small employers in Nevada.

A health insurer must accept everyone in your group. Employees or dependents (if you offer dependent coverage) with health conditions cannot be excluded from coverage. Your insurance for the group (or for any member of the group) cannot be canceled because someone in your group becomes sick. This is called “guaranteed renewal.”

Dependent Coverage

Dependent coverage must be extended to adult dependents until they are 26 years old.

Health Insurance Rates

Starting in 2014, how health insurers rate individuals and small businesses will also change. They will only be able to use age, composition of family, geographic area and tobacco as rating factors. Nevada has also expanded its review of health insurance rates. Nevada now reviews all health insurance rate changes in the individual and small group insurance markets.

The law also requires insurance companies to spend the majority of your premium dollars on health care. This means that insurers selling policies to individuals or small groups must **spend at least 80 percent of premiums** on direct medical care and efforts to improve the quality of care or provide a premium rebate to their customers.

The Nevada Division of Insurance is committed to consumer protection and transparency in regards to the cost of your health insurance. Read more about health insurance rates in Nevada at <http://doi.nv.gov/Health-Rate-Review/>.

Coverage Changes Effective January 1, 2014

The majority of health insurance market reforms take effect starting January 1, 2014. These changes mostly affect plans with members who enrolled after March 23, 2010; these plans are often referred to as non-grandfathered plans. If you were enrolled in a plan prior to March 23, 2010, which has not significantly changed, this is referred to as a grandfathered plan. Many of the reforms will not affect your grandfathered coverage unless otherwise noted.

Pre-Existing Conditions Exclusions and Health Underwriting Prohibited

In the small group health insurance market, pre-existing condition exclusions and pricing based on the health of the employees will be prohibited starting January 1, 2014.

Essential Health Benefits

All non-grandfathered small group health insurance policies must include the Essential Health Benefits. Essential Health Benefits are a set of health care services, selected by Nevada, that must be covered with no “annual or lifetime dollar limits.” These benefits may still have other limitations, such as a visit limit. These benefits include:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Please visit www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/nevada-ehb-benchmark-plan.pdf for more information.

Preventive Care Services

Preventive care services must be provided without any cost-sharing to the employee as long as the service is provided by a network provider. This means that a network provider cannot charge copays, deductibles or coinsurance to the covered person.

These services include, but are not limited to:

- Blood pressure, diabetes and cholesterol tests;
- Many cancer screenings, including mammograms and colonoscopies;
- Counseling on such topics as smoking cessation, weight loss, eating healthy, treating depression, and reducing alcohol use;
- Regular well-baby and well-child visits from birth to age 21;
- Routine vaccinations against diseases such as measles, polio and meningitis;
- Counseling, screening and vaccines to ensure healthy pregnancies; and
- Flu and Pneumonia shots.

For a complete list of preventive care services, please visit

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>
or uspreventiveservicestaskforce.org.

How can I purchase insurance coverage as a Small Employer?

Again, as a small business you are guaranteed to be able to purchase coverage. You may wish to maintain the expertise and relationships that already exists with your licensed agent, broker or insurer and continue to utilize their services in the selection of health insurance for your employees.

Starting October 1, 2013, you may also utilize the Exchange, with or without the assistance of a licensed agent or broker to enroll in a health insurance plan for your business.

You are not required to purchase insurance through the Exchange.

The Exchange will allow you to get quotes from multiple carriers at the same time. You will be able to select which plans to make available to your employees and determine the level of contribution you wish to make toward the employee's share of the premium (the Exchange has a minimum requirement). This also means that the individual employee may be able to choose from a variety of plans in a cafeteria style. You will be able to write a single check to the Exchange for your contributions and they will be responsible for distributing the premium payments to the appropriate insurers.

Navigators and other professionals will be employed by the Exchange to provide guidance and assistance in the selection and purchase of health insurance. They will be certified by the Nevada Division of Insurance which will indicate that they have met the minimum competency requirements to perform these tasks.

Remember to always verify with the Nevada Division of Insurance that the person or company you are working with is licensed, certified or authorized to conduct business in this state. You can do this at doi.nv.gov or you can contact the Division in Northern Nevada at (775) 687-0700 and in Southern Nevada at (702) 486-4009.

I am a Small Employer with employees who live or work outside of Nevada. How does that affect my ability to purchase insurance for them?

If some of your employees live or work outside of Nevada, they may participate in your health insurance plan. However, depending on the plan selected, those employees may experience limited access to in-network providers and seek services from non-network providers. Whenever a service from a non-network provider is used, there may be additional costs to the employee in the form of deductibles, higher copays or coinsurance.

How will the Affordable Care Act affect my Association Health Plan?

Effective when your policy renews on or after January 1, 2014, the ACA will change the rules applicable to Association Health Plans. Traditionally these plans were offered to individuals and employers and allowed them to band together and purchase health insurance on a “group basis” and gain the purchasing power enjoyed by a large group.

The ACA eliminated all exemptions for coverage sold by an association, including a “bona fide association,” by eliminating the requirement that only association members could purchase the coverage.

The law also mandates that a single loss pool exist for the individual market and separately for the small group market. This means that an association of small employers must be treated as a small group, and an association of individuals be treated as individual plans. Neither of these can be treated as a large group.

Questions for Large Employers

I am a Large Employer and offer insurance to my employees. Do I have to change plans?

No, it is not necessary to change plans. You can keep the same plan you've always had. The following reforms apply to all plans (including grandfathered plans):

- Lifetime dollar limits cannot be applied to health benefits that are Essential Health Benefits; and
- Dependent coverage must be extended to adult children until they are 26 years old.





Coverage Changes Effective for Plan Year 2014 in the Large Group Market

Large group health insurance plans are not required to offer Essential Health Benefits. However, any benefits offered by these plans that are Essential Health Benefits cannot have annual or lifetime dollar limits.

Preventive care services must be provided without any cost-sharing to the employee as long as the service is provided by a network provider. This means that a network provider cannot charge copays, deductibles or coinsurance to the covered person. These services include, but are not limited to:

- Blood pressure, diabetes and cholesterol tests;
- Many cancer screenings, including mammograms and colonoscopies;
- Counseling on such topics as quitting smoking, losing weight, eating healthy, treating depression, and reducing alcohol use;
- Regular well-baby and well-child visits from birth to age 21;
- Routine vaccinations against diseases such as measles, polio and meningitis;
- Counseling, screening and vaccines to ensure healthy pregnancies; and
- Flu and Pneumonia shots.

As a Large Employer how can I purchase insurance?

Your licensed insurance broker, agent or company will still be your best resource for purchasing insurance. Remember to check with the Division of Insurance at doi.nv.gov to ensure that they are licensed.

Can I offer a different level of coverage, different contribution rate, or different cost-sharing for my management employees (or other selected employees) than what is offered to the rest of the employees?

In the past, an insured group health plan could provide non-taxable benefits to executives and other highly compensated individuals even if the plan discriminated in favor of those individuals with regard to eligibility to participate or the benefits provided. The ACA has now subjected insured group plans to similar rules as those contained with the IRS Code 105(h) if they discriminate in favor of those persons. (Grandfathered plans are not subject to this change as long as the plan retains its “grandfathered” status.) Under the ACA, an employer that sponsors a plan that discriminates in favor of highly compensated individuals is subject to at least a \$100 per day penalty multiplied by the number of persons subject to the discrimination.

Guidance when you need it most

Purchasing insurance for your business can be confusing. As you navigate the Affordable Care Act and the new challenges and opportunities it has created in the health insurance marketplace, remember that the Nevada Division of Insurance is here to help you.

If you still have questions after reading this guide and talking to your agent, broker or insurance company, please contact the Nevada Division of Insurance in Northern Nevada at (775) 687-0700 or from Southern Nevada call (702) 486-4009. The Division may also be contacted from rural areas in Nevada by calling (888) 872-3234.

Remember to always verify with the Nevada Division of Insurance that the person or company you are working with is licensed, certified or authorized to conduct business in this state. You can do this at the phone numbers above or online at doi.nv.gov.

