benefit basics

complying with ACA affordability requirements

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As required by the Affordable Care Act (ACA), the Internal Revenue Service (IRS) annually announces what is considered affordable in terms of the maximum employee contribution for at least one health insurance option that offers minimum essential coverage of minimum value. Applicable large employers (ALEs) should annually look at their coverage options to ensure that they meet these requirements in order to avoid paying penalty taxes, writes Jack M. Towarnicky, CEBS, ERISA counsel at aequum LLC.

What constitutes an affordable health plan under the Affordable Care Act (ACA) continues to be a moving target as health care costs rise, both at the point of enrollment (contributions) and point of purchase (deductibles, copayments, coinsurance). Health plan sponsors must be aware of these changes to avoid paying penalty taxes for failing to comply with the ACA employer mandate requiring ALEs to offer "affordable, minimum essential coverage of minimum value."

ACA requires the Internal Revenue Service (IRS) to annually index and announce what is affordable in terms of the maximum employee contribution. Indexation is calculated as the excess of the rate of premium growth over the rate of income growth. After 2018, there is a further adjustment to reflect the excess of the rate of premium growth over the rate of growth in the consumer price index (CPI).

The affordability percentage decreased from 9.12% of pay in 2023 to 8.39% for 2024. This means that employee contributions for single coverage cannot exceed 8.39% of the employee's total household income. ALEs[1] will be charged a penalty tax if they fail to offer an affordable plan of minimal essential coverage[2] and minimum value[3] if one or more workers enroll in coverage offered by the health insurance marketplace—also called the exchange—and receive a taxpayer subsidy.

How Do Employers Determine Affordability?

To calculate affordability, employers start with the employee contribution for single coverage in the lowest cost ACA-compliant option offering minimum essential coverage of minimum value. If the employee contribution is less than the affordability percentage for the current year times the household's current year modified adjusted gross income (MAGI), the coverage is deemed affordable. MAGI consists of the household's gross income and is adjusted to include untaxed foreign income, nontaxable Social Security benefits and tax-exempt interest.

IRS recognizes that employers don't know the employee's household MAGI. In fact, most employees don't know their own household's MAGI.[4] Because of this challenge, safe harbors are available to make compliance easier. Plan sponsors can use different methods for different groups of workers—salaried vs. hourly, by job class, by state, represented vs. not represented—so long as the same definition is used for all members of a group. And, unique rules apply to workers covered by the Service Contract Act (SCA) and Davis-Bacon Act (DBA).[5]

The following three safe harbor methods all incorporate the affordability percentage in the determination.

1. **Form W-2:** An ACA-compliant option is affordable if the annual employee contributions for single coverage during the current year are less than the affordability percentage times the worker's Box 1 wages for the current year.
2. **Rate of pay:** (Not available for those who have tip or commission income.) For salaried workers, an ACA-compliant option is

affordable if the monthly employee contribution is less than the affordability percentage times the monthly salary. For hourly workers, the ACA option is affordable if the monthly employee contribution is less than the affordability percentage times the hourly rate times 130.

3. **Federal poverty level (FPL):** The ACA option is affordable if the annual employee contribution is less than the affordability percentage times the individual FPL in the mainland United States.

A catch: Under a cafeteria plan, flex credits or opt-out credits that employees can elect to take as taxable compensation will reduce the affordability safe harbor.[6] Following is an explanation of how employers can structure flex credits without triggering penalty taxes.

- If the employee contribution coupled with flex credits might trigger the employer mandate penalty tax, the plan sponsor should consider limiting flex credits as necessary so that the employee can use them to pay only employee contributions for health coverage or as contributions to a health flexible savings account (FSA) or health savings account (HSA) and cannot be received as taxable wages.
- Opt-out credits should be limited to those employees who confirm that they (and eligible dependents) have other group coverage that is minimum essential coverage.

For employers that use Form W-2 or rate of pay safe harbors, affordability will generally change each year since worker pay and the affordability percentage typically change every year. If the employee contribution for all workers is based on the full-time worker with the lowest level of compensation, a new hire might also affect the determination.

The simplest safe harbor option is FPL. Both the FPL and the percentage typically change each year. So, if both decline, employee contributions may have to be reduced to meet the affordability requirement. If both increase, employee contributions that were affordable in the prior year are likely still affordable. And if one increases and the other declines, as occurred from 2023 to 2024, the relative change will determine whether prior year contributions

are still affordable. For example, in 2023, the FPL calculation was: $14,580 x .0912 = $1,329/year, $110/month. The FPL definition of affordable declined in 2024: $15,060 x .0839 = $1,263/year, $105/month.

Finally, the above calculations may also vary for certain part-time and seasonal workers.

ALEs should check each year to confirm that a health option that offers minimum essential coverage and minimum value and has the lowest employee contribution will meet the affordability test they currently use. If not, they must determine whether to change the test or change the employee contribution—or both—to avoid paying the employer mandate penalty tax.

What Is Affordable, Minimum Essential Coverage of Minimum Value in 2024?

The following sample plan design would meet ACA affordability requirements even if no one enrolls in this option.

- **Eligibility:** Full-time workers defined as individuals who work 30 or more hours per week and their children up to age 26 (excluding the spouse)
- **Minimum essential coverage:** Preventive services[7] plus ordinary clinical trial expenses[8]
- **Minimum value** (2024):[9]
  - o In-network care
    - –Annual deductible: $9,450 individual/$18,900 family
    - –Annual out-of-pocket expense maximum: $9,450 individual/$18,900 family
  - o Out-of-network care
    - –Annual deductible: $9,450 individual/$18,900 family
    - –Coinsurance: 50%
    - –Out-of-pocket expense maximum: $18,900/$37,800
    - –In-network and out-of-network cost sharing do not cross-apply.[10]
- **Employee contributions:**
  - o Single coverage: 8.39% of 2024 household MAGI. (While enrolling for coverage, at hire or at annual enrollment for the subsequent plan year, the worker would be required to estimate their household MAGI and document the calculation. They would also be required to acknowledge that a true-up (either an increase or a reduction) in their contribution will apply at the end of the plan year should actual household MAGI vary from the estimate the worker provided at the time of enrollment.) The worker contribution throughout the calendar year would be 8.39% of all direct compensation on an after-tax basis. The following provides examples of maximum monthly and annual employee contributions depending on earnings.
    - –MAGI of $25,000: $174/month, $2,088/year
    - –MAGI of $50,000: $349/month, $4,188/year
    - –MAGI of $100,000: $699/month, $8,388/year
  - o Nonsingle coverage: 100% of the per capita cost to cover each child would be added to the single premium. All contributions are on an after-tax basis. The following provides examples of the employee's contribution for employee-plus-one coverage where the cost to cover a child is $400/month.
    - –MAGI of $25,000: Total of ~$575/month
    - –MAGI of $50,000: Total of ~$750/month
    - –MAGI of $100,000: Total of ~$1,100/month

Family Glitch Is No More

Following a 2022 change to the definition of *affordable*, many more family members of a worker's household may qualify for taxpayer-subsidized public exchange coverage. However, the change does not affect the employer shared responsibility calculation of affordability described above.[11]

Prior to the 2022 change, for purposes of taxpayer subsidies, when family members selected coverage in the marketplace, the employer-sponsored plan's affordability was based solely on the cost of single coverage. That meant that if the employee contribution for single coverage was affordable, family members were not eligible for taxpayer subsidies for public exchange coverage, regardless of the cost of family coverage.

It is unclear how employers will respond, but over time, some are expected to change their strategy to increase worker contributions for family coverage, which will lower costs directly and also lower costs indirectly by ensuring that workers can waive unaffordable family coverage in favor of taxpayer-subsidized public exchange coverage.

Understanding the Employer Mandate Penalty Taxes

Penalty taxes for ALEs that fail to comply with the requirements are as follows.

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- **IRC §4980H(a)—The A Penalty:** The 2024 A Penalty is $247.50/month ($2,970 annualized) multiplied by all full-time employees (reduced by the first 30). It applies where the ALE fails to offer minimum essential coverage to at least 95% of its full-time employees in any given calendar month and is triggered when one full-time employee who was not offered minimum essential coverage (regardless of affordability or minimum value) enrolled in taxpayer-subsidized coverage on the public exchange.
- **IRC §4980H(b)—The B Penalty:** The 2024 B Penalty is $371.67/month ($4,460 annualized) per full-time employee receiving subsidized coverage on the exchange. It applies where the ALE is not subject to the A Penalty and only applies to a full-time employee who was not offered affordable, minimum essential coverage of minimum value and who enrolled in public exchange coverage and received a taxpayer subsidy.

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Endnotes

1. Under Internal Revenue Code (IRC) Section 4980H(c)(2)(A), an *applicable large employer (ALE)* is "an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year." Specific rules apply in calculating full-time equivalency regarding part time, seasonal and other employees.
2. Under IRC Section 5000A(c), minimum essential coverage (MEC) includes "A self-insured group health plan under which coverage is offered by, or on behalf of, an employer to the employee." Excepted benefits are excluded. MEC need not be comprehensive coverage, it need not meet minimum value and it need not include all essential health benefits.
3. Under Treasury Regulation §1.36B-6, an eligible employer-sponsored plan provides minimum value (MV) for an employee of the employer offering the coverage only if "(i) The plan's MV percentage, as defined in paragraph (c) of this section, is at least 60 percent based on the plan's share of the total allowed costs of benefits provided to the employee; and (ii) The plan provides substantial coverage of inpatient hospital services and physician services." Most plan sponsors look to the definition of essential health benefits (EHB) and its ten categories when complying with the "substantial coverage" requirement: (1) ambulatory patient services (outpatient care you get without being admitted to a hospital); (2) emergency services; (3) hospitalization (like surgery and overnight stays); (4) pregnancy, maternity and newborn care (both before and after birth); (5) mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy); (6) prescription drugs; (7) rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills); (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care, benefits for birth control and breastfeeding.
4. Generally, 26 USC Section 36B(d)(2)(A) defines *household income* as the sum of the modified adjusted gross income for the taxpayer plus the aggregate modified adjusted gross incomes of all other individuals who were taken into account in determining the taxpayer's family size—anyone for whom the taxpayer is allowed a deduction for personal exemptions. The term *modified adjusted gross income* means adjusted gross income increased by certain income amounts that were not included in gross income such as tax-free interest income or that portion of Social Security benefits that are not taxable.
5. Department of Labor, Certain Provisions of the Affordable Care Act (ACA) And Compliance with the Fringe Benefit Requirements of the Service Contract Act (SCA), Davis-Bacon Act (DBA) and Davis-Bacon Related Acts.
6. Internal Revenue Service (IRS) Notice 2015-87, Further Guidance on the Application of the Group Health Plan Market Reform Provisions of the Affordable Care Act to Employer-Provided Health Coverage and on Certain Other Affordable Care Act Provisions.
7. U.S. Preventive Services Task Force, "A & B" Recommendations.
8. Effective January 1, 2014, all self-funded and fully insured nongrandfathered health plans must cover certain routine patient costs for qualified individuals who participate in an approved clinical trial. The requirement mandates coverage of all medically necessary charges associated with the clinical trial, such as physician charges, labs, X-rays, professional fees and other routine medical costs. The coverage does not apply for the actual device, equipment or drug that is typically given to participating patients free of charge by the medical device or pharmaceutical company sponsoring the trial.
9. Author's estimates using the final 2023 Actuarial Value (AV) Calculator.
10. Author's calculation using the CMS 2024 AV Calculator.
11. IRS, Affordability of Employer Coverage for Family Members of Employees, 10/13/22. "As required by statute, employees have an offer of affordable employer coverage if the employee's required contribution for self-only coverage of the employee does not exceed the required contribution percentage of household income."

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