IMPLICATIONS OF THE AFFORDABLE CARE ACT FOR COUNTY EMPLOYERS

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Group Health Insurance Providers—Affordable Care Act ("ACA") Implementation

- The Patient Protection and Affordable Care Act of 2010, together with the Health Care and Education Reconciliation Act ("ACA"), represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.

- **Key Provisions**:
- Medicaid expansion;
- Insurance reforms;
- Individual and Employer Mandates; and
- Insurance Exchanges

- **What does this mean for counties**? As employers, counties are affected just like all other employers by several significant aspects of the ACA. There are no exceptions from the ACA for public employers. For those counties employing more than 50 full time equivalent employees, there are a broad range of requirements that are already effective and apply to their group health coverage and that will become effective and applicable to such insurance plans in January 2014.

Grandfathering Explained

Purpose: Provides for a smoother transition by allowing some health plans to remain as is and not be required to implement some aspects of ACA under certain conditions.

- **Maintaining such status**: To be and remain grandfathered, a group plan must have been in place as of March 23, 2010, and not make any major changes in coverage since then. (*Examples of major changes*: reducing or eliminating benefits for certain diagnosed conditions; increasing deductibles by more than growth in medical inflation since 3/23/2010, plus 15%; reducing share of premium employer pays by more than 5% since 3/23/2010; increasing co-payments by more than $5 (adjusted annually for medical inflation), plus 15%; decreasing annual dollar limits; change in insurance company providing coverage).

- **Why it matters**: Many of the ACA's provisions apply regardless of grandfathered status. For example, all plans providing dependent coverage must allow dependents up to age 26 to enroll (though only non-grandfathered plans must allow such enrollment when dependents have access to their own employer coverage). And lifetime limits on coverage are now prohibited under all plans. *However*, some key provisions do not apply to grandfathered plans:

- Requirement that plans provide a wide array of preventative services with no patient cost sharing;
- Rule allowing consumers to appeal denials of claims to third party reviewer;
- Requirement that insurance plans cover all "essential health benefits."

For those ACA requirements in effect now, the only one that grandfathered plans are exempt from and that materially affects costs is the one requiring coverage for preventative services at no cost to the employee. For non-grandfathered plans, this requirement is expected to increase premiums by about 1% according to the economic impact analysis accompanying the HHS regulation.

Significant requirements of ACA already in place (2010-2013):

- Authorize coverage for dependent children to age 26 on parent(s) policy regardless of residency or student or marital status (eff. 9/23/2010);

- Prohibit group health plans from placing lifetime limits on dollar value of coverage (eff. 9/23/2010);

- Prohibit insurance companies from cancelling or rescinding coverage except for fraud or material misrepresentation (eff. 9/23/2010);

- Prohibit charging the patient (no cost sharing) for certain preventative services—in order to remove any financial barrier to care, ACA prohibits charging of deductibles or visit co-pays for a broad range of preventative services. Examples: physical exams, routine vision and hearing exams, screenings such as mammography, colonoscopies and lab work; immunizations, smoking cessation counseling and women's health needs such as contraceptives. This list will expand in subsequent years (eff. 9/23/1010);*****

- Prohibit insurance companies from denying coverage for children under 19 years of age based on pre-existing conditions and from including existing condition exclusions on such children (eff. 9/23/1010);

Significant requirements of ACA already in place (2010-2013): (Cont'd)

- Limits Healthcare Flexible Spending Account annual contributions to $2500 (eff. 1/1/2013) and impose new over the counter product rules—all over the counter drugs must have a physician's prescription before they are eligible for reimbursement from such accounts (eff. 1/1/2011);

- Plans must provide a uniform "*summary of benefits and coverage*" no more than 4 pages in length to all applicants and enrollees (eff. 9/23/2012);

- States must notify HHS whether they will operate an American Health Benefit Exchange and Small Business Health Options Program Exchange ("SHOP") or allow the federal government to facilitate an exchange in that state (eff. 2/15/2013);and

- Employers that filed more than 250 W-2's in 2011 must report to IRS the full value of an employee's health plan coverage on that employee's W-2 for the 2012 tax year. Employers filing fewer than 250 W-2's in 2011 do not have to comply with this requirement for 2012 until further notice and guidance from the IRS (eff. 1/31/2013).

Future Implementation of ACA (late 2013-2018):

- Employers will be required to notify employees of availability of Exchanges and of possibility of federal subsidies (eff. pre10/1/2013);

- Enrollment in state or federally-facilitated Exchanges will begin (eff. 10/1/2013);

- All U.S. citizens and legal residents are required to have qualifying health coverage or pay phased–in tax penalties (starting in 2014 at the greater of $95/person or 1% of household income and increasing annually), with certain exemptions—the "*Individual Mandate*" (eff. 1/1/2014);

- Exchanges (American Health Benefit and Small Business Options Program Exchanges) will be open for business—market-based source for individuals up to age 65 and small businesses (with no more than 100 employees) to purchase qualified health coverage (eff. 1/1/2014);

- Health plans must provide "Essential *Health Benefits,"* which include: ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance use services; prescription drugs; rehabilitative services and devices; laboratory services; preventative and wellness services; chronic disease management; pediatric services); and contraceptive services(eff. 1/1/2014);*****

- Prohibits annual limits on dollar value of coverage. Non-dollar (e.g. number of office visits) limits on some benefits are still permitted such as physical therapy, occupational therapy and speech therapy (eff. 1/1/2014);

Future Implementation of ACA (late 2013-2018): (Cont'd)

- Provides refundable and advanceable premium tax credits and cost sharing subsidies to eligible individuals and families purchasing health coverage on Exchange. Subsidies available to families with incomes between 100-400% of the federal poverty level ("FPL") to purchase insurance through the Exchanges. Families with incomes below 50% of FPL (state obligation) are eligible for Medicaid coverage without Medicaid expansion by State. (FPL is $19,530 for a family of three in 2013). ACA originally mandated (until U.S. Sup. Ct ruled it was optional) states expand Medicaid to provide coverage for individuals with incomes up to 133% of FPL. Without expansion, there is a gap in coverage or subsidy assistance in purchasing coverage for those not eligible for Medicaid and yet not eligible for subsidies –incomes between 50% and 100% of FPL (eff. 1/1/2014);

- ACA mandates an EHB package that provides a comprehensive array of services, limiting annual cost-sharing between the employer and the employee (out of pocket cost to employee) to $6,350 for individuals and $11,900 for a family. (Out of pocket limits include deductibles, coinsurance and copayments.) (eff. 1/1/2014);*****

- Requires issuance and renewability of health insurance regardless of person's status (no pre-existing condition exclusions, etc.) and allows premium rating variations by insurers based only on age (limited to a 3 to 1 ratio), geographic area, family composition and tobacco use (limited to 1.5 to 1 ratio) for individual and the small group market and Exchanges (eff. 1/1/2014);

- Limits plan waiting periods for coverage to no more than 90 days; and

- New fee on employer plans to help fund public exchange risks ($63 per covered person) (eff. 1/1/2014).

Employer Mandate/Employer Shared Responsibility—What Does it Mean?

- Every employer of an average of 50 or more "full time equivalent" ("FTE") employees during the preceding calendar year must provide a group policy of health coverage for those employees or be subject to a tax penalty;

- FTE means any employee who worked an average of 30 hours per week during the prior calendar year;

- "Look Back Period" for determining how to compute number of FTE's-- federal government flexible as to period (3, 6, 9 months) but if an employee crosses 30 hr. /wk. threshold, then he must receive coverage. If numbers of FTE's are up and down (close to 50 FTE's over look back period), then err on side of coverage to avoid penalty. Employer needs tracking system to monitor this at all times;

- All full time and part time employees are counted to determine number of FTE's-- seasonal workers and true contract employees (not W-2 employees) are excluded from this calculation. (Total monthly hours of PT employees divided by 130 hrs. per month equals the employer's number of FTE's);

- *When is an employer assessed a tax penalty?* **If** required to comply with Employer Mandate, **and 1)** if coverage is not offered to 95% of all FTE's by an employer **and** an FTE enrolls in an Exchange plan and receives premium assistance from the federal government, **then** the employer of the FTE is assessed a tax penalty of $2000 annually for each FTE it employs (less first 30). **OR 2) If** coverage is offered to all FTE's **but** an FTE enrolls in the Exchange anyway and qualifies for and receives premium assistance from the federal government, **then** the employer is assessed a tax penalty of $3000 annually for each FTE receiving such assistance, capped at an amount equal to $2000 for all FTE's (less first 30);

Employer Mandate/Employer Shared Responsibility—What Does it Mean? (Cont'd)

- *When does an employee qualify for federal subsidy giving rise to penalty?* Individuals with household incomes between 100%-400% of the FPL may qualify for a premium subsidy if they purchase insurance from an Exchange as follows: **if** the individual is not enrolled in his employer's health plan and does not have access to employer-based coverage that **either 1)** provides a "minimum value" (pays at least 60% of covered medical costs --every $1 of medical charges, plan pays for $.60 --most plans pay $.80) **or** 2) if the employer's coverage is "unaffordable"-- priced such that the employee's contribution for single coverage exceeds 9.5% of the individual employee's household income (W-2 income);

- Employees may waive an employer's offer of "affordable" and "minimum value" health coverage and go to an Exchange to purchase coverage but in that event, the employee receives no federal subsidy and the employer is not penalized;

- 400% of FPL is presently approximately $46,000/year for an individual and $100,000/year for a family of 4. Those with incomes less that these amounts but above 100% of the FPL are eligible for federal subsidized insurance premium assistance in the Exchanges. If employee qualifies for Medicaid, no employer penalty is assessed for his obtaining coverage through that program.

- Penalties are assessed by IRS monthly and the Exchange notifies the employer that one of its FTE's has become eligible for and is receiving tax credit assistance, triggering penalty;

- **IMPORTANT: Bad insurance plan design (does not provide required coverage or costs employees too much) defeats purpose of offering group insurance to employees and results in employer penalties.**

Employer Fees:

- Beginning in 2014, employers (plan sponsors) pay a *Transitional Reinsurance Fee* in the amount of $63/member/ year to the federal government. This pool of money funds the reinsurance pool and helps stabilize the state exchanges. In 2015-16, the fee is reduced slightly.

- Beginning in 2014, employers sponsoring plans also must pay a *Patient Centered Outcome Research Fee* of $1/member/year and this fee cannot be shared by the employees. This fee increases to $2/member/year in 2015.

- It is important for all employers, including county employers, to begin reviewing their current plans, to determine if they are grandfathered plans, and even so, be certain they are prepared for the January 2014 requirements for coverage so that the plans will be sufficiently robust so that no county employer will incur penalties for any employee's seeking and receiving federal subsidies at an Exchange.

- If you have questions, please feel free to contact the MAS office and we will either try to get answers or refer you to someone who can help.