The Patient Protection and Affordable Care Act

What Employers Need to be Doing to Successfully Implement the New Law at Their Workplace in 2015

LONG TERM PLANNING

2015 is the fifth full year of the Patient Protection and Affordable Care Act (ACA). NASRO is providing employers with a roadmap that will lay out the provisions of the law that have been delayed, but are now being implemented. The U.S. Departments of the Treasury, Health and Human Services and Labor are continuing to develop regulations and provide guidance. State governments may also interpret the law's provisions differently unless there is clear guidance from the federal agencies. The federal web site, www.healthcare.gov, is a good basic resource for the most recent news on health care reform. In the meantime, this guide will help provide an overview of what can be expected in the years to come.

Important to our Mission

NASRO is a non-profit health services administrator and advocate for small employers from 1-100 employees. Our mission is both broad and specific in support of our members who have all too frequently had their voices drowned out by economic forces in health care represented by the drug companies, the health insurance companies and the hospital associations, whose products and services we buy. While the Affordable Care Act is a good step in health care reform that has been delayed for 50 years, it is only the beginning of the process that needs to take place to limit the costs of health care and health insurance services and to improve the quality of medical outcomes for all segments of our country.

What does the Law Provide?

The ACA is the most sweeping reform of the American health care system since the passage of Medicare for seniors and the disabled, and Medicaid for people living in poverty in the 1960's. While the ACA affects every aspect of the health care system, this overview focuses on the impact to NASRO members and the small business community. The law changes the rules for health insurers in significant ways and expands health care coverage to millions more Americans. With many of the most significant changes coming in 2014, the ACA has had a considerable impact on consumers, hospitals, health care providers, employers, workers, health insurance companies and state and local governments.

The law limits medical underwriting, including pre-existing medical conditions, broadens the use of preventive services beyond just the HMO plans, legislates the percentage of health insurance premiums that must be spent on medical costs and increases the scrutiny of premium increases. In 2014, it mandated that most Americans obtain health insurance. It also expanded public coverage through Medicaid in many states and private coverage through subsidies.

Key Provisions of the Affordable Care Act

We begin with a recap of the many changes that took place in 2014, and continue through 2018. The listing is an overview and not a detailed analysis. There are many other provisions of the ACA that will impact government programs such as Medicare and Medicaid, as well as the overall health care system, that we do not address. More information about these other provisions can be found on the government's ACA web site, www.healthcare.gov and www.cciio.cms.gov or through well-regarded private sources, such as the Kaiser Family Foundation web site at www.kff.org.

NASRO hopes our members and our community will find this information to be a helpful resource as we face the changes that will be necessary in our business operations to help fix our broken health care system.

REVIEW OF 2014

Essential Health Benefits

The ACA established 10 broad categories of "essential health benefits (EHB) "– health services that must be included in all small group and individual plans. The EHB services include ambulatory patient services; hospitalization; prescription drugs; laboratory services; preventive and wellness services, chronic disease management; mental health and substance use disorder services, including behavioral health treatment; pediatric services, including dental and vision care; emergency services; rehabilitative and habilitative services and devices; and maternity and newborn care. The EHB requirements do not apply to grandfathered plans, transitional or grandmothered plans for individuals and small groups, large groups or self-insured groups. The ACA specified that the scope of the EHB benefits package must be equal to the scope of benefits offered under a typical employer plan.

The ACA requires health plans for individuals and small groups to meet four actuarial value categories, also known as the metal tiers; the least rich is the bronze plan with an actuarial value of 60% (i.e., the health plan covers approximately 60% of the total benefit costs); the silver level or tier is 70%, gold is 80% and the platinum level is 90% of all allowed benefits. NASRO used a similar system for our own benefit plans we offer to small employer groups and self-employed people beginning in 1990. Other important benefit thresholds include:

1. Annual deductibles for small groups are generally limited to $2,000 for an individual and $4,000 for a family;
2. Out of pocket maximums were limited to $6,350/$12,700 in 2014 and to $6,600/$13,200 in 2015. They are linked to the annual HSA high deductible health plan out-of-pocket limits in future years.

In addition to the above small group plan requirements, many health insurance companies also ensured their plans were updated for large employers starting with the January 1, 2014 renewals. While large employers are not subject to the Essential Health Benefits standards,

They must comply with the limits on out-of-pocket maximums. Many health insurance companies also ensured that all of their large group plans met the 60% minimum value in 2014 (i.e., the plans cover 60% of the total benefit cost).

Promoting Individual Responsibility and Social Responsibility

Most individuals who can afford to do so are required to obtain basic health insurance coverage or pay a fee to help offset the cost of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption. Since there remain tens of millions who continue to be uninsured, there remains an unfulfilled social responsibility to achieve universal health care as is practiced in every other economically advanced country, except ours.

Making Health Care More Affordable

Subsides to make it easier to afford the never ending rising costs of health care are an important new benefit for millions of Americans who enrolled in new health plans in 2014. People with incomes above 100% and below 400% of poverty level ($11,670 / $46,680 for an individual or $23,850 / $95,400 for a family of four in 2014 and 2015) who are not eligible for or offered other affordable coverage qualify for the subsides. Enrollment remains limited to the government run Exchanges and can not be provided by private Exchanges like provided by NASRO to its members to qualify for the subsides.

There remain difficulties for individuals enrolling through the various state exchanges as well as the exchange run by the federal government. During the open enrollment periods it can be difficult to find a representative to talk to and responses to emails are not automatic. Information provided by call centers can also vary from representative to representative. Government web sites remain works in progress, with a number of states continuing to have parts of the web sites that do not function properly.

It is important to provide the correct annual income figures to the government contractors because if income is underestimated a tax will be owed for all unqualified premium payments made by the government to the health insurance companies.

Health Insurance Company Premium Tax

This tax on health insurers is based on the value of net premiums sold in the U.S. Not for profit insurers are assessed the fee based on half the value of their net premiums.

ACA Reinsurance Fee

This fee supports a transitional reinsurance program for individuals in each state from 2014 through 2016 to stabilize the market while other provisions of the ACA are implemented. All health insurance carriers and third party administrators, on behalf of self-insured group health plans, submit ACA reinsurance fee contributions. In 2014, the ACA reinsurance fee was $63 annually or $5.25 per member per month. In 2015, the fee decreases to $44 annually or $3.67 per member per month.

Waiting Period

Group health plans are prohibited from establishing waiting periods of more than 90 calendar days for coverage.

Eliminating Annual Limits on Health Insurance Coverage

New plans and existing plans are prohibited from imposing annual dollar limits on the coverage of essential benefits an individual can receive. There is an exception for grandfathered individual plans. Non-dollar limits, such as visit limits, are permitted.

Eliminating Discrimination due to Pre-existing Conditions or Gender

Health insurance companies are prohibited from refusing to sell coverage or renew policies, or set premium rates because of an individual's or an individual's dependents' pre-existing conditions or gender. The same prohibition against pre-existing conditions and gender discrimination of small business employees and their dependents apply.

Prevention/Wellness

The HIPPA non-discrimination rules on wellness programs are now part of the ACA. The incentive cap for participation in health-contingent wellness programs is increased to 30% of the total annual premiums for individual coverage. A health-contingent program requires participants to meet certain specified goals or at least show they tried to achieve those goals. Examples are losing weight or decreasing cholesterol levels. For wellness programs focused on preventing or reducing the use of tobacco, the incentive cap increases to 50%.

2015 Employer Mandate for Large Employer Groups

Employers Not Offering Coverage

Employers with an average of 50 or more full-time employees, including full-time equivalents, in the prior calendar year who do not offer coverage to their employees and have at least one full-time employee who receives a premium subsidy through a government exchange, must pay a penalty for each month they do not offer coverage to any of their full time employees (only full-time employees, not full-time equivalents, are included in the calculation of the penalty amount). In 2015, the penalty is $166.67 per month (up to $2,000 for the entire year) per full-time employee. For purposes of calculating the penalty, the first 30 employees are not included. However, for 2015 only the first 80 full-time employees are not included.

Employers Offering Coverage

Employers with an average of 50 or more full-time employees, including full-time equivalents, in the prior calendar year who offer coverage to their employees and have at least one full-time employee who receives a premium tax credit through a government exchange must also pay a penalty for each month an employee obtains coverage and a subsidy through a government exchange. This situation could occur if the employee's share of the premium exceeds 9.5% of the employee's household income or if the plan covers less than 60% of the total cost of benefits. The employer would have to pay up to a $3,000 penalty per year for each full-time employee who receives a premium subsidy from the government. Similar to the situation of employers not offering coverage, only full-time employees, not full-time equivalents, are counted in the calculation of the penalty.

Note: We have just presented the information concerning the basic employer mandate. In addition, there are a number of transition rules that could waive or decrease a potential penalty, depending upon certain criteria being met. One key transition rule applies to employer groups with 50 to 99 full-time employees (including full-time equivalents). If certain requirements are met no penalty will apply for any calendar month during 2015 or any calendar month during the portion of the 2015 plan year that falls in 2016 for these employers if they do not offer coverage or did not offer coverage that meets minimum value (60%). These employers will have to provide such coverage in 2016 and report it in 2017. In 2016, they are required to certify to the IRS that they are eligible for this transition relief. There are additional transition rules relating to dependent coverage, the percentage of covered full time employees and dependents, multi-employer arrangements, etc., that are detailed in the IRS Employer Shared Responsibility FAQ (updated on December 15, 2014) in questions 29 to 39. Due to the complexity of these transition rules, NASRO strongly recommends that large employers review the IRS FAQ and consult their tax accountant or legal counsel to determine if the transition rules apply to their situation.

Reporting on Health Care Coverage

For tax years beginning in 2015, the ACA requires large employers (50 or more full-time employees, including full-time equivalents) to annually report certain information. This includes:

1. Whether the employee was offered minimum essential coverage (MEC); if the plan is fully insured the health insurance company provides this information on Form 1095-B.
2. Whether the employer met the employer shared responsibility requirements to avoid a potential penalty; both fully insured and self-insured large employers will provide this information on Form 1095-C; the insurance company does not complete the form 1095-C.

Basic Information that Large Employers Must Provide the IRS

- The name, address and Employer Identification Number (EIN) of the large employer.
- The name and telephone number of a contact person at the large employer.
- The calendar year for the information return.
- A certification whether the employer offered to its full-time employees (and dependents) the opportunity to enroll to enroll in MEC under an eligible employer sponsored plan, by calendar month.
- The months during the calendar year for which coverage was available.
- Each full-time employee's share of the lowest-cost monthly premium for self-only coverage providing minimum value offered to that employee by month.
- The number of full-time employees for each month during the calendar year.
- The name, address and Tax Identification Number (TIN) – or date of birth if the TIN is not available for each full-time employee during the calendar year and the month(s) during which the employee was covered under the plan. Generally, an individual's TIN is his or her Social Security Number (SSN).
- Any other information the IRS may require by form or instructions.

2016

New Definition of Small Group

The ACA is changing the definition of a small group. Historically, states have defined small groups as having 50 or fewer employees. The ACA changed this definition to 1 to 100 employees beginning in 2014, but gave states the option to retain their existing definitions until 2016.

2018

Excise Tax on High-Cost Plans

Commonly referred to as the “Cadillac Plan” tax, this tax will be effective in 2018: a 40% excise tax on the value of employer-sponsored coverage in excess of $10,200 for individual coverage in excess of $10,200 for individual coverage and $27,500 for family coverage. The dollar thresholds are indexed to the Consumer Price Index (CPI) plus 1% in 2019 and to the CPI only in the years that follow. Retirees who are at least 55 but not yet eligible for Medicare and persons employed in certain high-risk professions such as firefighting, construction, mining, etc. have higher dollar thresholds.

For the Latest Information on health care reform call NASRO at 800-638-8113