The Patient Protection and Affordable Care Act

2015 marks the beginning of the fifth full year of the Patient Protection and Affordable Care Act (ACA). We want to take the opportunity to look ahead and clarify, at a high level, the ways the law's provisions will affect employers.

It is important to note that the federal agencies charged with implementing the ACA (i.e., the Departments of the Treasury, Health and Human Services and Labor) continue to develop regulations and subsequent guidance, and have also delayed some major provisions that affect employers. States 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 starting point for the most up-to-date news on health care reform. In the meantime, we hope this guide will provide an overview of what you can expect in the coming years.

What Does The Law Entail?

The ACA is the most sweeping reform of the American health care system since the advent of Medicare and Medicaid in the 1960s. While it affects every aspect of the health care system, this overview focuses on the impact to HR Knowledge and its clients. 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 occurring in 2014, the ACA has had a considerable impact on consumers, hospitals, health care providers, employers, health insurance companies, and state and local governments.

The law limits medical underwriting, including pre-existing conditions, encourages the use of preventive services, legislates the percentage of premiums that must be spent on medical costs and increases 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 and tax credits; created Marketplaces (aka exchanges) through which individuals and small businesses may purchase coverage; and defined the "essential benefits" that individual and small group plans sold within and outside of the exchanges must cover.

Moving Forward

In the coming year, we expect there will be continued changes to health reform at the state and federal levels, including the expected ruling from the Supreme Court on the availability of subsidies in exchanges run by the federal government.

Key Provisions

The following is a listing of key provisions of the Affordable Care Act, beginning with a recap of the many changes that took effect in 2014, and continuing through 2018. This listing is not intended to be exhaustive or detailed. There are many other ACA provisions that will impact government programs such as Medicare and Medicaid, as well as the overall health care system that are not addressed in this brochure. More information about these other provisions can be found on the government's ACA Web sites, 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.

2014 Recap

Here is a summary of 2014 provisions that will impact employers and consumers in 2015 and beyond.

Essential Health Benefits

The ACA established 10 broad categories of "essential health benefits (EHB)"— services that must be included in all small group and individual market plans, whether offered in a Marketplace or outside of a Marketplace. EHB services include ambulatory patient services; hospitalization; prescription drugs; laboratory services; preventive and wellness services and 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 grand mothered plans in the individual and small group markets, large groups or self-insured groups. The ACA specified that the scope of the EHB package must be equal to the scope of benefits offered under a typical employer plan.

The ACA requires health plans in the individual and small group markets to meet four actuarial value categories, also known as the metal tiers: the least rich plan is the bronze plan with an actuarial value of 60% (i.e., the health plan covers approximately 60% of total allowed benefit costs); the silver level or tier is 70%, gold is 80% and the platinum level or tier covers 90% of all allowed benefit costs. Other important parameters include:

1. Annual deductibles in the small group market are generally limited to $2,000 individual/$4,000 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 changes, the carriers we work with also ensured its plans were updated for large employees starting with January 1, 2014 renewals. While large employers are not subject to EHB, they must comply with the limits on out-of-pocket maximums. The carriers we work with also ensured that all of its large group plans met 60% minimum value in 2014 (i.e., the plans cover approximately 60% of total benefit costs).

Promoting Individual 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 costs of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption.

Establishing Health Insurance Marketplaces (aka Health Insurance Exchanges)

Individuals and buy insurance through a Health Insurance Marketplace. The Marketplaces represent a new, transparent and competitive option where individuals and small businesses can buy affordable The Marketplaces offer a choice of health plans that meet certain benefit and cost standards. States have chosen to either create their own state-based Marketplace (SBM), default to a federally facilitated Marketplace (FFM) or enter into a partnership with the federal government whereby certain insurance regulatory functions and responsibilities remain with the state, although the federal government establishes the overall Marketplace (also an FFM).

Making Care More Affordable
Tax credits to make it easier to afford insurance became available through the Marketplaces for people with incomes above 100% and below 400% of poverty ($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. These individuals may also qualify for reduced cost sharing (e.g., copayments, coinsurance and deductibles).

Increasing Small Business Health Insurance Tax Credit
The second phase of the small business tax credit for qualified small businesses and small non-profit organizations increased the tax credit from 35% to 50% of the premiums paid by employers with fewer than 25 employees (there are other criteria as well). To be eligible for the tax credit, small businesses must provide health insurance for employees through the SHOP — Small Employer Health Options Program — the official name of the Marketplace for small businesses.

Health Insurance Company Premium Tax
This tax on health insurers is based on the value of net premiums sold in the U.S.

ACA Reinsurance Fee
This fee supports a transitional reinsurance program for the individual market in each state from 2014 through 2016 to stabilize the market while other provisions of the ACA are implemented. All health insurance carriers and TPAs, 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 Insurance Coverage
New plans and existing group plans are prohibited from imposing annual dollar limits on the coverage of essential health benefits an individual may receive. There is an exception for grandfathered individual (i.e., nongroup) plans. Non-dollar limits, such as visit limits, are permitted.

Eliminating Discrimination Due to Pre-Existing Conditions or Gender
Insurance companies are prohibited from refusing to sell coverage or renew policies because of an individual's pre-existing conditions. Also, in the individual and small group markets, insurance companies cannot charge higher rates due to gender or health status.

Prevention/Wellness
The HIPAA nondiscrimination 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 - Mandate on Large Employers (Delayed From 2014)

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 tax credit through a Marketplace, 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 Marketplace, must also pay a penalty for each month an employee obtains coverage and a premium tax credit through a Marketplace. 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. Employers would have to pay up to a $3,000 penalty per year for each full-time employee who receives a premium tax credit. 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: The information in this section describes the basic mandate. However, 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 employers with 50 to 99 full-time employees (including FTEs). 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 did not offer coverage or did not offer affordable coverage that meets minimum value (60%). These employers will have to provide such coverage in 2016 and report on it in 2017 (see next section). 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 d 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, we strongly recommend that employers review the IRS FAQ and consult their tax accountants or legal counsel to determine if the transition rules apply to their situation.

Reporting on Health Care Coverage

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

1. Whether the employee was offered minimum essential coverage (MEC); if self-insured, the employer provide this information on Form 1095-C; if the plan is fully insured, your medical carrier may 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 medical insurance carriers will not complete the form 1095-C. More information to follow later in 2015 on how HR Knowledge may be able to assist with this requirement.

The basic information that the large employer must provide to the IRS includes:

- 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 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 calendar 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. Connecticut, Massachusetts, Maine and New Hampshire all retained their own definitions.

2018

Excise Tax on High-Cost Plans

The so-called "Cadillac" 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 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.