

“ACA 101”

Employment-Based Health Benefits

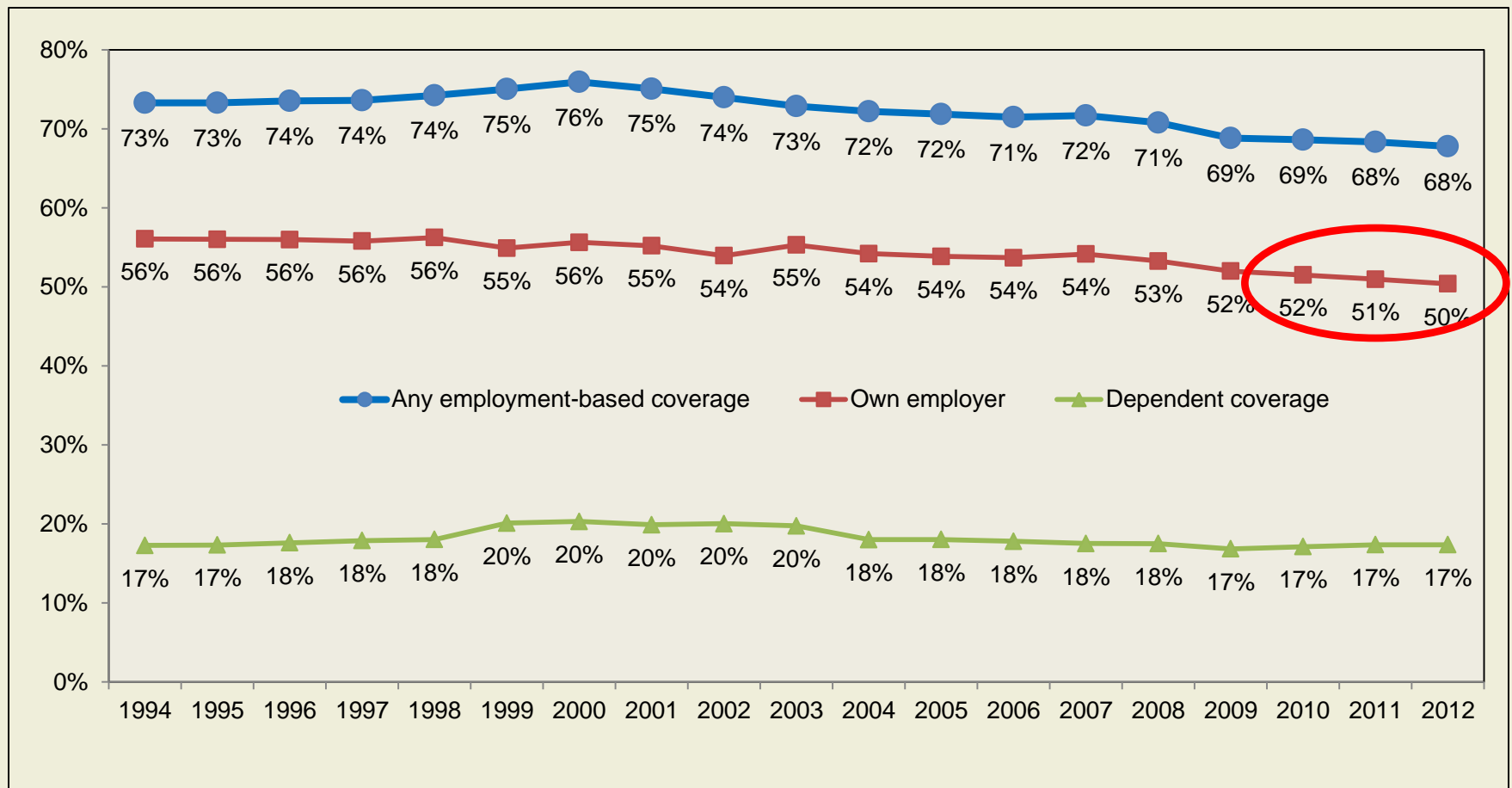
Alliance for Health Reform
March 6, 2015

Paul Fronstin, Ph.D.
Director, Health Research and Education Program
Employee Benefit Research Institute
Washington, DC

Copyright© - Employee Benefit Research Institute Education and Research Fund, 1978-2015. All rights reserved.

The information contained herein is not to be construed as an attempt to provide legal, accounting, actuarial, or other such professional advice. Permission to copy or print a personal use copy of this material is hereby granted and brief quotations for the purposes of news reporting and education are permitted. Otherwise, no part of this material may be used or reproduced without permission in writing from EBRI-ERF.

Percentage of Workers 18-64 with Employment-Based Health Benefits, 1994-2012



Cost Sharing Trending Higher

- Deductibles
- Co-payments for physician office visits
- Co-payments for non-generic prescription drugs
- Increased use of 4+ tiers for pharmacy co-payments
- Increased use of co-insurance for pharmacy cost sharing
- Increased use of CDHPs

Exceptions

- Co-insurance for prescription drugs constant
- Value-based insurance design
- Wellness programs
- Telemedicine

2010

2011

2012

2013

2014

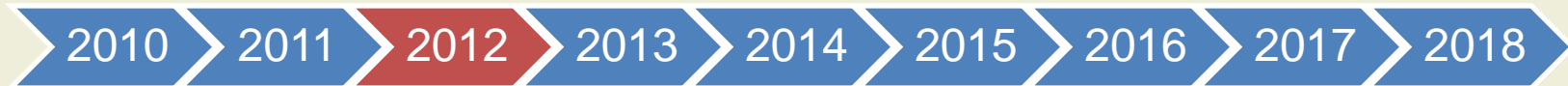
2015

2016

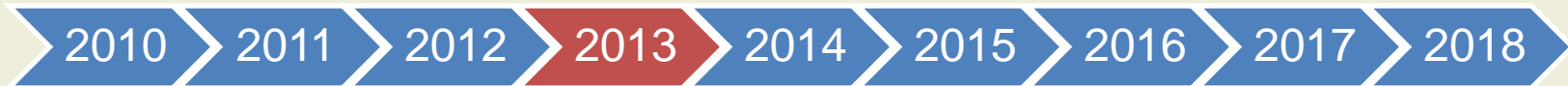
2017

2018

- Emergency care at in-network rates
- Expanded appeal rights
- Expanded dependent coverage to age 26
- Free preventive care
- No rescissions (retroactive cancellation of coverage) except for fraud or intentional misrepresentation of a material fact
- Over the counter (OTC) medications without a prescription no longer reimbursable from a FSA, HRA or HSA
- Patient protections (select own PCP; direct access to OB/Gyn)
- Pre-65 Early Retiree Reinsurance Program (ERRP)
- Removed lifetime limits on “essential health benefits”
- Removed pre-existing condition limits for children
- Restricted annual limits for “essential health benefits” (phased out over 3 years)
- Simple Cafeteria Plan created to provide small businesses an easier way to sponsor a Cafeteria Plan
- Small business tax credit



- Medical loss ratio (MLR) rebates
- Preventive care guidelines for women
- Summary of benefits and coverage (SBCs)
- W-2 reporting for large employers



- Elimination of Part D subsidy deduction in retiree health plans
- Limit FSA contributions to \$2,500
- New 0.9% Medicare tax on \$200,000+ income
- Notice of exchanges
- PCORI excise tax

2010

2011

2012

2013

2014

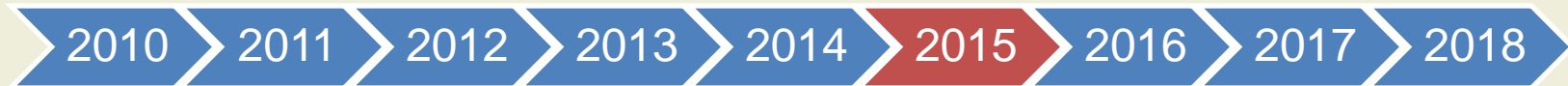
2015

2016

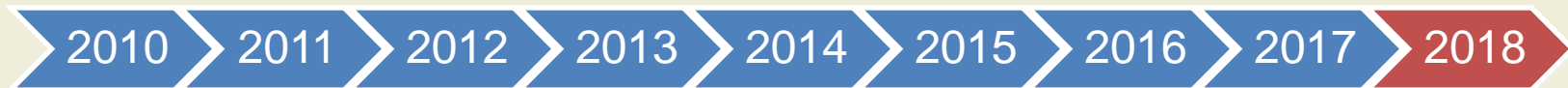
2017

2018

- Coverage for clinical trials
- Eliminating all pre-existing condition exclusions for adults
- Eliminating all remaining annual limits on essential health benefits
- Health insurance exchanges “marketplace” and subsidies
- Increasing small business tax credits
- Individual mandate
- New wellness rules
- No waiting period longer than 90 days
- Out-of-pocket maximums limit \$6,350 employee-only/\$12,700 family (indexed)
- Small group policies must limit deductibles to \$2,000 employee-only/\$4,000 family
 - (eliminated in the 2014 Protecting Access to Medicare Act)
- Small group policies must provide essential health benefits



- Coverage for biological, adopted, step and foster children
- Shared responsibility provision for large employers (Pay or Play Mandate)
- Reporting



- Excise tax on high cost health plans, so called “Cadillac Tax”



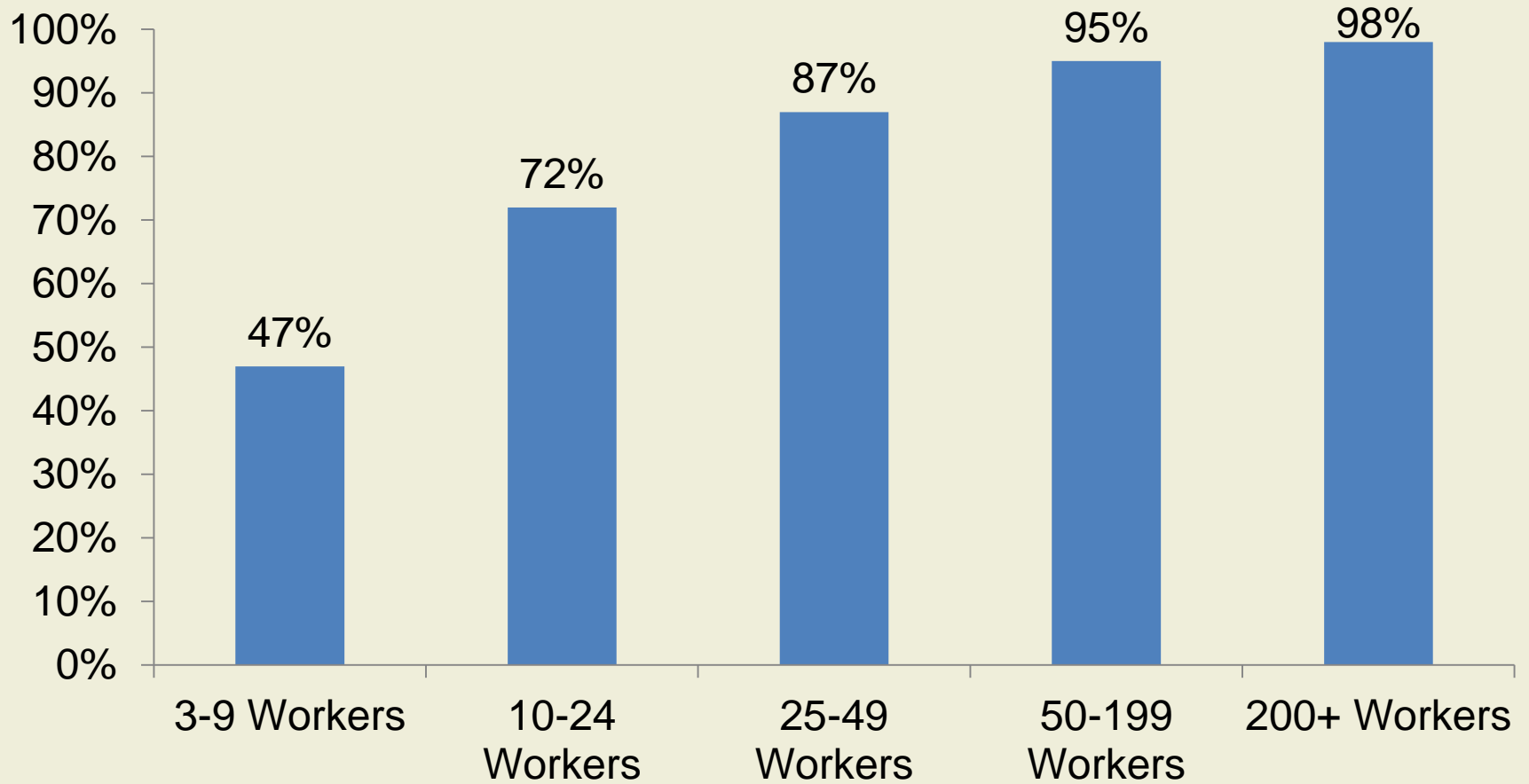
Date unknown

- Auto enrollment for employers with over 200 workers
- Non-discrimination testing for fully-insured group health plans

Employer Shared Responsibility Provision

- Offer coverage or pay \$2,000 per full-time “equivalent” employee (FTE), if at least one FTE receives a premium tax credit
- Must offer to at least 70% of FTEs (95% in 2016)
- Employers with 49 employees or fewer FTEs excluded
- First 30 employees excluded from the assessment
- Only workers employed 40+ hours included in assessment
- Employees of businesses that are under common control are combined to determine how shared responsibility provision applies
- Effective date moved from Jan. 1, 2014 to:
 - 2015: employers with 100+ FTEs
 - 2016: employers with 50-99 FTEs

Percentage of Firms Offering Health Benefits, by Firm Size, 2009



Employer Shared Responsibility Qualifications

- Definition of full-time worker changed.
 - A FTE is an individual employed on average at least 30 hours per week
- Coverage must be offered to worker *and* dependents
 - Dependents defined as children up to age 26
 - Spouses are not dependents
- Minimum essential value must be offered
 - Covers at least 60% of total allowed costs
- Affordable coverage must be offered
 - Unaffordable if employee share of the premium is above 9.5% of employee annual household income
 - Safe harbors include W-2 wages, rate of pay, federal poverty line

Family Glitch

- Affordability determined by premium for employee-only coverage
- Employee may not be able to afford family premium
- Spouse/children are ineligible for premium tax credit when offered minimum value coverage that was deemed affordable
- Spouse/children may be exempt from individual mandate if the lowest-priced policy available costs more than 8% of household income
- Medicaid/CHIP may fill some holes, but 2-4 million spouses/children may be affected

\$3,000 Assessment Applies When...

- Coverage is offered to at least 70% (95% in 2016) of FTEs
- But at least one employee received a premium tax credit

Implications of King v. Burwell

If Supreme Court rules that tax subsidies are not allowed in federal exchanges....

- Shared responsibility assessments will not be imposed on employers not offering coverage
- Assessments are triggered only when an employee receives subsidized coverage on an exchange

Small Business Health Options Program (SHOP Exchanges)

- Marketplace for small businesses to shop for health insurance for employees
- Increase choice of carriers and plan options for both employers and workers
- Allowed employers to set a “fixed” or “defined” contribution
- Key dates:
 - 2014 (full implementation was delayed until 2015) – businesses with up to 50 employees
 - 2016 – businesses with up to 100 employees
 - 2017 – states may allow employers with 100 or more employees into the SHOP exchange

Types of SHOP Exchanges

State-based (14 states): States are responsible for performing all Marketplace functions. Consumers apply for and enroll in coverage through Marketplace websites established and maintained by the states.

Federally-supported State-based (3): This type of exchange is considered to have a State-based Marketplace. States are responsible for performing all functions, except that it will rely on the Federally-facilitated Marketplace IT platform. Consumers apply for and enroll in coverage through healthcare.gov.

State-Partnership (7): States may administer in-person consumer assistance functions. HHS performs the remaining Marketplace functions. Consumers apply for and enroll in coverage through healthcare.gov.

Federally-facilitated (27) : In a Federally-facilitated Marketplace, HHS performs all Marketplace functions. Consumers in states with a Federally-facilitated Marketplace apply for and enroll in coverage through healthcare.gov.

Small Business Tax Credits

- Tax credit to employers < 25 employees & average wages < \$50,000
- 2010-2013: tax credit up to 35% of employers contribution if employer contributes at least 50% of premium
- 2014-beyond: tax credit up to 50% of employers contribution if employer contributes at least 50% of premium
 - Credit available for only 2 years
 - Tax exempt businesses only get 35%
 - Coverage must be purchased through exchange
- In both phases:
 - Full credit for employers with <11 employees & average wages of \$25,000 or less
 - Credit then phases-out as firm size & average wage increases

Workplace Wellness Programs

- Allows employers to provide financial incentives of as much as 30 percent of the total cost of coverage when tied to participation in a wellness program
 - HIPAA allowed 20%
- 50% for interventions designed to prevent or reduce tobacco use
- Financial incentives can come in the form of premium discounts, cost sharing reductions, or other benefits
- Incentives tied to participation in a wellness program and/or by meeting certain health-related standards
- Employers must provide alternative standards for individuals for whom it is unreasonably difficult or inadvisable to meet the standard

Excise Tax on High Cost Health Plans: “Cadillac Tax”

- Beginning in 2018, 40% excise tax on the cost of coverage exceeding \$10,200 (employee-only coverage) or \$27,500 (family coverage)
- Higher thresholds of \$1,650/\$3,450 for early retirees & high risk professions
- Adjustments for age & gender of workers
- Aggregate value includes reimbursements from FSA and HRA, and employer contributions to HSA
- Regulations not yet released, so questions remain on how adjustments will be determined
- Effective Jan. 1, 2018

Source: 19th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care

EBRI : Just the Facts™



www.ebri.org

www.choosetosave.org