

Health Care Reform Under the ACA - What You Need To Know Right Now



July - August 2013
Maine Municipal Employees
Health Trust
1-800-852-8300
www.mmeht.org
The Difference Is Trust

Agenda

Topics to be covered:

- 90 day waiting period limit
- W-2 reporting
- Employer notice requirements
- Individual mandate
- The Exchange
- Wellness program requirements
- Cadillac tax
- Employer mandate / Employer Shared Responsibility (Large Employers)
 - How to determine if you are a Large Employer
 - Calculating Affordability
 - Calculating the penalty



What Is the ACA, and Why Should We Care?

- PPACA = Patient Protection and Affordable Care Act (frequently referred to now as simply the ACA)
- Signed into law on March 23, 2010
- Goals:
 - Increase the rate of health insurance coverage for Americans
 - Reduce the overall cost of health care

Some Changes Have Already Happened

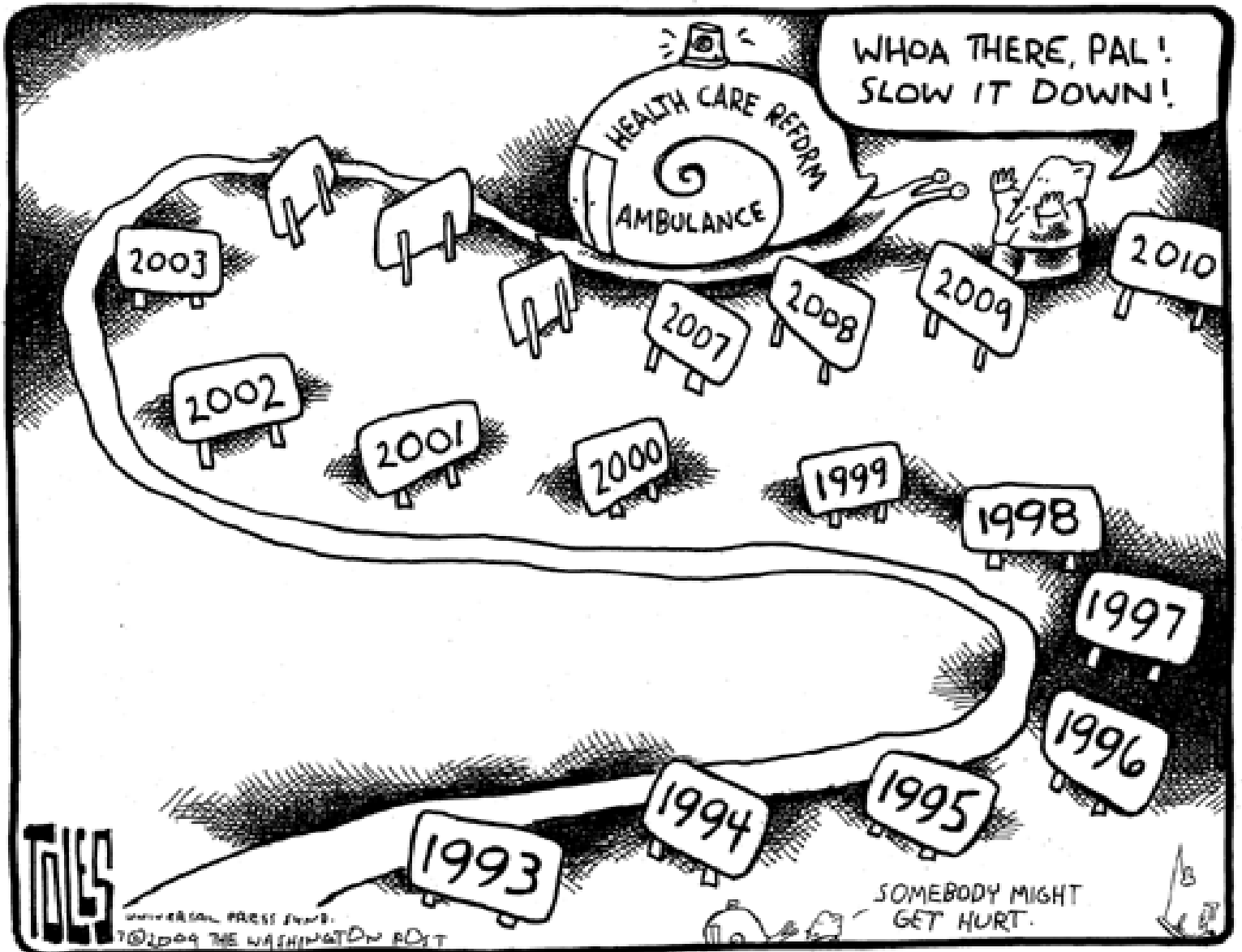
- Mental health parity (groups ≥ 50)
- Children covered to age 26
- No more annual limits on essential benefits
- Summaries of Benefits and Coverage (SBCs)
- FSA annual limits lowered to \$2,500
- W-2 Reporting (>250 W-2 employees)
- Preventive Care covered at 100%
 - Health Trust is in compliance with all applicable changes

Some Changes Are Coming Up Soon (1/1/2014)

- No more lifetime maximums
 - Health Trust is already in compliance
- Maximum 90 Day Waiting Period for health insurance
- Public Exchanges or Marketplace
- Individual Mandate for coverage

Some Changes Are Coming Down the Road

- “Play or Pay” (groups >50)
 - Originally effective 1/1/2014, delayed to 1/1/2015
- “Cadillac Tax”
 - Effective 1/1/2018
- Automatic Enrollment (groups >200)
 - Date TBD



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90 Day Waiting Period Limit

- Effective January 1, 2014, waiting periods for health insurance coverage cannot exceed 90 calendar days
- Each Health Trust employer group determines its own waiting period
- Health Trust coverage begins first day of the calendar month following the end of the waiting period
- As of 1/1/2014, Health Trust will not allow waiting periods to exceed 60 days, with coverage to begin first of the month following
- Health Trust will contact all employers with waiting period for health coverage currently in excess of 60 days
- Coverage will begin on 1/1/2014 for any employee in the midst of completing a longer waiting period



W-2 Reporting of Health Insurance

- Starting with tax year 2012, required for employers with 250 or more W-2 employees
- Optional for employers with fewer than 250 W-2 employees
 - Further guidance required from IRS
 - Six (6) months advance notice required before change
- Some employers are exempt:
 - State and local governments that maintain plans primarily for members of the military and their families
 - Federally recognized Indian tribal governments
 - Tribally chartered corporations wholly owned by a federally recognized Indian tribal government (until further guidance is issued)

W-2 Reporting of Health Insurance

- Purpose of reporting: to provide employees with “useful and comparable consumer information on the cost of their health care coverage” ([www.IRS.gov](http://www.irs.gov))
- Will not cause excludable employer-provided health coverage to become taxable
- Reporting is based on total cost of each individual employee’s coverage
 - Includes employer portion and employee portion of premium
 - Includes cost for dependent coverage, if employee is enrolled in dependent coverage
 - If employee covers Domestic Partner, any amount of premium cost included in employee’s gross income must be included in reported amount

W-2 Reporting of Health Insurance

- Information must be reported in Box 12 of the W-2, Code DD
- Does not include cost of standalone dental or vision plans
- May include employer contribution to HRA, but this is optional
- If employee terminates mid-year, can request W-2
 - Employer must provide W-2 within 30 days, if request made in writing
 - Employer is not required to provide health insurance cost information for mid-year W-2s
- FMI: www.irs.gov => Affordable Care Act Provisions
=> Employers => Large Employers => Reporting



"Do we have a health plan?
Why — Don't you feel well?"

Required Notices Under the ACA

Summaries of Benefits and Coverage (SBCs)

- Must be distributed to all benefits-eligible employees:
 - Prior to the employee first enrolling in health insurance
 - Prior to the beginning of the plan's open enrollment period each year
- Employer is responsible for distributing the SBCs
- If an employee is able to choose among different health plan options, the employer should provide the employee with the SBCs for each health plan in which he/she may enroll
- SBCs must also be provided for EAP
- SBCs for Health Trust plans available on the Trust website: www.mmeht.org (click on the link for SBCs)
- Updated SBCs for 2014 - available by October 1

Required Notices Under the ACA

Notice of Health Care Exchanges

- Must be distributed to all employees:
 - Prior to October 1, 2013, for all existing employees
 - Within 14 days of the employee's start date, for all new employees hired on or after October 1, 2013
 - Notice must be given regardless of the employee's eligibility for employer-sponsored health plan
 - Annual notice is not required at this time
- Employer is responsible for distributing the Notices, and for completing some basic information about the employer-sponsored coverage

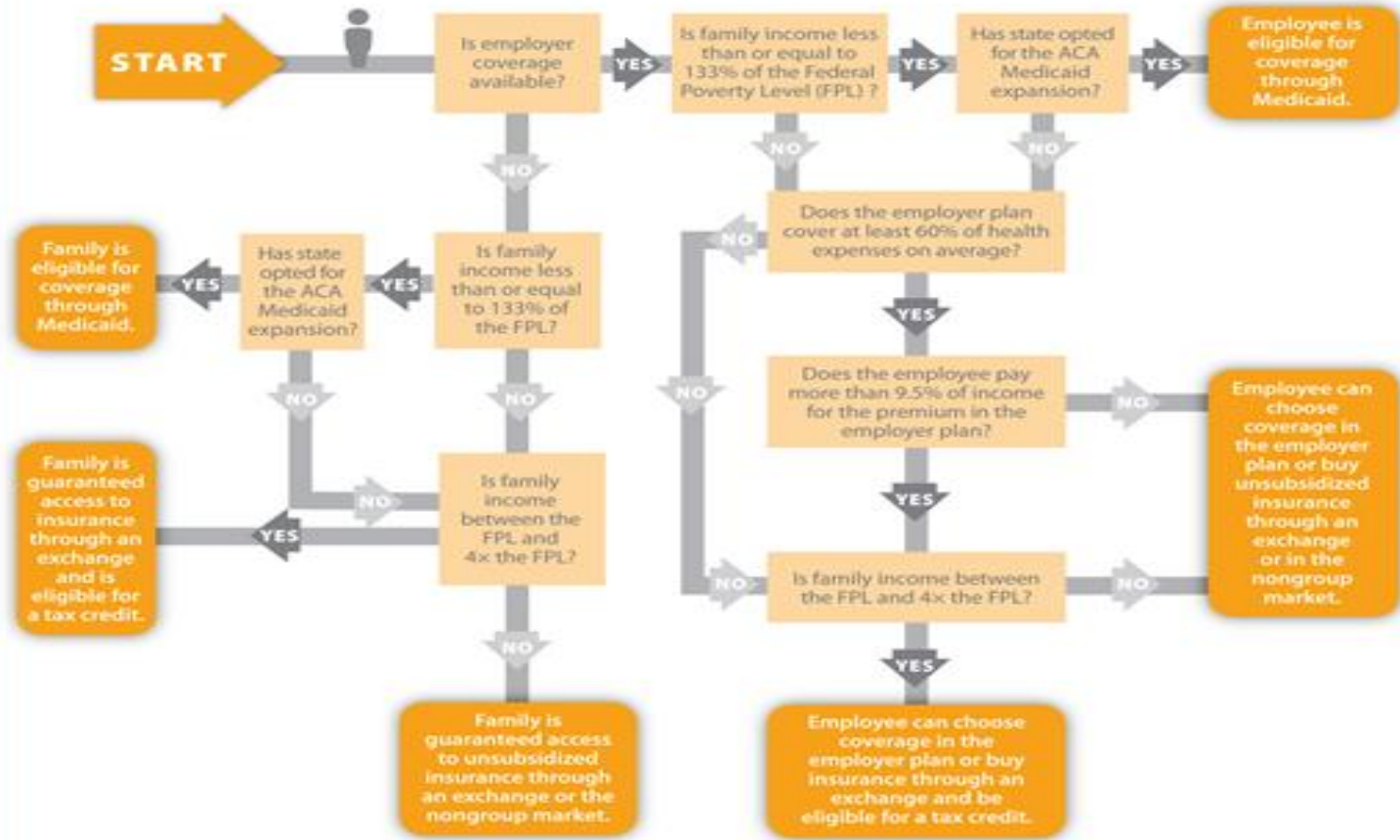
Required Notices Under the ACA

Notice of Health Care Exchanges

- Separate Notices for employers that offer health insurance and those that do not
- May be combined with other communications, as long as they are distributed to all employees
- Model Notices may be found online at:
www.dol.gov/ebsa/healthreform
 - Look under Affordable Care Act Regulations and Guidance, Notice to Employees of Coverage Options
- COBRA Notices will also be updated to include information about the Exchanges

HEALTH COVERAGE UNDER THE AFFORDABLE CARE ACT (ACA)

How to Get Coverage Beginning in 2014



KEY FACTS

- The FPL in 2012 is \$11 170 for a single individual and \$23 050 for a family of 4.
- In 2012 employees paid \$951 on average towards the cost of single coverage in an employer plan and \$4316 for a family of 4.

NOTES

- Some states may have higher income eligibility levels for Medicaid.
- In general, individuals who are currently eligible for Medicaid in their state of residence (who are mostly parents and children today) will continue to be eligible for Medicaid after ACA implementation. Those below 133% of the FPL who will be newly eligible for Medicaid after implementation are mostly adults without dependent children.
- For a discussion of the tax credit that may be available for insurance purchased through an exchange, please see Levitt L. "The Middle Class Tax Break: Hardly Anyone Is Talking About." *The JAMA Forum*. <http://tinyurl.com/chogaip>. August 2, 2012.
- In some cases, children may be eligible for public coverage through Medicaid or the Children's Health Insurance Program (CHIP) while their parents are covered through an employer or an exchange.
- Undocumented immigrants are ineligible for Medicaid and may not purchase coverage in an exchange or receive a tax credit.
- In general, people are required to obtain coverage or pay a penalty, but those whose health insurance premiums exceed 8% of family income (after tax credits or employer contributions are taken into account) will not be penalized if they choose not to purchase coverage.
- Final regulations specifying how dependents of workers with employer coverage available are treated have not yet been issued. Draft rules indicate that the affordability of employer coverage (ie, whether it costs more than 9.5% of income) will be based on the required premium for a single worker rather than family coverage.
- Small businesses may choose to buy insurance through newly created Small Business Health Options Program (SHOP) exchanges or directly from insurers.



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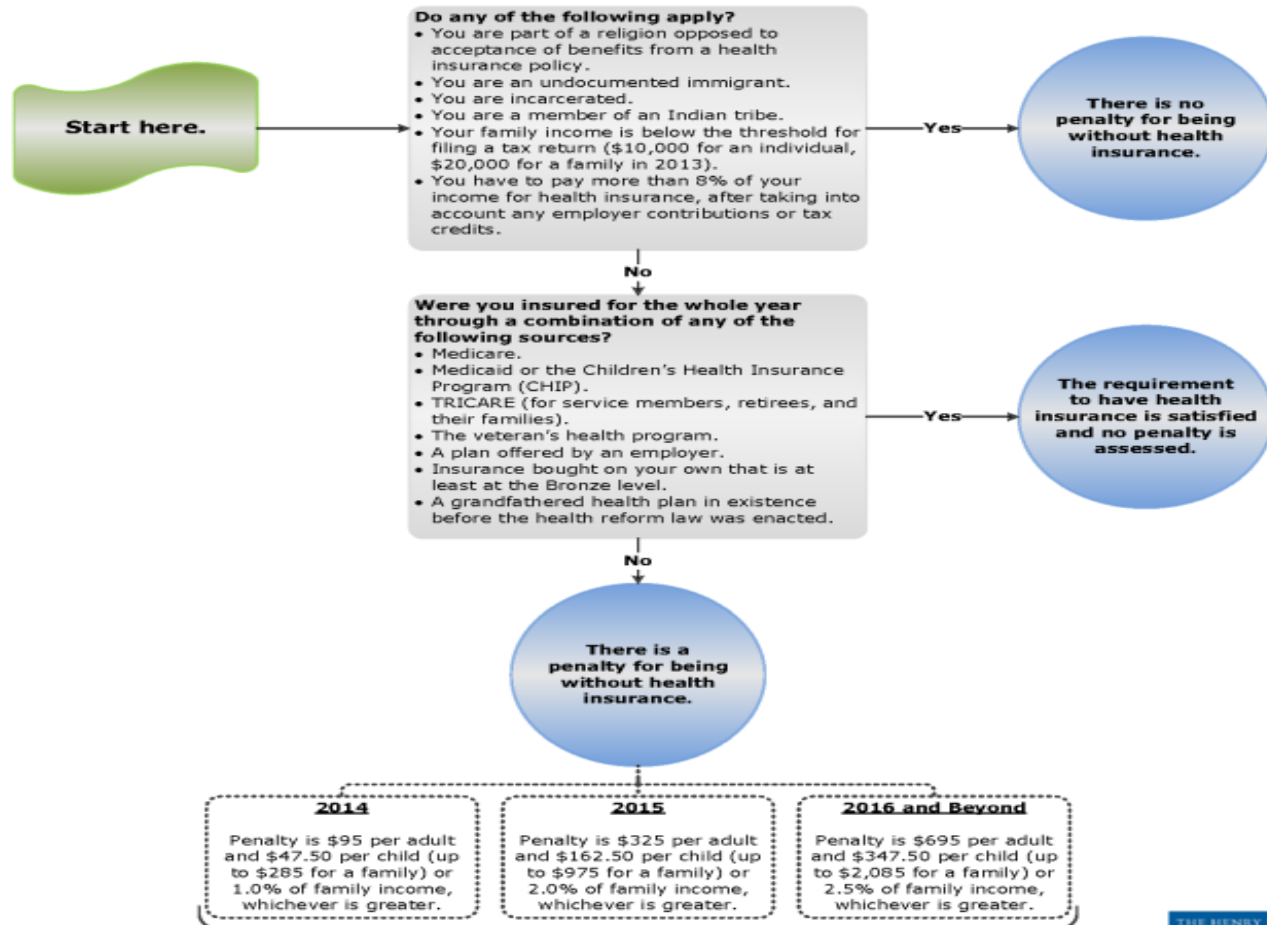
The Individual Mandate

- Starting in 2014, with a few exceptions, individuals will be required to have health insurance
 - Exceptions: Members of Indian tribes; certain religions; undocumented immigrants; incarcerated; family income below threshold for filing income tax; coverage is unaffordable (costs more than 8% of household income)
- Insurance may be through: an employer, Medicare, Medicaid, CHIP, veterans health or Tricare, grandfathered health plan, or individual coverage (through the Exchange or otherwise)
- Coverage must meet certain level of benefits
 - 60% actuarial value - Bronze plan

The Individual Mandate

- Starting in 2014, penalty will be assessed for not having insurance
- Annual penalties:
 - 2014: Greater of \$95 per adult and \$47.50 per child (up to \$285 per family), or 1% of family income
 - 2015: Greater of \$325 per adult and \$162.50 per child (up to \$975 per family), or 2% of family income
 - 2016: Greater of \$695 per adult and \$347.50 per child (up to \$2,085 per family), or 2.5 of family income
 - Note: “Income” = total income in excess of the filing threshold (threshold for having to file annual tax return; in 2013, this is \$10,000 / individual and \$20,000 / family)
- Penalty will be pro-rated by the number of months without coverage
- No penalty for a single gap in coverage of less than 3 months in a year

The Requirement to Buy Coverage Under the Affordable Care Act Beginning in 2014



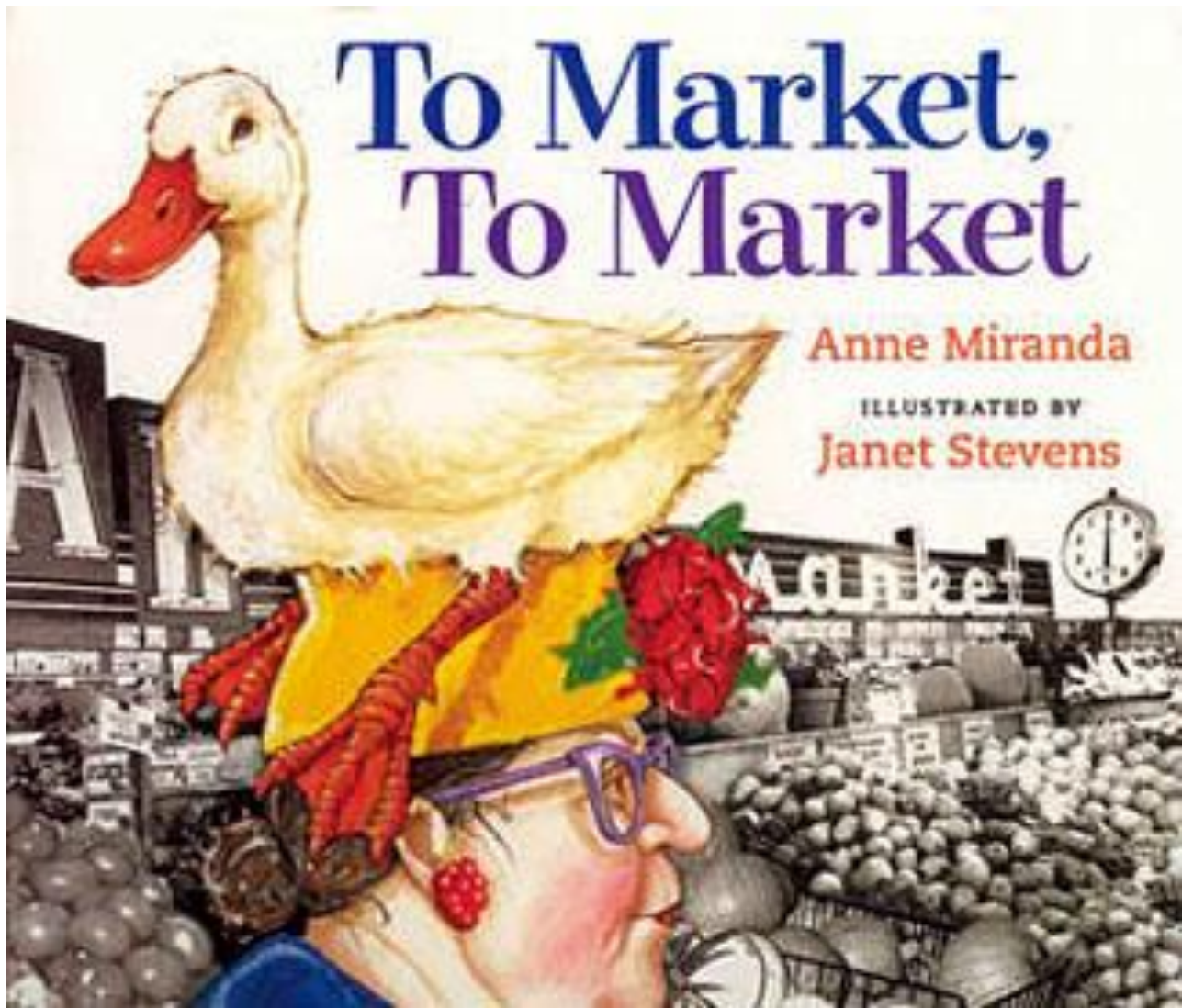
2014	2015	2016 and Beyond
Penalty is \$95 per adult and \$47.50 per child (up to \$285 for a family) or 1.0% of family income, whichever is greater.	Penalty is \$325 per adult and \$162.50 per child (up to \$975 for a family) or 2.0% of family income, whichever is greater.	Penalty is \$695 per adult and \$347.50 per child (up to \$2,085 for a family) or 2.5% of family income, whichever is greater.

Income is defined as total income in excess of the filing threshold (\$10,000 for an individual and \$20,000 for a family in 2013). The penalty is pro-rated by the number of months without coverage, though there is no penalty for a single gap in coverage of less than 3 months in a year. The penalty cannot be greater than the national average premium for Bronze coverage in an Exchange. After 2016 penalty amounts are increased annually by the cost of living.



Key Facts:

- Premiums for health insurance bought through Exchanges would vary by age. The Congressional Budget Office estimates that the national average annual premium in an Exchange in 2016 would be \$4,500-5,000 for an individual and \$12,000-12,500 for a family for Bronze coverage (the lowest of the four tiers of coverage that will be available).
- In 2012 employees paid \$951 on average towards the cost of individual coverage in an employer plan and \$4,316 for a family of four.
- A Kaiser Family Foundation subsidy calculator illustrating premiums and tax credits for people in different circumstances is available at <http://healthreform.kff.org/subsidycalculator.aspx>.



What Is the Marketplace?

- Health Insurance Marketplaces (aka Exchanges) are online markets for buying health insurance from commercial carriers (not government plans)
- Offer a choice of different Qualified Health Plans (QHPs)
- Goal: Consumers choose among different plans
- To date – two carriers in Maine (Anthem and Maine Community Health Options)
- Maine Marketplace will be overseen by federal government
- Serve primarily individuals and small businesses with up to 100 employees
 - Most states will limit to 50 for first 2 years
- Enrollment begins October 1, 2013

SHOP at the Marketplace

- SHOP = Small Business Health Options Program
- Small employers can access tax credits for providing health insurance to employees
 - Note: Local government entities are not eligible for this premium tax credit
- Employer can choose one plan to offer employees
 - In the future: employers can provide employee choice
- Employer must offer coverage to all full-time employees
 - Full-time = at least 30 hours per week
- Availability of premium tax credits and/or cost-sharing reduction for eligible individuals enrolled through the Marketplace
 - Based on projected income, percentage of Federal Poverty Level

What Will It Cost?

- The Congressional Budget Office (CBO) estimates the national average premium in an Exchange in 2016 will be:
 - Individual: \$4,500 - \$5,000 annually
 - Family: \$12,000 - \$12,500 annually
- This will be for Bronze Plan coverage (the lowest of the four levels – 60% actuarial value)
- Premiums will vary by age
- Possible Bronze Plan designs:
 - \$3,500 ded (med/Rx); 80%; \$6,000 OOP
 - \$3,500 ded (med); \$0 ded (Rx); 60% med; 75% Rx; \$6,400 OOP; Rx copays \$10/\$20/\$50/75%

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Health Care Reform and Wellness

- New rules effective January 1, 2014
- Employer-sponsored wellness programs must be nondiscriminatory with regard to health factors
- Two types of employer-sponsored wellness programs:
 - Participatory
 - Health-Contingent
- Health Contingent programs further broken down, into:
 - Activity Only
 - Outcome Based

Participatory Wellness Programs

- Do not offer rewards or financial incentives to members based on health factors
- Do not include conditions for obtaining a reward based on health factors
- Must be made available to all similarly situated individuals in the plan, regardless of health status
- No limits on financial incentives offered for participatory wellness programs
- Examples:
 - Discounts on gym memberships
 - Free health education programs
 - Diagnostic testing, as long as reward is not based on outcome of the test

Health-Contingent Wellness Programs

- Offer rewards or financial incentives to members who satisfy a standard related to a health factor
- Health-contingent wellness programs must:
 - Be reasonably designed to promote health or prevent disease
 - Have a reasonable chance of improving the health of, or preventing disease in, participants
 - Not be overly burdensome
 - Not be a way to discriminate based on health factors
 - Not be highly suspect in the method chosen to promote health or prevent disease
 - Offer a “reasonable alternative standard” to qualify for the same incentive, if member does not meet original health-related standard

Health-Contingent Wellness Programs

- Two types of Health-Contingent wellness programs:
 - Activity Only - reward member for completing an activity related to a health factor (examples: walking program, diet program, smoking cessation program)
 - Outcome Based - reward member for attaining or maintaining a specific health outcome (examples: quitting smoking, achieving weight loss goal, attaining specified biometric screening result)
- Maximum award allowed under these programs:
 - 30% of the total cost of employee-only coverage under the plan, for a wellness program offered in connection with a group health plan/insurance coverage
 - 50% of the total cost of employee-only coverage, for wellness programs designed to prevent or reduce tobacco use



The Cadillac Tax

- Effective January 1, 2018
- Imposes a 40% excise tax on high cost health insurance plans, with annual premiums in excess of:
 - \$10,200 for single coverage
 - \$27,500 for family coverage
 - Tax is on amount above \$10,200 / \$27,500
- Higher thresholds for “high risk” professions and employers with disproportionately older population
- Tax will be assessed against:
 - health insurance issuer (fully insured plans)
 - plan administrator (self-insured plans)
- Further guidance will be issued by the IRS, with regard to possible adjustment of the thresholds, and mechanism for payment of the tax



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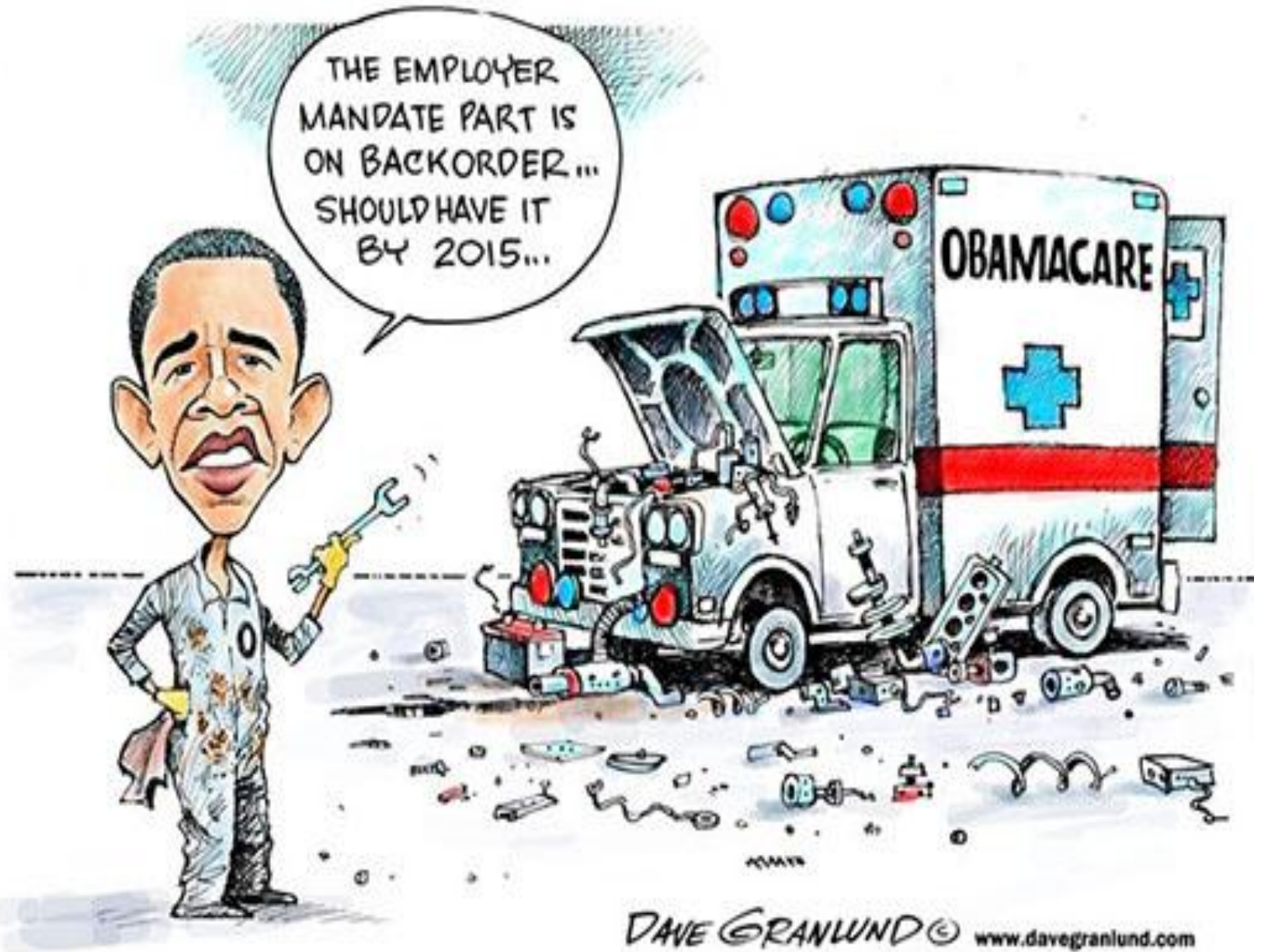


What Is “Play or Pay”?

- Originally effective January 1, 2014; postponed to January 1, 2015
- Employer Shared Responsibility
- Applies to “large employers” – those with at least 50 full-time (or full-time equivalent) employees
 - “Full-time” employees defined as those working 30 or more hours per week
 - “Full-time equivalents” (FTEs) counted when determining if group is a Large Employer, but do not all have to be offered coverage
 - Many rules regarding how to determine number of FTEs and eligibility for coverage

What Is “Play or Pay”?

- Not a **mandate**, but
- Imposes a **penalty** on large employers that either:
 - **Do not offer coverage** to substantially all eligible full-time employees (defined in the regs as employees working 30 hours or more per week); or
 - **Do offer coverage**, but that coverage does not meet key criteria



What Is the Penalty, and Who Will Have To Pay It? (1)

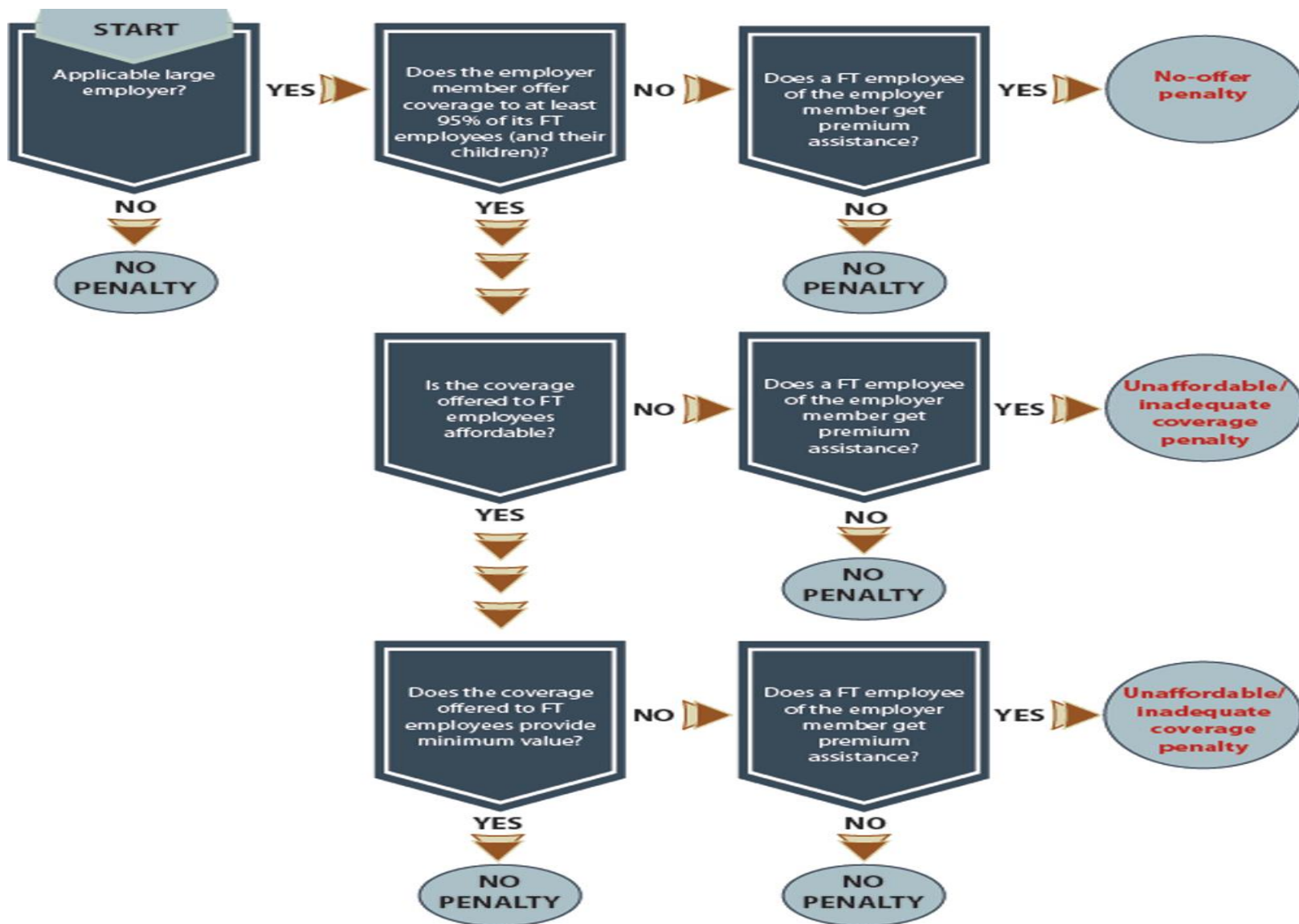
- An employer that **does not offer** Minimum Essential Coverage to “substantially all” full-time employees will be responsible for paying a penalty **if:**
 - at least one full-time employee obtains coverage through the Exchange, **and**
 - that employee receives a subsidy to help pay for coverage
- Penalty is equal to \$2,000 annually for each full-time employee employed by the employer, not counting the first 30 employees

What Is the Penalty, and Who Will Have To Pay It? (2)

- An employer that **does offer** Minimum Essential Coverage to “substantially all” full-time employees will be responsible for paying a penalty **if**:
 - at least one full-time employee obtains coverage through the Exchange, **and**
 - that employee receives a subsidy to help pay for coverage
- Penalty is equal to **the lesser of**:
 - \$2,000 annually for each full-time employee employed by the employer, not counting the first 30 employees, **or**
 - \$3,000 annually for each full-time employee that enrolls in coverage, and receives a subsidy, through the Exchange

How Can A Large Employer Avoid the Penalty?

- A large employer may avoid the penalty by doing all of the following:
 - Offer **Minimum Essential Coverage** to “substantially all” full-time employees and (after 2014) their dependents
 - Ensure that the plan provides **Minimum Value**
 - Ensure that the employee’s premium contribution for self-only coverage for the lowest-cost, Minimum Value plan is **Affordable**



What Is “Minimum Essential Coverage”?

- Minimum Essential Coverage includes coverage under employer-sponsored plan
- Must be offered to “substantially all” eligible full-time employees
- “Substantially all” = at least 95% of eligible employees (i.e., employees working 30 or more hours per week)
- After 2014, coverage must also be offered to dependent children to age 26
- Health Trust plans all provide Minimum Essential Coverage

What Is “Minimum Value”?

- Minimum Value = actuarial value of at least 60%
- Plan’s share of the total allowed cost of benefits provided under the plan is at least 60% of the costs
- Proposed “safe harbors” for determining Minimum Value:
 - \$3,500 ded (med/Rx); 80%; \$6,000 OOP
 - \$4,500 ded (med/Rx); 70%; \$6,400 OOP; \$500 ER contrib to HSA
 - \$3,500 ded (med); \$0 ded (Rx); 60% med; 75% Rx; \$6,400 OOP; Rx copays \$10/\$20/\$50/75%
- Health Trust plans all provide Minimum Value

When Is Coverage “Affordable”?

- Employee’s premium contribution for self-only coverage for the employer’s lowest cost, Minimum Value coverage may not exceed 9.5% of household income
 - Difficult for employers to know household income
 - Employers may use one of three “Safe Harbors” instead of actual household income
 - Federal Poverty Level (2013 annual FPL for single = \$11,490)
 - Form W-2 (as noted in Box 1 of that year’s W-2)
 - Rate of Pay (employee’s hourly rate x 130)
- Affordability will be determined at the individual employer level

Recap – How Can Large Employers Avoid the Penalty?

- Minimum Essential Coverage
- Minimum Value
- Affordability

Remember:

- Employer is only subject to penalty **IF** at least one employee enrolls in coverage, **and** receives a premium subsidy / tax credit, through the Exchange (now referred to as the Health Insurance Marketplace)



Who Is Eligible for a Subsidy Through the Exchange?

- Employee is eligible for subsidy if:
 - Between 100% and 400% of Federal Poverty Level;
 - Not eligible for coverage through a government-sponsored health insurance programs such as Medicaid or CHIP;
 - Not eligible for employer-sponsored coverage; or, eligible for employer-sponsored coverage but such coverage is considered to be **unaffordable** or does not provide minimum value

Determining Affordability - Federal Poverty Level Safe Harbor

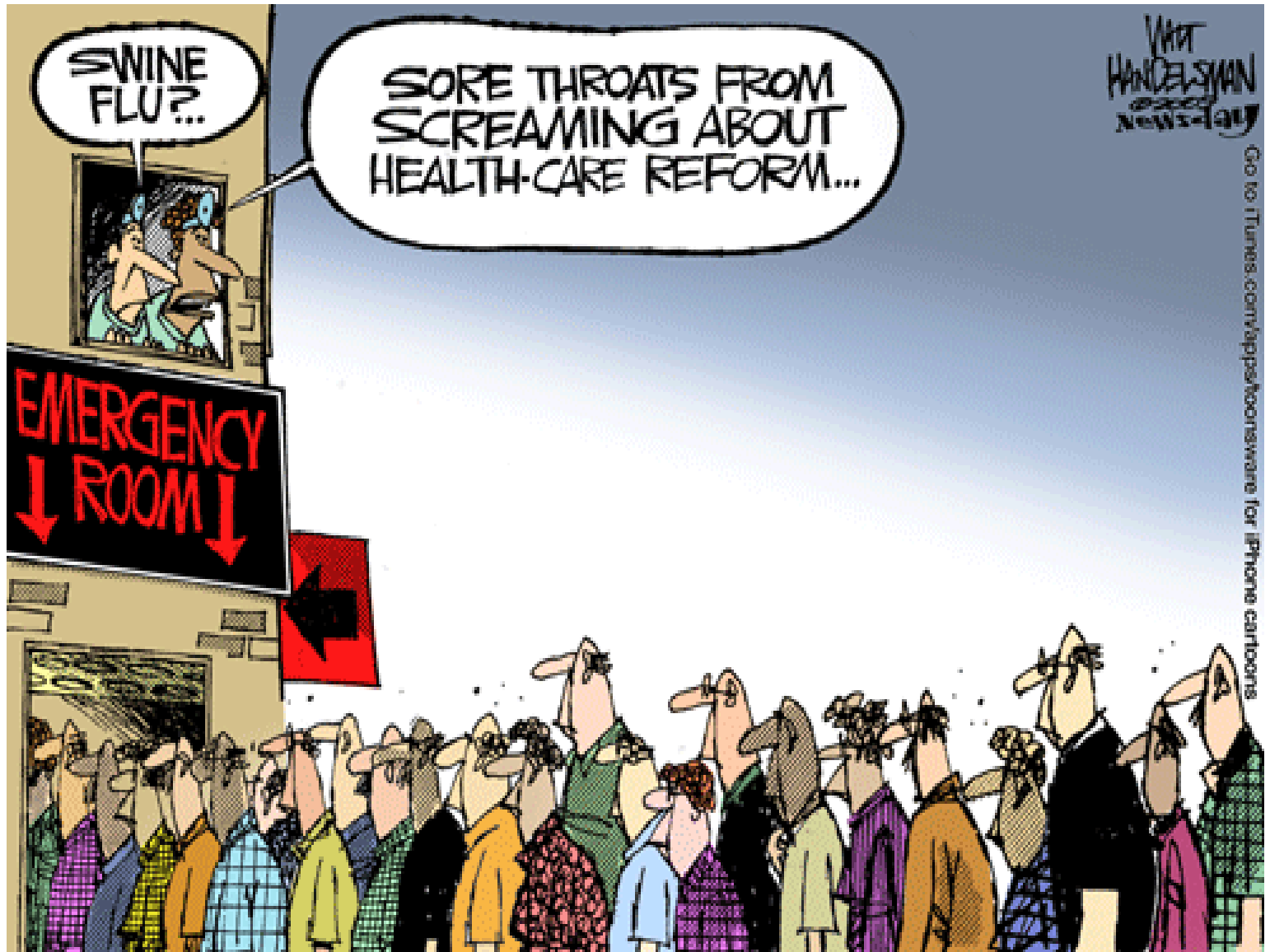
- Using the Federal Poverty Level “safe harbor” method for calculating whether a plan is Affordable:
 - Single FPL = \$11,490 (annual)
 - 9.5% of that = \$1,091.55 (annual)
 - Employee’s premium contribution for self-only coverage cannot exceed \$90.96 per month
 - Based on 2013 FPL

Determining Affordability - W-2 and Rate of Pay Safe Harbors

- Using the W-2 and Rate of Pay safe harbors will require the employer to look at the **lowest paid employee** in each contribution category, to determine whether coverage is Affordable
- If Affordable for the lowest paid employee, will be Affordable for all others

Will You Be Subject to a Penalty?

- If a large employer offers coverage that meets the definitions of **Minimum Essential Coverage**, **Minimum Value**, and **Affordable**, to **substantially all** (at least 95%) of its eligible **full-time employees** (working 30 or more hours per week), those employees **and their dependents** will not be eligible to receive a subsidy through the Exchange
- If no employees receive a subsidy, then the employer is not subject to a penalty
- All MMEHT health plans constitute Minimum Essential Coverage, and all provide Minimum Value
- Affordability will be determined at the individual employer level



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*Please note that the Maine Municipal Association
and the Maine Municipal Employees Health Trust
are sharing this information to assist you with
your compliance planning.*

*We recommend that you contact
your legal counsel
with specific questions relating to this law.*



QUESTIONS??

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