OEA **EDUCATION POLICY RESEARCH & MEMBER ADVOCACY** Bulletin

The Affordable Care Act: Review and Upcoming Changes

You are likely hearing (or will hear) about many changes coming to the insurance world due to the Affordable Care Act (ACA). This bulletin outlines the major changes that have already happened and those that are forthcoming.

* Please note that provisions with a star in front of them only apply to non-grandfathered health plans. Members should ask the treasurer whether their plan is grandfathered or non-grandfathered under the ACA.

2010

DEPENDENT COVERAGE EXTENDED TO AGE 26
Until 2014, grandfathered plans do not have to offer this extension if the child has coverage available through his/her own employer.

PROHIBITION OF PRE-EXISTING CONDITION EXCULSION FOR CHILDREN UNDER AGE 19

BAN ON RESCINDING ENROLLEE COVERAGE
Individuals can no longer be dropped from insurance based on health status.

* BAN ON LIFETIME LIMITS FOR ANY HEALTH PLAN PARTICIPANT

* PHASE OUT OF ANNUAL LIMITS ON ESSENTIAL HEALTH BENEFITS

2012

MINIMUM LOSS RATIO REBATES (August 1, 2012)
The ACA set minimums that insurers need to spend towards direct medical expenses versus administrative costs for the group health market. None of our locals have been impacted by this at this point.

* WOMEN'S PREVENTIVE CARE SERVICES (1st plan year on or after August 1, 2012)
A host of preventive services for women, including no cost-sharing on contraceptives (typically the generic) are added to the preventive care list.

UNIFORM SUMMARY OF BENEFITS AND COVERAGE (First open enrollment period beginning after September 23, 2012)
All employees eligible for benefits should receive a summary document of each plan offered to them which outlines various cost-sharing scenarios.

2013

W-2 REPORTING FOR COST OF BENEFITS (January 1, 2013)
Employers that issue 250 or more W-2s have to put the total cost (employee and employer portion) of all benefit plans in the prior year on each employee's W-2.

HEALTH FLEXIBLE SPENDING ACCOUNTS (FSAs) LIMITED TO $2,500 (January 1, 2013)
FSAs that do not follow a calendar year will be impacted in the first plan year that begins in 2013.

EMPLOYERS MUST NOTIFY EMPLOYEES OF THE EXCHANGES (October 1, 2013)

PATIENT-CENTERED OUTCOMES RESEARCH (PRCORI) FEES (July 31, 2013)
A $1 fee per life covered (employees and their dependents enrolled in coverage) by the medical benefits is due for plan years ending before January 1, 2013. This fee increases to $2 per life covered in 2014 and will increase with inflation in subsequent years.

2014 (All effective January 1, 2014)

WAITING PERIOD FOR BENEFITS LIMITED TO 90 DAYS

ELIMINATION OF ANNUAL LIMITS FOR ESSENTIAL HEALTH BENEFITS

* COST SHARING LIMITED TO HSA MAXIMUM
Medical plan out-of-pocket costs for network benefits will be limited to the IRS limit on the maximum out-of-pocket costs for a health savings account (HSA) qualifying high-deductible health plan. As of 2013, these limits are $6,250 for single coverage and $12,500 for family coverage.

INCREASE IN THE AMOUNT OF INCENTIVE/PENALTY THAT CAN BE APPLIED FOR WELLNESS PROGRAM PARITICPATION INCREASES FROM 20% to 30% AND UP TO 50% FOR TOBACCO CESSATION PROGRAMS.

EMPLOYEE AUTOMATIC ENROLLMENT
Employers are required to enroll new full-time employees in health coverage unless they specifically sign paperwork to opt out of the group health plan.

EMPLOYERS MANDATED TO OFFER HEALTH COVERAGE FOR FULL-TIME EMPLOYEES
A "full-time" employee is defined as one working, on average, 30 hours a week or more. This may be different from how employers currently define full-time employees. This mandate is for medical and prescription drug only. Dental and vision benefits are mandated for pediatrics only.

PENALTIES APPLIED FOR FAILURE TO OFFER HEALTH COVERAGE
Employers with 50 or more full-time equivalent employees will be charged an annual penalty of $2,000 per full-time employee who is not offered health coverage, minus the first 30 employees. There is also a safe harbor that employers will not be charged this penalty if they offer coverage to 95% of full-time employees.

INDIVIDUALS MANDATED TO HAVE QUALIFYING HEALTH COVERAGE
Individuals who do not have qualifying health coverage will be assessed a fine. Exceptions are made for very low income individuals.

PENALTIES APPLIED FOR FAILURE TO PROVIDE AFFORDABLE, MINIMUM VALUE, ESSENTIAL BENFITS
Employers cannot just offer any level of benefits to employees to avoid paying a fine. Employers who do not provide affordable, minimum value, essential health benefits are assessed a fine of the lesser of $3,000 per employee who purchases a plan in the exchange and receives a tax premium credit OR $2,000 for each full-time employee, minus the first 30.
Note: Most OEA local plans will not have met the minimum value and essential benefits requirement, as this does not apply to the large group market. However, there may be some cases (most likely classified staff) where members are not offered "affordable" coverage. Employers must provide notice to employees that they provide affordable coverage to full-time employees, so members should be made aware of whether they will qualify for a premium tax credit.

TRANSITIONAL REINSURANCE PROGRAM FEES (December 15, 2014)
This is a temporary fee applied to group health plans to help stabilize the individual market which is expected to see a large increase in high-cost individuals. This fee will be $63 per covered member on the plan (per belly button), not just per employee. The reinsurance fee will be applied in 2015 and 2016, but at a yet to be determined lesser amount.

* CLINICAL TRIALS COVERAGE – Group benefit plans have to include as a covered benefit the insured's participation in high-quality clinical trials to treat cancer and other life-threatening conditions.

2018

CADILLAC TAX
Plans with benefit levels above $10,200 single and $27,500 family will be subject to a 40% excise tax for the amount that exceeds the referenced thresholds. Thresholds for the Cadillac tax apply to all premiums (employee and employer share), and all employee and employer contributions to flexible spending accounts (FSA), health savings accounts (HSA), and health reimbursement arrangements (HRA), but not stand alone dental and vision plans. The threshold for the Cadillac tax will increase with inflation.

ADDITIONAL QUESTIONS/CONCERNS MEMBERS MAY HAVE:

I am hearing that insurance premiums are going to increase by 30% in 2014 because of the ACA. Is this true?

- Insurance premiums in the individual and small group market may increase in the 30% range, but probably not for OEA locals. This is because many of the benefits provided in the individual and small group market were bare boned, and they now have to offer specific benefits outlined in the ACA. Our locals are primarily in the large group market and already have benefit plans that provide the extent of coverage that the ACA is making mandatory.

Will our members be considered "full-time" employees per the ACA?

- Employees considered full-time per their contracts with the district, will also be defined as full-time employees under the ACA. Summer break will not be counted when figuring the number of hours a person works and school breaks (e.g. spring break, winter break, etc.) will be counted as "paid leave."

Does the ACA mandate that employers have to offer coverage to their full-time employee's spouses?

- No. The ACA mandates that employers have to offer health benefits to employees and their eligible dependents, but this does not include spouses. Because of this, we are seeing many brokers trying to push spousal waiver and carve-out language. Their argument is that this is what everyone in the private sector is doing.

What exactly are the exchanges and how do they work?

- In 2014, the exchanges are supposed to make it easier for people to purchase individual and small group insurance. The ACA sets a minimum standard for health plans that can be sold on the exchanges so people know what they are buying and can compare plans. People cannot be denied coverage for pre-existing conditions in the exchanges. Also, premium costs will be limited so high users don't have to pay more than others. The maximum difference that can be charged to older age individuals is three times the cost of a plan for a young individual. Tobacco users can be charged a 50% higher premium compared to a non-tobacco user.
- The majority of people who will purchase a plan on the exchanges are those without employer-sponsored health benefits. Depending on household income levels, individuals purchasing plans on the exchanges may qualify for a tax credit to help pay for their premiums. Households below 250% of the federal poverty line will receive cost-sharing subsidies to help pay for copays, deductibles, etc., in addition to the premium tax credits.
- Individuals with access to employer-sponsored coverage will only be eligible for premium tax credits on the exchanges if their group coverage does not meet the minimum value, minimum essential benefits, or affordability tests. The minimum value and minimum essential benefits tests do not apply to the large group market that most of our locals are in. So, the only way our members may qualify for a premium tax credit

is if they are not offered what is considered "affordable" coverage. Affordable coverage is defined by looking at the cost of the employee's share of the single premium. If the employee's contribution to the single premium exceeds 9.5% of that employee's household income, and that employee's household is at or below 400% of the federal poverty line (in 2013 400% of the federal poverty line is $47,760 for a single and $94,200 for a family of four), the employee will qualify for a premium tax credit in the exchange. If an employer offers more than one choice of benefits, the affordability calculation would be based on the cheaper plan available to the employee, regardless of whether the employee opts for a more expensive plan.

- Four tiers of coverage will be offered on the exchanges. Beginning with the richest benefits, the tiers are platinum, gold, silver and bronze. Premium tax credits are based on the silver level of coverage. Selection of a plan tier above the silver level will come at an additional cost to the subsidized premium.
- Each state will have designated "navigators" to assist people in purchasing a plan on the exchange. Navigators cannot tell individuals which plan to pick, but they can help them understand the differences between their options. Ohio opted to have the federal government run our state exchange.

Will any of my members qualify for a premium tax credit through the exchanges?

- The vast majority of OEA members will not qualify for a premium tax credit through the exchanges. This is because the affordability test for people with access to a group health plan is based on the employee's cost for a single premium. For the majority of our members, the contributions for single coverage relative to their income levels will not exceed 9.5% of household income.
- It is possible that some of our classified staff may have family incomes qualifying them for a premium tax credit through the exchanges. Here is a link that is helpful for people to gage whether they may qualify for a premium tax credit in the exchange: http://healthreform.kff.org/subsidycalculator.aspx
- Make sure employees keep in mind when considering the exchanges (if they will qualify for a premium tax credit) that they need to also consider the out-of-pocket expenses of the exchange plan versus the employer plan. Most likely, the out-of-pocket maximums on the employer plan will be lower than the exchange plan.

Resources

Kaiser Family Foundation: http://kff.org/health-reform/

U.S. Department of Health & Human Services: http://www.healthcare.gov/

U.S. Department of the Treasury: http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions