PCA Retirement & Benefits, Inc.

Healthcare Reform: The Affordable Care Act – Implications for Employers and Individuals

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The Patient Protection and Affordable Care Act of 2010, also known as the PPACA, the ACA or even "ObamaCare" in some circles, is a transformational change in the health insurance industry and will impact virtually every American. Many provisions of the 2000-page law are already in place, but some of the more notable and impactful changes occur in 2014 and beyond. While this article is not intended to thoroughly explain the entire law or certainly digest the over 10,000 pages (and climbing) of corresponding regulations, it will hopefully provide readers with enough information to answer questions and to seek resources for further information.

Elements of the law already in place

There are certain portions of the law that have already taken place or are already being phased in, including:

- Creating interim small employer tax credits available to for-profits through income taxes and for nonprofits through payroll withholding
- Requiring medical plans to allow children younger than age 26 the ability to access their parent's medical plan (if provided), at the employees' own cost
- Eliminating pre-existing condition exclusions for covered children under age 19
- Requiring larger employers to report the cost of healthcare coverage on form W-2
- Requiring carriers to create uniform "Summary of Benefits" that are the same across all plans and carriers nation-wide
- Requiring plans to offer preventive care services (including the widely controversial birth control components) without cost-sharing (that is, no co-pays)
- Placing limits on flexible spending accounts (to raise taxes to help pay for the ACA)
- Establishing several provider and insurance carrier fees (to help pay for the ACA)
- And many other provisions.[1]

Some of these elements have been welcomed, while others have been (and continue to be) challenged; regardless, these provisions are law – employers, carriers and plans nationwide must comply.

However, the more notable portions of the law, the mandates and the health insurance exchanges, will be effective beginning in January of 2014. The balance of this article will address these provisions and how they will impact both employers and individuals.

The Mandates

The mandates are just that: requirements to have (individuals) or to provide and/or to communicate information about (employers) minimum essential health insurance coverage. There are exceptions to the mandates, but most must comply.

The intent of the ACA is that all US citizens would have access to affordable and acceptable health insurance, either through individual plans or through employer-provided plans. In order to facilitate

[1] *International Foundation of Employee Benefit Plans*: Affordable Care Act (ACA) Implementation Time Line

this, a series of regulations, taxes and new insurance marketplaces, called health insurance exchanges, have been established: basically, "…starting in 2014, all Americans must have a minimum amount of health insurance or be taxed by the government."[2]

Employer mandate – Large employers

The ACA will require organizations with more than 50 employees to provide "minimum essential" and "affordable" health coverage to at least 95% of their employees.[3] The terms *minimum essential* and *affordable* are important.

> Minimum Essential: the health plan must cover at least 60% (see Bronze-level tier referenced later) of the total cost of benefits.[4]
>
> Affordable: the premium for covering the employee (that is, single-only coverage) must be less than 9.5% of the employee's W-2 income.[5]

The 50 employee count is important as well: the ACA requires employers to count all employees working at least 30 hours a week and to count all employees working with related employer groups (such as churches and schools commonly controlled). Employers that do not comply will pay one of two types of penalties.[6]

> 1. The "Play or Pay" Penalty (also known as the 'sledgehammer tax'):
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> "If an employer does not offer coverage…and at least one employee acquires coverage through an exchange and qualifies for premium assistance…then the employer will pay an excise tax of $2,000 per full-time employees", minus the first 30 employees.[7]
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> 2. The "Unaffordable Plan" Penalty (also known as the 'tack-hammer tax'):
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> "If an employer does in fact offer coverage, but the plan reimburses less than 60% of the total medical costs incurred by the participant…or if the employer's required contribution for single-only coverage exceeds 9.5% of his W-2 income…then such a plan is deemed 'unaffordable.' The employer will be assessed a penalty of $3,000 per employee who opts out of an 'unaffordable' plan and is certified by the exchange as qualifying for premium assistance due to his family income level."[8]

While employers are allowed to disregard counts of seasonal employees (such as those who work for a church camp or periodic mission), benefits managers of larger employers are urged to learn more about

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[2] BlueCross BlueShield of Georgia: Health insurance exchanges: What to expect in 2014, May 2013.
[3] BlueCross BlueShield of Georgia: Employer mandate factsheet, May 2013.
[4] Ibid.
[5] Ibid.
[6] J. Smith Lanier & Co.: An Outline of the Employer Share Responsibility Rules of the PPACA, January 2013.
[7] Ibid.
[8] Ibid.

the definitions and penalties. Either of the two penalties listed above could meaningfully impact decisions on whether to provide health insurance to employees.

Employer mandate – Small employers

Important for churches and schools throughout the PCA, *the ACA does not require employers with fewer than 50 employees to provide healthcare coverage*. However, the ACA does require all employers of any size to provide employees with information about the health insurance exchanges (explained below) and to help employee(s) complete health insurance exchange paperwork as necessary.

Individual mandate

The ACA generally requires individuals to have minimum essential coverage (60% value, see Bronze-level tier referenced later) or pay a penalty. Employer-provided insurance, insurance purchased on a health insurance exchange, qualifying individual coverage and government insurance programs (such as Medicare, Medicaid, Tricare, etc.) each qualify as minimum essential coverage. Further, those with medical cost-sharing plans (such as Christian Care Medi-Share and Samaritan Ministries), undocumented immigrants, American Indians, or those in financial hardship are exempted from the penalty.[9] The individual penalty for not having insurance coverage is modest to begin with (greater of $95 or 1% of taxable income in 2014), but climbs in future years.[10]

Health Insurance Exchanges

One of the more unique features of the ACA is the creation of "Health Insurance Exchanges, which are marketplaces where individuals and smaller employers will be able to shop for insurance coverage. They must be setup by October 1 of 2013 for policies that will go into effect on January 1, 2014."[11] A few states (17) are creating their own health insurance exchanges (under federal guidelines) or are partnering with the federal government to do so. However, most states have opted for the federal government to implement and run them. Initially, exchanges will be open only to individuals buying their own coverage and to small employers – most Americans will continue to receive coverage from their employers, not from insurance purchased on the health insurance exchanges.[12]

Tax Credits for Individuals

While any individual or family (without insurance provided through their employer) may purchase from the exchange, some may qualify for tax credits to assist in paying premiums for plans on the exchange. Such credits will be available (payable in advance of income tax filing based on estimated adjusted gross income) to individuals and families with adjusted gross income below 400% of the federal poverty level

[9] *Aetna Health Reform Connection*: Q & A on the Individual Mandate, accessed May 2013.
[10] BlueCross BlueShield of Georgia: Health insurance exchanges: What to expect in 2014, May 2013.
[11] *Kaiser Health News*: A Guide to Health Exchanges, January 2013.
[12] Ibid.

(FPL). The health insurance exchange application process will guide applicants in working through the details of whether a credit is available (FPL varies by number in the household).[13]

Types of Plans on the Health Insurance Exchanges

"Under the ACA, health insurers must offer plans within health insurance exchanges that meet distinct levels of coverage in the 'metal tiers': bronze, silver, gold and platinum. Each metal tier corresponds to an actuarial value…calculated by computing the ratio of total expected payments by the plan for essential health benefits and cost-sharing rules, such as deductibles, co-insurance, co-payments and out-of-pocket limits."[14] For example, a bronze plan is required to have an actuarial value (AV) of 60 percent with covered individuals being expected to pay 40 percent through deductibles, co-pays and other cost-sharing features. Silver plans, with an AV of 70 percent, will have cost-sharing of 30 percent. Likewise, Gold plans will have an AV of 80 (cost-sharing of 20 percent) and Platinum will have an AV of 90 (cost-sharing of 10 percent). Bronze-level plans will feature the least expensive premiums, but they will have the most out-of-pocket cost-sharing responsibility each year. At the other end of the spectrum, the Platinum plans will feature the most expensive premiums, but provide the least annual out-of-pocket cost-sharing responsibility.[15]

"Skinny" Plans

While the ACA intended for Bronze-level plans to be the minimum essential health insurance coverage, recently certain catastrophic health plans known as 'skinny' plans, have been referenced in several news stories. In fact, *The Wall Street Journal* mentioned that, "employers are increasingly recognizing they may be able to avoid certain penalties under the federal health law by offering very limited plans that can lack key benefits such as hospital coverage." [16]

The plans would have to provide preventive care services, but may offer little else. "Federal officials say this type of plan, in concept, would appear to qualify as acceptable minimum coverage under the law."[17] Instead of facing a $2000 penalty for every full-time employee, employers offering plans that do not meet the minimum value…would be liable for a $3,000 penalty only for those eligible employees who use federal premium subsidies {tax credits} to buy coverage in an {insurance} exchange.[18] These types of plans may provide realistic options for organizations who employ a large number of lower wage workers and who have not traditionally offered health benefits.[19] While this may be a viable consideration for larger PCA employers who have not traditionally provided uniform health insurance (such as schools), it is expected that most PCA organizations will eventually either provide ACA-qualifying group health

[13] J. Smith Lanier & Co.: For Your Information – Health Reform…Looking Ahead, August 2012.
[14] *Becker's Hospital Review*: The Metal Tiers of PPACA Health Coverage – Bob Herman, February 2012.
[15] Ibid.
[16] *The Wall Street Journal*: Employers Eye Bare-Bones Health Plans Under New Law – Christopher Weaver and Anna Wilde Mathews, May 20, 2013.
[17] Ibid.
[18] *Business Insurance*: Limited Plans may satisfy reform law rule – Jerry Geisel, June 2, 2013.
[19] *The Wall Street Journal*: Employers Eye Bare-Bones Health Plans Under New Law – Christopher Weaver and Anna Wilde Mathews, May 20, 2013.

insurance or provide funding for their employees to purchase traditional health insurance either through the individual, small group or health insurance exchange marketplace.

What does this mean for me and my church? In short, it depends.

For PCA organizations with 50 employees, including those with staffing levels near this number or those associated with more than one group (such as churches that own or are related to schools), it is very important that more is learned about the ACA and that efforts are made to comply. Such organizations are encouraged to reach out to local benefit agents, brokers and advisors as soon as possible. If the organization has not traditionally offered health insurance to all employees working at least 30 hours a week, efforts will need to be made to add minimum insurance (or to adjust employee hours or employment headcount) in time. While the deadline for the employer mandate is January 2014, the "look-back period" for employee counts (and the number of hours worked each week) actually begins October 1, 2013.

For PCA organizations with 49 or fewer employees (the vast majority), the ACA is still important. Such employers will see group medical plans cancelled and re-issued before January 2014 to insure that they are structured to comply with minimum essential coverage as outlined under the law. In addition, all employers of any size (including churches) must inform their employees of the health insurance exchanges and provide assistance in completing paperwork. For churches that have only one employee, the health exchange notice is still required. However, it is very likely much less scrutiny will be on such small employers, as regulators will be pre-occupied with enforcing compliance by larger organizations. Sample notices and guidance may be obtained from local agents or through the resources referenced at the end of this article.

For individuals, the options available under the ACA can vary as well. If one works for a larger employer with 50 or more employees, the ACA will standardize and enhance coverage but will likely mean the health insurance exchange will not be available: since larger employers must provide minimum essential, affordable coverage, the health insurance exchanges will likely not be an option. However, individuals working for smaller employers will be able to access the exchange to purchase health insurance and may be eligible for tax credits to help lower insurance premiums. Based on household income levels and family size, many PCA families may qualify for the tax credits.

Guidance and Further Information

There are numerous resources available, governmental and otherwise. Local insurance agents should be able to provide some information. State insurance offices can provide information as well. However, most information is provided by the government organizations charged with implementing and regulating compliance with the ACA: the Department of Labor (DOL), Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), and the Internal Revenue Service (IRS). The government resource most helpful for individuals and small employers is www.healthcare.gov, which is operated by HHS. Further, the PCA Retirement & Benefits, Inc. website at www.pcarbi.org will provide links and PDF documents for a number of resources as well, including guidance provided by those referenced within this article and resources from www.healthcare.gov.