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The Affordable Care Act
The Bottom Line Facts

ACA: What Employers Need to Know

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DEFINITIONS

- **Minimum Essential Coverage (MEC)**
  - **Very Loose Definition**
    - Employer Sponsored Group Medical Plans
    - Individual Medical Plans
    - Government Sponsored Plans (i.e. Medicare)
    - Grandfathered Health Plans
    - Self-Funded Student Health Coverage
    - State High Risk Pool Coverage
  - **Doesn't Include Specialty Plans (i.e. Dental, Vision, etc.)**
  - **Avoids Individual Mandate and $2,000 Employer Penalties**

DEFINITIONS

- **Actuarial Value (AV)**
  - **Actuarial Calculation**
    - Expressed as a Percentage
    - Normalized Over a Large, Average Population
    - The Percent of Total Claim Dollars Expected to be Paid for a Given Benefit Plan
    - Example: $1,000,000 Of Claims Incurred By a Plan and Plan Pays Out $600,000 Equals a AV of 60%
  - **Applies to Small Group Plans Only – 50 or Less**
  - **Government Calculator Available**

DEFINITIONS

- **Actuarial Value (AV) Continued**
  - **Small Groups Restricted to Metal Plans Only**
    - Bronze 58 – 62% AV
    - Silver 68 – 72% AV
    - Gold 78 – 82% AV
    - Platinum 88 – 92% AV
  - **Small Groups Not Required to Offer Coverage**
  - **Small Group Plans, if Offered, Must Include Essential Benefits**

DEFINITIONS

- **Essential Benefits - Federal**

  Ambulatory Services
  Emergency Services
  Hospitalization
  Maternity and Newborn Care
  Mental Health/Substance Abuse/Behavioral Disorders
  Prescription Drugs
  Rehabilitative Services and Devices
  Lab Services
  Preventative Services
  Chronic Disease Management
  Pediatric Services (including oral and vision)

DEFINITIONS

- **Minimum Value (MV)**
  - Nearly Identical to Actuarial Value (AV)
  - Applies Only to Large Groups (51+)
  - Large Employers Must Offer a Health Plan with a MV of at least 60% - Essential Benefits Not Required
  - Employer Penalty for Not Offering an “Affordable” Health Plan of MV to Employees

DEFINITIONS

- **Affordability**
  - The Plan Does Not Charge the Employee More Than 9.5% of Their Income for Single Coverage
  - 9.5% of the Federal Poverty Level (FPL) for a Single Person Can Substitute (approx. $90/Month)
  - Does Not Apply to Employee's Cost for Dependent Coverage

DEFINITIONS

- **Grandfathered Plans**
  - If Provisions and Cost Sharing of a Plan Have Not Changed Since Passage of The Affordable Care Act, The Plan is Considered Grandfathered.
  - Minor Changes Are Permitted, But Extremely Easy to Lose Grandfathered Status
  - Grandfathered Plans Still Subject to Some Provisions, But Not Others

ACA – 2014 Issues

- **Summary of Benefits & Coverage (SBCs)**
  - For Plan Years in 2014
  - Provide at Open Enrollment
  - Penalties not imposed on plans and issuers working diligently and in good faith to comply

ACA – 2014 Issues

- **Waiting Period**
  - No more than 60 days (30+ days in reality) in CA for Fully Funded Groups
  - No more than 90 days (60+ days in reality) for Self-Funded Groups
  - Penalty for Non-compliance - $100/day/individual
  - Limited Exceptions – Be Careful

ACA – 2014 Issues

- **Fees**
  - **PCORI (Patient Centered Outcome Research Fee $2/Member/Year**
  - **Traditional Reinsurance Fee (2014 – 2016)**
    - $5.25/Covered Individual/Month
    - Tax Deductible Per IRS
    - Annual Enrollment Count Due to HHS by 11/15
    - Billed by HHS
    - Currently Under Scrutiny - May be Delayed

ACA – 2014 Issues

- **No Pre-existing Condition Limits**
- **No Limits on Essential Health Benefits**
  - Insured, non-grandfathered small groups & individuals
  - Not required for large group plans
- **Clinical Trials for Qualifying Individuals**
- **Individuals Must Maintain "Minimum Essential Coverage"**

ACA – 2014 Issues

- **Employers May Provide Premium Discounts for Wellness Program Participation**
  - Up to 30%
  - Higher for non-smoking programs

- **Amend FSA Plans for $2,500 Limit**

ACA – 2015 Issues

- **Employer Shared Responsibility (Pay or Play) Delayed Until 2015**
  - **Employers With More Than 50 Full Time Equivalent Employees Not Offering Minimum Essential Coverage That is Both:**
    - Affordable, and
    - Provides Minimum Value
  - **Will Be Subject to a Penalty**

ACA – 2015 Issues

- **Pay or play (con't)**
  - **Penalty 1** - $2,000/EE/Yr. (minus 30) Applies if Employer Does Not Offer Minimum Essential Coverage (MEC) To at Least 95% of Full Time Employees
  - **Penalty 2** - $3,000/EE/Yr. for Any Employees Receiving a Subsidy from an Exchange
    - Applies Only if Coverage is Unaffordable, OR
    - Does Not Meet Minimum Value (60%)

ACA 2015 Issues

- Reporting Requirements Associated with Pay or Play Delayed Until 2015
- Auto Enrollment for Plans with 200+ Employees Delayed Indefinitely
- Non-discrimination Testing Delayed With No Definite Timeline Indicated

ACA 2016 – 2018 Issues

- **2016 – Small Group Expansion to 100 Employees**
- **2017 – Large Employers Allowed to Join Exchanges**
- **2018 – Cadillac Tax**
  - 40% Excise Tax on Rich Benefit Plans
  - Imposed on Cost over $10,200/$27,500
  - Paid by Insurers for Fully Funded Plans
  - Paid by Plan Sponsor for Self-Funded Plans

How Do Exchanges Work?

- **Employees Eligible for Employer Sponsored Health Plans that are Affordable and Provide Minimum Value are NOT Eligible for Credits or Subsidies on the Exchanges**

Applying to the Exchange

- **Employer's Contact and Tax ID Number**
- **Whether Employee is Full Time (130 hours/month)**
- **Whether Employer's Plan Provides Minimum Essential Coverage**
- **What is the Employee's Contribution for the Lowest Cost Employer Provided Plan**

Applying to the Exchange

- **Exchange Must Verify Information Provided by the Employee About Enrollment and Eligibility for Employer's Plan**
  - From Any Electronic Data Source Available and Approved by HHS
  - Connectivity Not Yet in Existence

Applying to the Exchange

- **If Information Provided by the Employees Cannot be Verified by the Exchange**
  - Exchange Selects Statistically Significant Random Sample of Such Applicants, and
  - Notifies the Applicant that Exchange may Contact Any Employer Identified on the Application to Verify the Information Provided
  - If No Response From the Employer, Exchange Makes a Decision Based Upon the Individual's Attestation

Applying to the Exchange

- **If Exchange Determines an Employer is Subject to a Penalty**
  - Exchange Notifies the Employer
  - Identifies the Employee
  - Notifies the Employer that Employee is Eligible for a Subsidy
  - Notifies the Employer that They May be Subject to a Penalty
  - Notifies the Employer of Right to Appeal
  - Employer Has 90 Days to Respond

Small Group ACA Mandates

Applies to employers with 2-50 eligible employees in 2014 (2-100 in 2016)

1. Member-level age rating structure
2. Family rating
3. Risk Adjustment Factor (RAF)
4. Rating region standardization
5. Metal levels
6. Rate Calculation
7. Grandfathered vs. Non-Grandfathered
8. Annual Limits

1. Member-level age rating structure

- Children ages 0-20 charged the same rate
- Adults ages 21 to 63 rated in single year age bands
- Adults ages 64 and older charged the same rate

- The 3:1 age band: For adults between the ages of 21 to 63, the oldest members cannot be charged more than three times what the youngest members are charged

Pre-ACA Census:

DOB	***Family Tier***	***Company Zip Code***
8/8/65	EE+Fam	92606
7/5/80	EE Only	92606
6/5/75	EE+Spouse	92606
3/2/85	EE+Child(ren)	92606

1. Member-level age rating structure

ACA Census:

DOB	***EE or DEP***	***Member Zip Code***
8/8/65	EE	92614
9/7/65	DEP (SP)	92614
2/15/05	DEP (CH)	92614
4/4/06	DEP (CH)	92614
7/3/07	DEP (CH)	92614
5/3/11	DEP (CH)	92614
7/5/80	EE	92604
6/5/75	EE	92606
3/5/75	DEP (SP)	92606
3/2/85	EE	92614
8/1/12	DEP (CH)	92614

2. Family rating

- Families with more than 3 dependent children will only be charged for the first 3 oldest children, each additional dependent child will not be charged

3. Risk Adjustment Factor

- No longer assessed, all groups receive 1.0

4. Rating Region Standardization

- All health plans must adhere to standardized rating regions in California.

Rating region 1:	Alpine, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, Tuolumne
Rating Region 2:	Napa, Sonoma, Solano, Marin
Rating Region 3:	Sacramento, Placer, El Dorado, Yolo
Rating Region 4:	San Francisco
Rating Region 5:	Contra Costa
Rating Region 6:	Alameda
Rating Region 7:	Santa Clara
Rating Region 8:	San Mateo

4. Rating Region Standardization

Rating Region 9:	Santa Cruz, Monterey, San Benito
Rating Region 10:	San Joaquin, Stanislaus, Merced, Mariposa, Tulare
Rating Region 11:	Madera, Fresno, Kings
Rating Region 12:	San Luis Obispo, Santa Barbara, Vetura
Rating Region 13:	Mono, Inyo, Imperial
Rating Region 14:	Kern
Rating Region 15:	Los Angeles (906-912, 915, 917, 918, 935)
Rating Region 16:	Los Angeles (Zip codes not listed above)
Rating Region 17:	San Bernardino, Riverside
Rating Region 18:	Orange County
Rating Region 19:	San Diego

5. Metal levels

- All health plans offering coverage to small businesses with Non-Grandfathered health plans, whether they participate in the exchanges or not, are required to offer four standardized levels of coverage.

Bronze:	60% actuarial value
Silver:	70% actuarial value
Gold:	80% actuarial value
Platinum:	90% actuarial value

- These plans also cannot have an out-of-pocket maximum (OOPM) greater than $6,350 per member, or $12,700 per family

6. Rate Calculation (per member - i.e.: employee, spouse, child1, child2, child3)

- Health plan book rate (1.0) x Plan value (.88) x Area (.90) x Age factor (1.22) = Rate

- $300 (1.0) x .88 = $264 x .90 = $238 x 1.22 = $290 (assessed per member)

7. Grandfathered vs. Non-Grandfathered

- Employers with an Unlimited Grandfathered benefit plans can keep their plan even though it does not meet minimum value or OOPM greater than $6,350/$12,700

- Employers with an Unlimited Non-Grandfathered benefit must move to a plan that fits within a metal level and has an OOPM of $6,350/$12,700 or less

8. Annual Limits

- Annual limits are no longer allowed regardless of Grandfathered / Non-Grandfathered status

Large Group ACA Mandates

Applies to employers with 51+ full time equivalent employees in 2014 (101+ in 2016)

1. Minimum Value
2. Grandfathered vs. Non-Grandfathered
3. Annual Limits

1. Minimum Value

- All Unlimited Non-Grandfathered health plans must meet Minimum Value (Minimum Value = 60% Actuarial Value)

2. Grandfathered vs. Non-Grandfathered

- Employers with an Unlimited Grandfathered benefit plans can keep their plan even though it does not meet minimum value or OOPM greater than $6,350/$12,700
- Employers with an Unlimited Non-Grandfathered benefit must move to a plan that meets Minimum Value and has an OOPM of $6,350/$12,700 or less

3. Annual Limits

- Annual limits are no longer allowed regardless of Grandfathered / Non-Grandfathered status

Grandfathered Plans– What ACA Provisions Do Apply?

- Elimination of lifetime limits on essential benefits
- Phase-out of annual limits on essential benefits by 2014
- Extending eligibility for dependents up to age 26
- Elimination of all pre-existing condition limitations in 2014
- Limitation of benefit waiting periods to no more than 90 days in 2014 (60 days in CA if fully funded)
- Insurer rebates if minimum loss ratio standards not met (insured plans only)
- Assessment of “Cadillac plan tax,” if applicable
- Assessment of employer mandate charge, if applicable

Grandfathered Plans– What ACA Provisions Don't Apply?

- Immunizations and preventative care with no cost sharing
- Cover emergency services without pre-authorization or increased cost sharing if out of network
- Provide internal and external review processes for certain denied claims
- Eliminate discrimination in favor of highly compensated individuals
- Prohibit discrimination based on participation in a clinical trial
- Apply certain federal rating limitations in 2014 for small group plans (state rating rules will still apply)
- **Provide essential benefits in the small group market in 2014**
- **Abide by cost sharing and deductible limits in 2014**

Employee ACA Training Tools

Open Enrollment

- Participate in the enrollment process
- Review the coverage that your employer offers before making a decision about purchasing health insurance through the Exchange (Covered California)
- Make sure you understand what's changing. Use the information and tools provided to become educated about your options and to make well informed decisions.

Open Enrollment

- You will hear a lot about the Covered California including the availability of federal subsidies based on your income. In most cases, if your employer offers coverage that meets certain minimum coverage and the coverage is considered affordable, you will not be eligible for a subsidy in the marketplace.

Open Enrollment

- Make sure you take the time to understand the health plans your employer is offering before declining coverage to purchase insurance through the Exchange. It is important to note that most employers subsidize coverage they offer and allow you to pay for it on a pretax basis, which saves you money by lowering your taxable income. Coverage purchased through the Exchange, however, is not pretax.

Your Options

- **Exchanges or Employer Sponsored Plan**

  a. Employer Sponsored Plan

  b. Exchanges
     - Eligibility to Enroll – Must be a U.S. Citizen (or a non-citizen lawfully present in the U.S.)

Bronze Plus Plan vs. Covered California

	United Ag Bronze Plus	Covered California Bronze
Deductible	$6,350	$5,000
Preventative Care Copay	No Cost - at least 1 yearly visit	No Cost - at least 1 yearly visit
Primary Care Copay	$20 - 10 visits per year before deductible applies	$60 - 3 visits per year before deductible applies
Specialtist Copay	Combined with Primary Care benefit	$70 after the annual deductible is met
Urgent Care Copay	Combined with Primary Care benefit	$120 - 3 visits per year before deductible applies
Generic Medication Copay	$20 - unlimited prescriptions	$19 after the annual deductible is met
Professional Lab Copay	$20 - unlimited visits	30% after the annual deductible is met
X-Ray Costs	0% after the annual deductible is met	30% after the annual deductible is met
Emergency Room Copay	0% after the annual deductible is met	$300 after the annual deductible is met
In Patient Hospital Care	0% after the annual deductible is met	30% after the annual deductible is met
Imaging (MRI, CT, PET Scans)	0% after the annual deductible is met	30% after the annual deductible is met
Preferred Brand Medication Copay	0% after the annual deductible is met	$50 after the annual deductible is met
Non-Preferred Brand Medication Copay	0% after the annual deductible is met	$75 after the annual deductible is met
***Maximum Out-of-Pocket For One**	$6,350	$6,350
***Maximum Out-of-Pocket For Family**	$12,700	$12,700
Mexico Panel	$5 Copay	N/A
Note: Out-of-pocket maximums apply only to services provided by In-Network providers.		

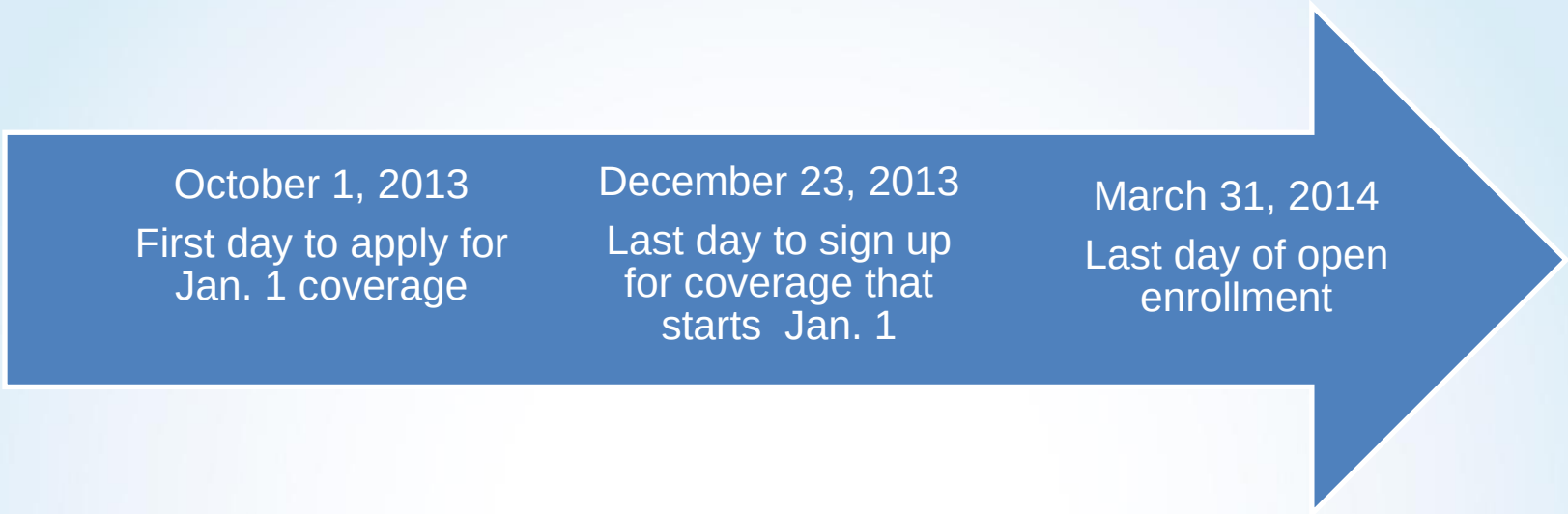
Open Enrollment Period

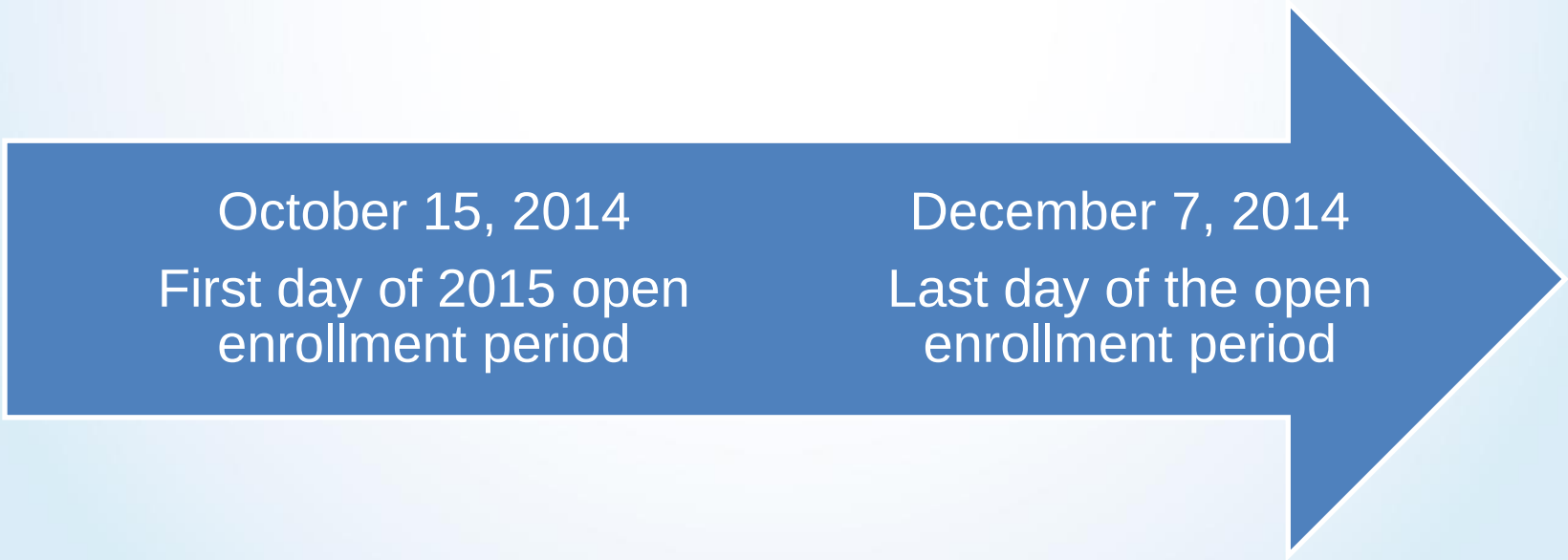
A. Employer Sponsored Plan

- During your employer's open enrollment period. Please contact your employer.

B. Exchanges

- Exchanges will:
  - Determine eligibility to enroll
  - Assess (or determine) eligibility for Medi-Cal, state's Medicaid health care program
  - Determine eligibility for premium tax credits and cost-sharing reductions ALL year
  - Only enroll members into the Exchange during open enrollment (unless "special enrollment" requirements are met)


October 1, 2013
First day to apply for Jan. 1 coverage
December 23, 2013
Last day to sign up for coverage that starts Jan. 1
March 31, 2014
Last day of open enrollment


October 15, 2014
First day of 2015 open enrollment period
December 7, 2014
Last day of the open enrollment period

Effective Dates of Coverage through the Exchange for 2014 Open Enrollment Period

- Plan selection date determines when coverage will take effect
- Coverage will start on schedule only if the enrollee pays the first month's premium on time – Moving target lately
- Deadlines for the first month's premium are typically set by the insurer, but have been "influenced" by Washington

Plan Selection Date	Coverage Effective Date
Jan. 15, 2014	Feb. 1, 2014
Feb 15, 2014	Mar. 1, 2014
Mar. 15, 2014	Apr. 1, 2014
March 31, 2014	May 1, 2014

Please Note

If you decline your option to enroll with your employer sponsored health plan and miss the deadline for your employer's current open enrollment period but later change your mind about your enrollment with the Exchange, you will not be able to return to the Employer Sponsored Plan.

You can only switch during the next open enrollment!

Subsidy

A. Premium Credits (Premium Tax Credits)

- Subsidized when income is between 138 to 400% of the Federal Poverty Line (FPL) excluding individuals eligible for employers' sponsored coverage, Medicare, Medicaid, CHIP, TRICARE, coverage through Veterans Affairs

2013 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA			
Person in Family/household	**Poverty guideline**	**138%**	**400%**
1	$11,490	$15,856	$45,960
2	$15,510	$21,404	$62,040
3	$19,530	$26,951	$78,120
4	$23,550	$32,499	$94,200
5	$27,570	$38,047	$110,280
6	$31,590	$43,594	$126,360
7	$35,610	$49,142	$142,440
8	$39,630	$54,689	$158,520
For families/households with more than 8 persons, add $4,020 for each additional person			

Subsidy

- **You are NOT eligible for premium credits if**
  1. Your employer provided plan is a minimum value plan. A plan is considered as a minimum value plan if it pays at least 60% of the total allowed costs for benefits.
  2. Your employer provided plan is an affordable plan. A plan is considered as an affordable plan if the employee contribution toward the self-only premium does not exceed 9.5% of the employee's W-2 wages.

Premium Sharing Subsidy

- **If an employee qualifies based on the previous criteria the premium credit an employee receives is equal to the *LESSER* of:**

  1. The total monthly premium for the health plan in which the employee or any covered dependents of the employee is enrolled through the Exchange

  OR

  2. The amount by which the adjusted monthly premium for a plan purchased through the Exchange exceeds a defined percentage of household income (a sliding scale based on FPL ranging from 2% to 9.5% of income)
     - The premium credit is determined in advance based upon taxpayers' last tax return. The credit is paid directly to the insurer by the Treasury, and the insurer must reflect the payment on the member's premium bill.

Cost Sharing Subsidy

- Cost sharing subsidies are available for individuals with household incomes between 100 to 400% of the Federal Poverty Line. The cost sharing subsidy reduces the maximum Out of Pocket limits for the individual
- To be eligible for a cost-sharing subsidy an individual must be enrolled in a “Silver” plan through the Exchange.
- The amount of the cost-sharing subsidy is based upon a sliding scale depending on Federal Poverty Line (ranging from a subsidy of 1/3 to 2/3 of the out of pocket limit)

The Penalty for Failure to Obtain Coverage

Annual Penalty is the GREATER of:			
	Flat dollar amount	**OR**	**Percentage of income**
2014	Each adult: $95 Each child: ½ adult ($47.50) Maximum: $285		1% of applicable income Applicable income: Income above the tax filing threshold
2015	Each adult: $325 Each child: ½ adult ($162.50) Maximum: $975		2% of applicable income
2016 And Beyond	Each adult: $695 Each child: ½ adult ($347.50) Maximum: $2,085		2.5% of applicable income

2013 Filing Thresholds (under age 65)	
Single: $10,000	Head of Household: $12,850
Married Filing Jointly: $20,000	Married Filing Separately: $3,900

Exemptions from the Penalty

Exemptions Granted by the Marketplace

- Religious Conscience
- **Hardship**
  - Financial hardship
  - State failure to expand Medicaid
  - Unaffordability of insurance

Exemptions Granted through Tax Filing

- Income below filing threshold
- Insurance is unaffordable
- Undocumented resident
- Short coverage gap (< 3 months)

Exemptions Granted by Either

- Indian tribe membership
- Incarceration
- Health care sharing ministry

Questions?

Presenter

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