



# The Affordable Care Act 101: What You Need to Know

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Note: This presentation was current @ November 28, 2012.



# Agenda

- Recap of the legislative history around the law
- Recap of the SCOTUS (Supreme Court) decision at the end of June
- The Court of Public Opinion
- The current political dynamic following the November 6<sup>th</sup> election
- The Affordable Care Act implementation calendar (i.e., 2010 through 2018)
- Takeaways

# Recap: Legislative history

On March 23, 2010 President Obama signed H.R. 3590, the *Patient Protection and Affordable Care Act* (“PPACA”) into law, and on March 30, 2010 H.R. 4872, the *Health Care and Education Affordability Reconciliation Act of 2010*, a companion package of “fixes” to H.R. 3590.

Taken together these two Acts –referred to as “PPACA”, “Affordable Care Act”, “ACA”, “ObamaCare”, etc. – represent the most sweeping changes to our health care delivery and financing systems since the enactment of Medicare and Medicaid in 1966.



# Recap: Legislative history

The ACA passed the Senate on December 24, 2009 by a vote of 60–39 with all Democrats and two Independents voting for and all Republicans voting against. It then passed the House of Representatives on March 21, 2010 through a legislative process known as “budget reconciliation” by a vote of 219–212, with 34 Democrats and all 178 Republicans voting against the bill.

# Recap: Legislative history

Because of the unexpected election (at the time) of Scott Brown to the Senate in January of 2011, “the 41<sup>st</sup> vote against the federal healthcare law”, the House actually ended up passing the Senate-passed version of the bill with all of its glaring imperfections and inconsistencies. This is one of the reasons there are over 1,000 occurrences of the phrase “The Secretary (of HHS) Shall...” leaving much of the future direction of the law to be determined through the promulgation of regulations.

# Recap: Legislative history

## Then there was the 2010 mid-term election

The Republican Party gained 63 seats in the House, recapturing the majority and making it the largest seat change since 1948 and the largest for any midterm election since 1938.

The GOP also gained 6 seats in the Senate, expanding its minority, and gained 680 seats in state legislative races to break the previous majority record of 628 set by Democrats in the post-Watergate elections of 1974. This left the GOP in control of 29 state legislatures, and it also took control of 29 of the 50 State Governorships.

# Recap: Legislative history

As soon as the 112<sup>th</sup> Congress was convened, HR 2 AKA “Repealing the Job-Killing Health Care Law Act” was filed on January 3, 2011 and just 16 days later it was passed in the House by a 245-189 margin largely along party lines.

The “McConnell Amendment,” the House-passed legislation for repeal of the Affordable Care Act, subsequently failed in the Senate by a vote of 51 to 47 on February 2, 2011.

The law has since been repealed another **30 times** by the House during the 112<sup>th</sup> Congress, the most recent being a vote in July after the SCOTUS decision, but there have been no further votes taken in the Senate.

# SCOTUS (Supreme Court) decision

- The Supreme Court upheld the constitutionality of the Affordable Care Act and the individual mandate by a 5-4 margin.
- Although the mandate was ruled as not constitutional under the Commerce Clause, it was nevertheless deemed to be an appropriate use of the Congressional power of taxation. Therefore it is a tax, and not a penalty.



# “So it is a tax after all!”

- But it will only affect Americans who file tax returns.
- Many are exempted from the mandate -
  - If you are between jobs and without insurance for up to three months
  - Religious objections
  - Undocumented immigrants
  - Jail inmates
  - Members of Indian tribes

# SCOTUS (Supreme Court) decision

- The court also ruled 7-2 to allow the law's expansion of the Medicaid program, but it struck down the portion of the law that would have penalized states that chose not to expand their Medicaid programs by taking their existing federal Medicaid funds away. This part of the ruling gives states significant leverage, as it will create a coverage hole in states that choose not to expand their programs for financial reasons.

# The Court of Public Opinion

- Voters remain closely divided over whether President Obama's health care law will be good or bad for the country, but about half of the electorate still wants the law to be repealed.
- A Rasmussen Reports national telephone survey conducted on November 4<sup>th</sup> just prior to the election finds that 50% of Likely U.S. Voters favor repeal, while 44% are opposed. This includes 39% who Strongly Favor repeal of the measure and 37% who Strongly Oppose it.

# November 6<sup>th</sup> election outcome

- The final Electoral College vote tally was 332 votes for Obama and 206 for Romney. The President ended up with a 3 million popular vote advantage.
- The political makeup of the House and Senate remains unchanged with the Democrats in control of the Senate and Republicans maintaining control of the House of Representatives.
- In 2013 the GOP will control 30 state houses (up from 29).

# November 6<sup>th</sup> election outcome

## Congress

ELECTION 2012

*Projected party divisions; as of 5 p.m. ET Nov. 7*

### Current House

435 seats

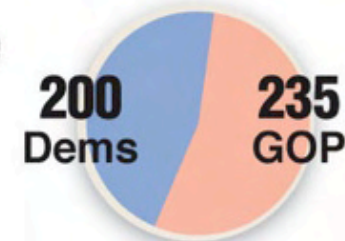


Independent 0

Vacant 5

### New House

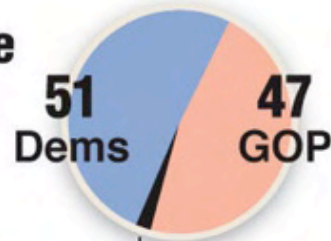
Projected



Independent 0

### Current Senate

100 seats

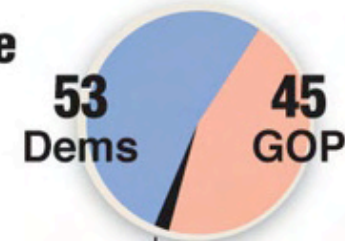


\*Independents who caucus with Democrats

Independent\* 2

### New Senate

Projected



Independent\* 2

Source: AP

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**BIPARTISANSHIP?**

**IS IT AN IMPOSSIBLE DREAM?**

# After the Election

- In the next few weeks and months expect the release of many ACA-related regulations.
- Some will be proposed rules, meaning that they may be changed and others will be interim final rules, which means they have the force of law immediately.
- Congress has an extremely long and significant list of items to address before December 31, 2012
  - Expiration of Bush tax cuts and other tax extenders
  - AMT Fix
  - Payments for Medicare Providers
  - Budget sequestration / Fiscal Cliff
- Major changes to ACA in lame duck session unlikely.



# After the Election

- Shaping new federal regulations and guidance that will govern health reform implementation for individual consumers and employers
- Potential legislative changes in the 113<sup>th</sup> Congress:
  - Medical Loss Ratio (MLR)
  - Small Group Deductibles
  - Premium Subsidies
  - Employer Mandate
  - Rating and Market Reforms
- Expect a renewed focus on reforms to address the cost of medical care and improve health care quality, rather than health insurance market reforms



# Possible Fiscal Cliff Effect?

- The GOP may win some concessions about later changes to ACA provisions, particularly those that have yet to be implemented.
- A likely example are the tax subsidies for people earning less than 400% of the FPL. This may be ratcheted back during the upcoming Fiscal Cliff negotiations to some lesser FPL multiple.



# Let's talk about compliance



*Enid was finally ready to admit that compliance was a bit more complicated than she first thought.*

# Health Reform Implementation

| Already Implemented  | 2012-2013  | 2014  | Beyond 2014   |
|--|--|---|---|
| Grandfathered plan requirements  | Summary of coverage requirements for all plans                   | Individual mandate  | Auto-enrollment for groups 200+   |
| Small business tax credits for purchasing private coverage   | Exchange notification requirements for all employers             | Employer responsibility/ minimum value requirements for 50+ groups                              | Automatic expansion of state small group markets to 100 employees   |
| <b>Sept. 23<sup>rd</sup> reforms - all plans</b><br>Dependent coverage to 26<br>No pre-ex for children<br>Restrictions on rescissions and annual/lifetime limits                     | Employee FSA contributions capped at \$2,500                     | Health insurance exchanges, private coverage subsidies and Medicaid expansion in willing states | States can let large group join exchanges, triggering market reforms for all fully-insured large groups     |
| <b>Sept. 23<sup>rd</sup> reforms for non-grandfathered plans</b><br>Preventive care<br>105(h) nondiscrimination rules ( <i>enforcement delayed</i> )<br>New coverage appeals process | Comparative effectiveness research funding tax impacts all plans | Insurance market reforms and new coverage standards for individual/small group market plans     | The "Cadillac" 40% excise tax goes into effect for all high-value group plans, including self-insured plans |
| Medical loss ratio requirements  | Expanded W2 reporting to employers issuing more than 250 W2s     | New national premium tax for fully-insured plans  |   |





# 2010

# 2010 Recap

- Increased adoption assistance exclusion – Increase in the tax credit under IRC §23 from \$10,000 to \$13,170 for all adoptions, including adoptions of children with special needs.
- Preexisting Condition Insurance Plan (PCIP) – Temporary high risk pools established.
- Early Retiree Reinsurance Program – Temporary reinsurance program for employers providing benefits for retirees age 55 and older who are not eligible for Medicare.
- Small Business Health Care Tax Credit launched for employers with less than 25 FTEs earning average annual wages less than \$50,000.



# 2010 Recap

- No lifetime limits
- Restricted annual limits
- Adult children permitted to remain on their parents' insurance plan until their 26th birthdays *(GF plans may exclude adult children who are eligible for other ER coverage.)*
- No coverage rescissions except in the case of fraud
- No pre-existing condition exclusions for children under 19
- First dollar coverage for preventive care (NGPs only)

NGP = “*Non-grandfathered plan*”



# 2010 Recap

- Revised appeals process
- Grandfathered status disclosure notice
- Transparency disclosure (guidance not yet issued)
- Nondiscrimination rules extended to insured NGPs (delayed indefinitely until further guidance)
- Prohibition on ER restrictions (NGPs only)
- Prohibition on PCP restrictions (NGPs only)

NGP = “*Non-grandfathered plan*”







# 2011

# 2011 Recap

- The excise tax for non-qualified HSA withdrawals was doubled from 10% to 20%.
- Flexible spending accounts (FSAs), health reimbursement accounts (HRAs), and health savings accounts (HSAs) cannot be used to pay for over-the-counter drugs, purchased without a prescription. The exception to this is insulin.
- \$200 million was allocated for worksite wellness grants for businesses with less than 100 employees.
- HHS issued a final regulation aimed at controlling large health insurance premium increases.

# 2011 Recap

- HHS issued final regulations about the medical loss ratio (MLR) rule. Insurers must spend a certain % of earned premiums (80% individual and small group, 85% large group) on eligible expenses. This does not apply to the SSBC because it is a self-insured program.
- Proposed regulations were released for state-based health insurance exchanges.
- SIMPLE cafeteria plans for employers with 100 or less EEs
- The free choice voucher provision was repealed by Congress, and the CLASS (Community Living Assistance Services and Supports Act) program was suspended.



# 2012

# 2012: Women's Preventive Care

- Based upon Institute of Medicine recommendations to HHS
- Effective for the first plan year on or after August 1, 2012
  - Screening for gestational diabetes
  - Human Papillomavirus (HPV) testing
  - Annual counseling and screening on STDs & HIV
  - All FDA approved contraceptives, sterilization procedures, and counseling
  - Lactation support and equipment rental
  - Screening and counseling for domestic violence
  - At least one well-woman preventive visit annually
- Per HHS:
  - New accommodation “Insurance Carriers must provide, not Employer”
  - Religious-based, nonprofits have until August 1, 2013 to comply



## 2012: Summary of Benefits Requirements

- All insurers and self-funded employers will have to give people who apply for or enroll in individual or employer-sponsored coverage a standardized summary of benefits and coverage that includes:
  - Four page coverage summary
  - Coverage terms glossary
  - Coverage examples of two set medical scenarios
  - Customer service and website information

## 2012: Summary of Benefits Requirements

- Intent is to give consumers standardized information for comparative purposes
- Effective date is the plan year that begins on or after September 23, 2012
- Applies to all plans, including grandfathered plans and self-funded plans.
- HIPAA excepted benefit plans (e.g., stand-alone dental, vision, specific diseases, etc.) do not have to comply

## **2012: Auto-Enrollment (Notice 2012-17)**

- The Administration has notified employers that the guidance on auto-enrollment will not be published before 2014.
- Auto-enrollment is not effective until guidance is issued.
- Consequently, there will be no auto-enrollment before 2014!



## 2012: Comparative Effectiveness Research Fee

- For policy or plan years ending after Sept. 30, 2012, issuers and employers sponsoring certain group health plans must pay a fee of \$1 per member per year. The fee increases to \$2 per member per year for policy years ending after Sept. 30, 2013.
- The first policy year to which the fee applies would be a policy year that ends on Oct. 1, 2012, and if the policy or employer plan is a calendar year plan, the first fee would apply for the 2012 calendar year.
- The fee does not apply to policy years ending after Sept. 30, 2019.



# 2013

# W-2 Reporting

- Employers will be required to include the value of group health plan coverage on W-2s issued after 1/1/2013.
- The new reporting requirements do not change the tax treatment of employer-provided health coverage. The reporting is for informational purposes only.
- **Small Employer Exception**
  - Employers issuing fewer than 250 Forms W-2 in the preceding calendar year are exempt from the reporting requirement (Important – This does not apply to the number of employees, but rather to the number of W-2s issued.).
  - May be on an entity rather than controlled group basis
  - Applies to all employers who provide applicable employer sponsored coverage

# W-2 Reporting

- Must report the “aggregate cost”
- Include pre-tax and post-tax coverage
- Include employer and employee contributions (e.g. employer premium contribution or employee cafeteria plan contributions)
- General Rule: Use COBRA equivalent premium costs (without the 2% surcharge)
- Sources of IRS guidance: Notices 2010-69, 2011-28, and 2012-9 and the Form W-2 Instructions

# Insurance exchange notice

- Exchanges are supposed to be operational by 1/1/2014. Employers must provide current employees and new employees at the time of hire with information about these exchanges, including information on 1) an employee's eligibility for coverage in the exchange if the employer's share of the health plan is less than 60%, and 2) the loss of employer contribution toward the value of coverage if the employee purchases coverage through the exchange.
- Notification must be in the form specified in upcoming DOL guidance (effective March 1, 2013 or such later date as set forth in future DOL guidance).

# Department of Labor (DOL)

The Department of Labor (DOL) has jurisdiction over many Affordable Care Act provisions.

The Department's overview page contains a wealth of information, and their Frequently Asked Questions pages give detailed answers to very specific ACA implementation scenarios.

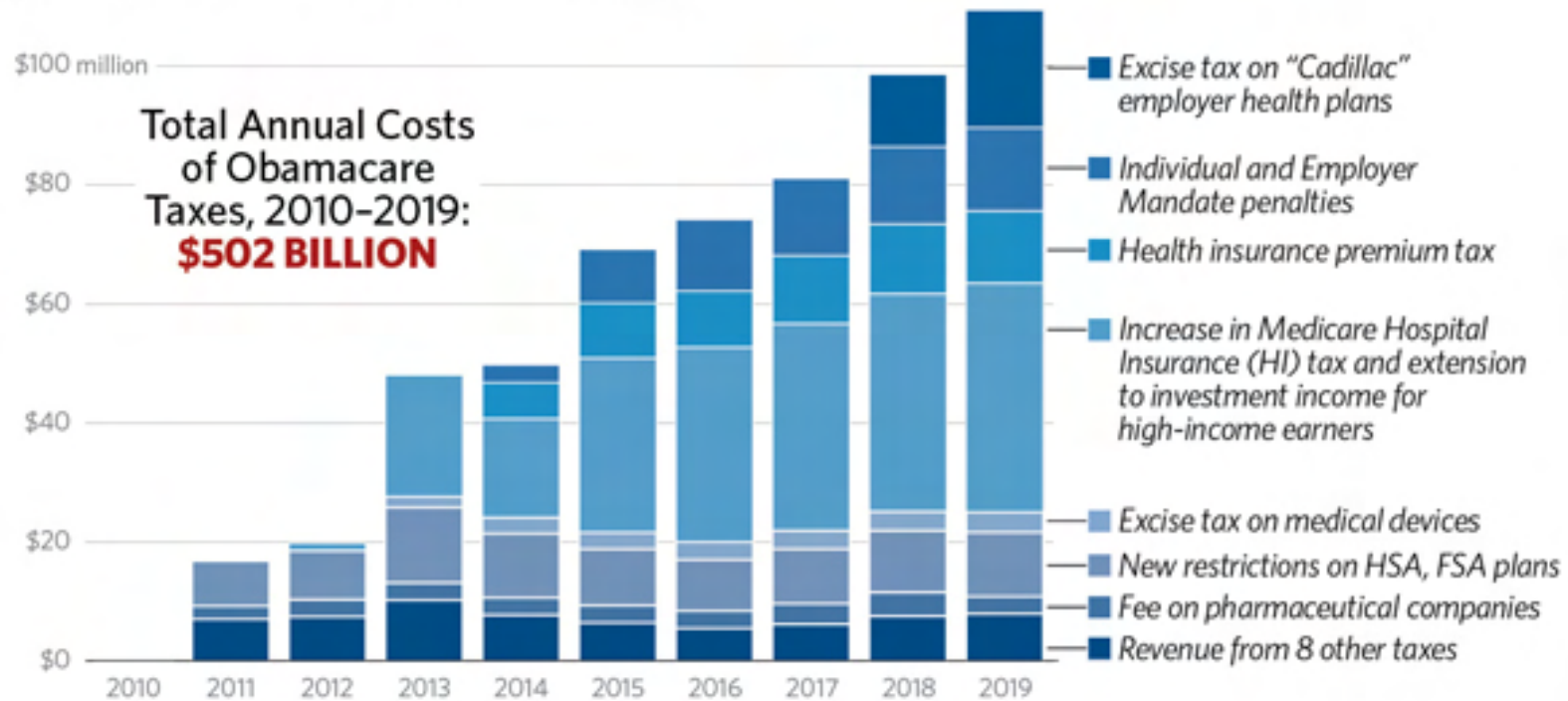
- DOL Affordable Care Act Overview page = <http://1.usa.gov/SBE3Qo>
- DOL FAQ page - <http://1.usa.gov/Rz8yd9>

# Taxes, taxes, and then even more taxes...

- **Surtax on investment income** - New 3.8% surtax on investment income earned in households making at least \$250,000 (\$200,000 single).
- **Medicare payroll tax increase** of 0.9% on incomes in excess of couples making \$250,000 (\$200,000 single).
- **Excise tax on medical device manufacturers**
- **Raise "Haircut" for medical itemized deduction** on Schedule A from 7.5% to 10% of AGI
- **New \$2,500 Flexible Spending Account (FSA) Cap** – aka “Special Needs Kids’ Education Tax”

# Taxed Enough Already? Just wait until Obamacare kicks in

To pay for generous subsidies to purchase health insurance, a huge expansion of Medicaid, and other new spending, Obamacare raises taxes and adds 17 new taxes or penalties that will affect all Americans.



**Source:** Heritage Foundation calculations based on data from the Joint Committee on Taxation, March 2010 report.

Obamacare in Pictures  [heritage.org](http://heritage.org)





# Internal Revenue Service (IRS)

The Internal Revenue Service has a site dedicated to the tax-related provisions of the health reform law. In addition, they have a separate site with news releases, multimedia and legal guidance.

## **Affordable Care Act Tax Provisions**

<http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions>

## **Affordable Care Act of 2010: News Releases, Multimedia and Legal Guidance**

<http://1.usa.gov/VeixHX>



# 2014

# Main Events

- Exchanges are (theoretically) in operation
- No pre-ex and Medicaid coverage expansion
- Individual mandate
- “Employer Responsibility” mandate aka “The Employer Mandate”

# Exchanges

- In 2014 the Affordable Care Act requires all states to create two types of exchanges:
  - **American Health Benefit Exchange (AHBE)** - An individual exchange
  - **Small Business Health Options Program ("SHOP")** - A Group Exchange for groups (in Illinois) with < 51 employees and with a multi-carrier option
- The tax subsidies will become available for people earning less than 400% of the FPL. Individuals can only access the subsidies through the public AHBE exchange, and small businesses are only able to access the small business tax credits through the public SHOP exchanges after 2014.

# Exchange development status

- Kaiser Family Foundation has a page that describes the current status of the states' exchange developments at <http://bit.ly/SZAbyu>. To date only 14 states and the District of Columbia have thus far made significant progress toward implementing or have already implemented exchanges.
- HHS recently announced that states will have an extended timeframe to submit their exchange plans to the federal government, moving the deadline from November 16<sup>th</sup> to February 15<sup>th</sup>.

# Exchanges to add 12 million?

## What will the newly insured look like?

The newly insured compared to the currently insured are...

### Race

... less likely to be white



### Health status

... less likely to rank self excellent/very good/good



### Marital status

... more likely to be single



### Language

... less likely to speak English



### Educational attainment

... less likely to have a college degree



### Employment status

... less likely to have full-time employment



|                   | Median age | Median income |
|-------------------|------------|---------------|
| Newly insured     | 33         | 166% FPL      |
| Currently insured | 31         | 333% FPL      |

Sources: PwC HRI analysis for year 2021, Current Population Survey, Medical Expenditure Panel Survey and CBO

# No pre-ex and Medicaid expansion

- **No Pre-Existing Condition Exclusions:** Group health plans and individual insurance policies are required to eliminate pre-existing condition exclusions completely.
- **Medicaid eligibility expansion:** All individuals with income up to 133% of the Federal Poverty Level (FPL) qualify for coverage, including adults without dependent children.

# Individual Coverage Subsidies

- The Affordable Care Act's premium tax credit (subsidies) only are available to qualified individuals purchasing coverage through health insurance exchanges after January 1, 2014.
- Individuals with family incomes between 100-400% of the federal poverty level will be eligible for a premium tax credit. Individuals with family incomes at or below 250% of the FPL will also qualify for reduced cost-sharing. Again, these FPL multiples are likely to be reduced.
- Individuals and their dependents who have been offered coverage through an employer that meets an affordability and minimum value test ***are not eligible to purchase coverage through an exchange or get a subsidy.***



# Does Group Coverage Meet the Affordability Test?

| Federal Poverty Limit - FPL       | 2012 FPL | Hourly Rate (40 hr week) | Employee Share of Single Premiums per Mo @ 9.5% income Standard |
|-----------------------------------|----------|--------------------------|---|
| 100% (Possibly Medicaid Eligible) | \$11,170 | \$5.37                   | \$88.43   |
| 133% (Possibly Medicaid Eligible) | \$14,856 | \$7.14                   | \$117.61  |
| 150%                              | \$16,755 | \$8.06                   | \$132.64  |
| 200%                              | \$22,340 | \$10.74                  | \$176.86  |
| 250%                              | \$27,925 | \$13.43                  | \$221.07  |
| 300%                              | \$33,510 | \$16.11                  | \$265.29  |
| 350%                              | \$39,095 | \$18.80                  | \$309.50  |
| 400%                              | \$44,680 | \$21.48                  | \$353.72  |
| 400% family of 4                  | \$92,200 | \$44.33                  |   |

*\$353.72/mo since employer only has to use the single rate for lowest tier plan to calculate affordability*



# Individual Coverage Subsidies

- The premium subsidy will come in the form of a refundable and advanceable tax credit paid directly to the individual's insurer.
- The amount of the refundable premium tax credit received is based on the premium for the second lowest cost qualified health plan in the exchange (the silver plan) and in the rating area where the individual is eligible to purchase coverage.

# 2014-2016 individual mandate penalties

- **2014 penalties** of \$95 per adult and \$47.50 per child, up to a family maximum of \$285 or 1% of family income, whichever is greater.
- **2015 penalties** of \$325 per adult and \$162.50 per child, up to a family maximum of \$975 or 2% of family income, whichever is greater.
- **2016 penalties** of \$695 per adult and \$347.50 per child, up to a family maximum of \$2,085 or 2.5% of family income, whichever is greater.

# Employer mandate aka “Pay or Play”

- Employers with 50 or more employees will be required to offer “minimum essential coverage” to all full-time employees (working 30+ hours).
- If an employer does not such provide coverage and at least one full-time employee receives coverage through a public Exchange for which a federal premium or cost sharing subsidy is received, the employer will be assessed a tax penalty.
- The tax does not apply to the first 30 full time employees, and the "applicable payment amount" for 2014 is \$166.67 (\$2,000 annually), which will be indexed for inflation in the years that follow.

# Employer mandate aka “Pay or Play”

- For employers that sponsor group medical plans, if their plans fail either the Quality or Affordability standard, the tax penalty is equal to \$250 (1/12 of \$3,000) times the number of full time employees for any month who are in receipt of a federal premium or cost sharing subsidy.
- The \$3,000 figure is for 2014, and will be adjusted for inflation after 2014. The number of employees is not reduced by 30 for purposes of calculating this penalty, and this penalty tax is capped at an overall limitation equal to the penalty calculation above for an employer who does not offer coverage.

# Employer mandate aka “Pay or Play”

- If an employee is offered coverage under an employer-sponsored plan that satisfies prescribed Quality and Affordability standards, then the employee is ineligible for a federal premium or cost-sharing subsidy for health insurance purchased through a public Exchange.
- As the law currently stands, individual consumers will be eligible for a federal premium / cost sharing subsidy if their income is between 138% to 400% of the federal poverty level and their employers’ plans fail to satisfy both of the following standards:

# Employer mandate aka “Pay or Play”

- **Quality Standard:** The plan must have at least a 60% Actuarial Value (i.e., the plan must be expected to pay at least 60% of covered medical expenses across a typical population).
- **Affordability Standard:** The premium for single coverage under the plan cannot exceed 9.5% of the employee's W-2 wages (per the recently announced Affordability Safe Harbor Notice 2012-17, permitting employers to use an employee's current W-2 wages instead of household income).

# Facts about the Employer Penalty and Subsidies

- If an employer drops coverage and sends employees to the exchange, employees do not see one dime of the penalty money the employer pays. The entire fine amount goes straight the federal treasury and employees reap no coverage assistance from it.
- Many employers think that if they drop coverage and send people to the exchange, their employees will get free or drastically reduced coverage there, but for many employees, particularly those without dependents, the subsidy benefit will not be that great.



## Are Employers Likely to Drop Coverage?

- Conflicting assessments in 2011 by McKinsey and Company (30% of employers would drop) vs. the Congressional Budget Office (CBO), Rand Corporation, and the Urban Institute all suggesting minimal impact.
- “Truven Health Analytics Study Finds No Short- or Long-Term Advantage for Employers to Drop Group Health Insurance Under PPACA” – <http://bit.ly/PqtnVI>, July 3, 2012
- “Deloitte: One in 10 U.S. Employers to Drop Health Coverage”- <http://on.wsj.com/Or2zJ6>, July 24, 2012
- “Will PPACA Cause Employers to Drop Employee Health Insurance?” - <http://bit.ly/QGVEqT>, April 5, 2012, Wolters Kluwer



# 2018

# The “Cadillac Tax”

- The Affordable Care Act imposes a non-deductible excise tax of 40% on the value of health insurance benefits exceeding \$10,200 for single coverage and \$27,500 for family coverage (indexed to CPI).
- The thresholds are higher for qualified retirees and “high risk” professions (\$11,850 for single and \$30,950 for family.).

# Takeaways

- The ACA does very little to address the underlying costs of health care. In the years ahead employers will still need to engage in strategic ways if they expect to be able to reasonably manage health benefit costs.
- There is a decided trend, a “tsumani” if you will, from defined benefit (DB) toward defined contribution (DC) health insurance.
- This trend in health insurance parallels the shift from DB to DC that we have seen in the qualified retirement plan space over the last 20-25 years.

# Takeaways

- Employer-sponsored group health insurance costs too much, and even though trend has moderated recently, at current premium levels even 7%-8% year-over-year rate increases are not sustainable long term.
- Because of Health Care Reform and other market factors our country appears to be transitioning to more of an individual product model in the future.

# Thank you for your valuable time and attention!

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