

Summary of Provisions Affecting Employer-Sponsored Insurance

Much of the public discussion about the Affordable Care Act (ACA) has focused on the expansion of coverage to the uninsured through subsidies to individuals and the expansion of Medicaid. The law will also result in changes for some of the 150 million Americans who are covered through an employer-sponsored plan.¹ This summary addresses common questions from unions and employers about the law's impact on employer-sponsored insurance. This summary reflects our interpretation of the ACA statute and regulations that have been released to-date by the Department of Treasury, Department of Health and Human Services and Department of Labor.

What is the exchange and who can utilize it?

- The law creates a new health insurance exchange, a marketplace that will offer a choice of plans that meet standards for coverage and that will provide information to consumers and employers to help them make educated choices about the policies they are purchasing.
- Small employers can participate when the exchanges open by 2014. States have the option to define small employers as up to 50 or 100 employees through 2015, and must define small employers as up to 100 employees beginning in 2016. States can choose to expand exchanges to larger businesses beginning in 2017.
- Citizens and legal residents may purchase coverage through the exchange. The coverage will be subsidized for individuals in families with income not exceeding 400 percent of the Federal Poverty Level (\$46,000 for an individual and \$94,200 for a family of four in 2013) who are not eligible for Medicare, Medicaid, the Children's Health Insurance Program, or affordable employer-sponsored insurance.
- For purposes of determining eligibility for exchange subsidies, affordable employer-sponsored insurance is defined as requiring an employee contribution of less than 9.5 percent of household income for an employee-only plan that covers at least 60 percent of medical costs on average ("minimum value"). If self-only coverage costs less than 9.5 percent of household income, then both employees and their family members are ineligible for subsidies regardless of whether or not family coverage is affordable.
- Employers of all sizes may also continue to purchase coverage outside of the exchange.

Are employers required to provide coverage?

- **Free-rider policy:** Employers are not required to provide coverage to any employee or dependent, but large employers with at least one full-time employee enrolling in subsidized coverage in the Exchange are subject to a penalty, beginning in 2014.
 - Large employers not offering coverage or offering coverage to less than 95 percent of its full-time employees pay \$2,000 multiplied by the total number of full-time employees minus 30. This penalty only applies if at least one full-time employee receives subsidies in the exchange. Beginning in 2015, the \$2,000 penalty also applies to employers that do not offer coverage to the children (under age 26) of full-time employees, regardless of whether or not the coverage offered to children is affordable.
 - Large employers offering coverage to at least 95 percent of its full-time employees pay the lesser of \$3,000 multiplied by the number of full-time employees receiving subsidies, and \$2,000 multiplied by the total number of full-time employees minus 30. This penalty may occur because an employer did not offer coverage to a full-time employee or because the coverage offered was unaffordable or did not provide minimum value.
- **Applicability of the penalties:**
 - Large employers are those with at least 50 full-time equivalent non-seasonal employees. Affiliated members of a controlled group of large employers are treated as a single employer for purposes of determining large employer status, but as separate employers for assessing penalties. Treasury is still determining the circumstances under which related public employers will be treated as a single employer.
 - Full-time is defined as an average of at least 130 paid hours of service (including vacation, holiday, illness, incapacity including disability, layoff, jury duty, military duty or leave of absence) with respect to any month.
 - Employers have the option to determine full-time status for ongoing employees and new “variable hour” or seasonal employees using a look-back and stability period of 3 to 12 months in length. The employer also has the option to use a 90-day administrative period between the measurement and stability period, but the measurement period and administrative period combined must last less than 14 months. For newly-hired employees who are “variable hour” or seasonal, employers that choose a long measurement period would have more than a year to determine these employees’ full-time status and would not be subject to penalties during that time, under draft regulations. For newly-hired employees who are reasonably expected to be full-time as of their start date, an employer will be subject to penalties if they do not offer coverage by the end of the employee’s initial three full calendar months of employment.
 - Seasonal is defined as working fewer than 120 days in a calendar year for purposes of determining large employer status. For purposes of determining an employee’s full-time status, seasonal is still being defined by Treasury and employers are expected to use a reasonable standard in the meantime.
- **Affordability safe harbors:** The draft Treasury regulations provide three affordability safe harbors that employers may use to ensure that they will not owe the \$3,000 penalty. The use of these safe harbors does not affect employees’ eligibility for subsidized coverage in the Exchange. The

employer will not be subject to a penalty if the employee's cost of coverage for the lowest cost employee-only plan with minimum value does not exceed 9.5 percent of the employee's W-2 income. A second safe harbor compares the cost of the plan to an hourly employee's rate of pay multiplied by 130 hours or a non-hourly employee's monthly salary. A third safe harbor is based on the federal poverty level for a single individual.

- **Multiemployer plan transition rule:** Through 2014, an employer will not owe a penalty if, pursuant to a collective bargaining agreement, the employer contributes to a multiemployer plan that offers affordable coverage that provides minimum value to its full-time employees and their children. Rules for 2015 and beyond are still being determined.
- **Automatic enrollment:** Employers with more than 200 full-time employees must automatically enroll employees into a plan unless they opt out of coverage. This provision will be effective once final regulations are issued, which the Department of Labor does not expect to happen in time to take effect in 2014.

Can employers apply a waiting period before an employee is eligible for health coverage?

- Waiting periods of more than 90 calendar days (including weekends and holidays) are banned effective 2014. This ban applies to all plans, including grandfathered plans and self-insured plans, and to all coverage offered, whether employee-only or family. This ban is applicable to all employees who would otherwise be eligible for coverage, including part-time workers who are offered coverage.
- Eligibility conditions may not be based solely on the lapse of a time period of more than 90 days, but substantive eligibility conditions such as being in an eligible job classification or achieving job-related licensure requirements are allowed.
- For new variable hour employees, coverage must begin less than 14 months from the employee's start date.
- Cumulative hours-of-service requirements are allowed if they do not exceed 1,200 hours. The 90-day waiting period may begin after the hours-of-service requirement is completed. Hours-of-service requirements must be one-time only and not applied to the same individual each year.
- Multiemployer plans: Hours banks and eligibility conditions based on compensation are allowed.
- Employers that offer coverage will not be subject to penalties during the first three months after employee's date of hire.

What standards must employer-sponsored plans meet?

- The law establishes new standards for employer-sponsored plans, but plans in existence as of March 23, 2010 are grandfathered with regard to many of the standards for current employees, their family members and new employees, as noted in Table 1.
- Certain changes to plan design will nullify a plan's grandfathered status, such as elimination of benefits for certain conditions; any increase in coinsurance percentage; an increase in deductible or out-of-pocket limit by more than 15 percent plus medical inflation; an increase in co-payment by

Table 1.
Standards for Employer-Sponsored Plans, by Plan Type

	Exchange plan	Grand-fathered plan	New employer-sponsored plan	Self-insured plan
No lifetime or annual limits: Plans are prohibited from limiting the lifetime dollar value of benefits effective now. Annual limits are currently restricted to between \$1.25 million and \$2 million depending on the plan year start date, and are banned completely beginning Jan. 1, 2014. Some plans have been granted waivers to the annual limit requirements through 2013.	✓	✓ <small>(annual limits do not apply to grandfathered individual plans)</small>	✓	✓
Dependents under age 26: Plans must allow adult children under age 26 to enroll in a parent's plan effective now. Through 2013, adult children may only enroll in a parent's grandfathered plan if they are ineligible for another employer-sponsored plan.	✓	✓	✓	✓
Plan administrative costs: Plans must provide rebates to consumers if the percentage of premiums spent on medical services falls below 85 percent for large group plans or 80 percent for small group and individual plans (or higher standard set by state, if applicable) effective now.	✓	✓	✓	
Preventive services: Plans must offer first dollar coverage (no co-payment or deductible) for certain preventive services effective now. ²	✓		✓	✓
Patient protections: Plans are prohibited from requiring a referral to see an OB-GYN and from requiring prior authorization or higher cost sharing for out-of-network emergency services, effective now.	✓		✓	✓
Out-of-pocket maximums: Plans must limit out-of-pocket costs to \$6,400 for single coverage and \$12,800 for family coverage effective in 2014. ³	✓		✓	✓
Pricing: Medical underwriting is prohibited and rating variation is only allowed based on age (3:1 ratio), tobacco (1.5:1.0), family composition and geography effective in 2014. ⁴	✓		small group only	
Deductibles: Plans must limit deductibles to \$2,000 for single coverage and \$4,000 for family coverage beginning in 2014. Plans may exceed limit if they cannot reasonably reach the specified actuarial value.	small group only		small group only	
Minimum services covered: Plans must cover preventive and primary care, emergency, hospital, physician, outpatient, maternity and newborn care, pediatric (including dental and vision), medical/surgical care, prescription drugs, lab, and mental health and substance abuse, effective in 2014. States set benchmarks within each category.	✓		small group only	

more than \$5 adjusted for medical inflation or 15 percent plus medical inflation, whichever is greater; an increase in employee share of premium by more than 5 percentage points; or certain increases in a plan's annual benefits limit. These limits are applied on a cumulative basis, not an annual basis. Changes to premiums, changes made to comply with federal or state laws, or a change of third party administrator will not cause a plan to lose its grandfathered status. Employers that change insurers can maintain grandfathered status as long as the new plan has cost sharing and benefits that are similar to the original plan.

- Fully-insured plans pursuant to a collective bargaining agreement (CBA) are grandfathered until the last expiration date of a CBA related to that coverage. Grandfathered status may be maintained upon the CBA expiration date if no changes were made since March 23, 2010 that would have otherwise caused the plan to lose its grandfathered status.
- Self-insured plans are exempt from some of the plan requirements, as noted in Table 1 .

How will the excise tax impact employer-based plans?

- Insurers will be taxed at 40 percent of the aggregate value of plans above a high-cost threshold beginning in 2018. In the case of self-insured plans, the tax will be paid by plan administrators.
- The cost of this tax will likely be passed on to employers and enrollees through higher premiums. To avoid the tax, some employers and unions will want to make changes to their plans, such as changes in benefits, cost sharing or provider networks.
- The aggregate value of a plan includes the combined worker and employer contributions to premiums, in addition to employer contributions to a Health Savings Account, Health Reimbursement Account, Medical Savings Account or a Flexible Spending Arrangement. The value will be calculated excluding dental and vision benefits. Employers are responsible to pay any tax on the HSA or MSA amounts and to notify the insurer of the full cost of coverage.
- In 2018, the high-cost thresholds will be \$10,200 for individual coverage and \$27,500 for family coverage. The thresholds will be adjusted firm-specific age and gender and increased by \$1,650/\$3,450 for retirees aged 55 and over who are not Medicare-eligible, electrical and telecommunications installation/repair workers and individuals in high-risk jobs (including longshore work, emergency response, firefighting, law enforcement, construction, mining, agriculture, forestry and fishing). The thresholds may be adjusted upwards initially to the degree that Federal Employee Health Benefits Program premiums rise more than expected between 2010 and 2018 and will be indexed by inflation in 2020 and subsequent years (inflation plus 1 percent in 2019).

Does the law make other tax changes related to health insurance?

- Stand-alone Health Reimbursement Accounts (HRAs) will no longer be allowed in 2014, except for retiree-only HRAs.
- Contributions to a Flexible Spending Arrangement (FSA) for medical expenses are limited to \$2,500 beginning in 2013.

- Funds from a HRA, FSA, Health Savings Account (HSA) or Medical Savings Account (MSA) cannot be used as reimbursement for over-the-counter medications not prescribed by a doctor beginning in 2011.
- Distributions from a HSA or a MSA that are not used for qualified medical expenses will be taxed at an increased rate of 20 percent beginning in 2011.
- The law eliminates the tax deduction for employers who subsidize Medicare Part D retiree drug payments effective in 2013.

Will subsidies be available to help small businesses afford coverage?

- Tax credits are available for small businesses with 25 full-time equivalent employees or fewer and average wages of no more than \$50,000 through 2013, adjusted for cost of living in subsequent years. To be eligible, businesses must contribute at least 50 percent towards premiums.
- The credit pays up to 35 percent of employer contributions through 2013 and up to 50 percent beginning in 2014. In the case of tax-exempt small businesses, the credit will pay 25 percent through 2013 and up to 35 percent beginning in 2014. The credit varies based on employer size and average wage—employers receive the full credit if they have 10 FTEs or fewer and average wages of \$25,000 or less, but the credit phases out as firm size and average wages increase.
- Beginning in 2014, the credit is only available for employers that purchase coverage through the exchange and an employer can only receive the credit for two consecutive years once they begin offering coverage through the exchange.
- The credit can be reflected in calculating estimated tax payments which can reduce employers' tax liability right away.

Does the law impact employer wellness programs?

- Beginning in 2014, employers can provide rewards to employees of up to 30 percent of the total plan premium as part of a wellness program incentive, up from the current limit of 20 percent.
- Under the law, the Secretary of Health and Human Services may increase this limit to 50 percent if deemed appropriate. Rewards may be in the form of a premium discount, reduced cost-sharing, the absence of a surcharge, or a benefit that would not otherwise be provided under the plan.
- The law sets new standards for wellness programs. For example, rewards must be made available to all similarly situated individuals and a reasonable alternative standard must be made available to individuals for whom it is difficult or inadvisable to meet the standard due to a medical condition. Additionally, wellness programs must be “reasonably designed to promote health or prevent disease.”
- The law also creates a five-year grant program to encourage small employers that do not currently have wellness programs to establish them. The program would offer \$200 million in Fiscal Year 2011–2015 to employers with fewer than 100 employees who work 25 hours or more per week.

Are employers required to do any new reporting?

- **Employee notification of coverage options:** Employers must provide information to employees about the exchange. The original deadline was March 2013, but the Department of Labor delayed the requirement until late summer or fall of 2013.
- **W-2 reporting:** Employers must report the value of the benefits on each employee's annual Form W-2 beginning with the calendar year 2012 forms. Some employers are exempt from this requirement until the IRS issues further regulations, including but not limited to employers filing fewer than 250 W-2s in the prior calendar year, multiemployer plans, HRA plans and self-insured plans not subject to COBRA rules.
- **Coverage reporting:** Employers providing minimum essential coverage must report to the IRS annually with information about the coverage offered, beginning in 2014. Large employers with at least 50 full-time equivalent employees must annually file additional information pertaining to fulfillment of employer responsibilities beginning in 2014.

Endnotes

¹ Congressional Budget Office, March 20, 2010.

² Only certain preventive services are covered under this provision. Examples include mammograms, pap smears, colonoscopies, certain blood tests, CDC-recommended immunizations and well child office visits. See the list of covered preventive services: <http://www.healthcare.gov/law/about/provisions/services/lists.html>.

³ Separate out-of-pocket limits for different services are allowed only in the first plan year beginning on or after January 1, 2014 in cases when plans use multiple service providers to help administer benefits such as one third-party administrator for major medical coverage and a separate pharmacy benefit manager or managed behavioral health organization. In future years, the out-of-pocket limits will have to be coordinated between service providers.

⁴ These pricing standards will apply to all fully-insured large group plans in and out of the exchange in states permitting large group plans in the exchange in 2017.

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