The Affordable Care Act:
Overview and Impact on DSRA-BT

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FIRST PERSON

The Affordable Care Act – What Is It?

- The Patient Protection and Affordable Care Act ("ACA") is a complex set of statutes, regulations, and subregulatory guidance impacting the health care delivery system (hospitals, doctors, and other medical providers), the employment-based health benefit system, and the health insurance market.
- Two primary areas of impact:
  - Health care delivery
  - Health care access
- Although a primary intent of the law was to make health care more affordable, nothing in the law or its implementing regulations has a direct, positive impact on the cost of health care or health insurance.

Applicability of the Law to DSRA-BT's Health Plans

- As a retiree-only benefit plan, the DSRA-BT is exempt from the eligibility and coverage mandates included in the ACA (e.g. expanded/first-dollar preventive care, adult child eligibility, patient protections, elimination of annual and lifetime dollar limits, elimination of pre-existing condition exclusions for children, expanded claims review procedures).
  - *Note:* although not required due to the retiree-only exemption, the gold, silver and bronze plans offered by DSRA-BT are already compliant with ACA mandates, and should fall into the definition of "minimum essential coverage" when the ACA is fully implemented in 2014.

Eligibility and coverage mandates

- As of 1/1/13, nearly all of the ACA's health plan eligibility and coverage mandates have been fully implemented.
- Provisions effective in 2014 include:
  - Complete elimination of all annual dollar limits on essential health benefits
  - Elimination of all preexisting condition exclusions
  - Implementation of new market rules for individual and small group market plans (fewer than 100 employees)
    - Premiums may only vary by age (max 3:1 ratio), tobacco use, geographic location and family size
    - Rate increases must be submitted to HHS

What happens in 2014?

- ACA “shared responsibility provisions” come into play – employers required to provide and individuals will be required to buy health coverage or face tax penalties
- State-based public “exchanges” (operated by either the state or federal government) will provide a marketplace to purchase health coverage for individuals and small employers
- Low-income individuals will be eligible for the federal “Insurance Affordability Program” and could receive premium tax credits and cost-sharing subsidies if coverage is purchased through the state-based public exchange.

What else happens in 2014?

- HCTC expires January 1, 2014.
  - HCTC premium subsidies *will no longer be available* for purchase of coverage through DSRA-BT
  - DSRA-BT members who qualify for the Insurance Affordability Program (e.g. federal premium tax credits and cost-sharing subsidies) will have to buy coverage in the state-based exchanges in order to receive government subsidies for the purchase of health coverage.

ACA's "Shared Responsibility" Provisions

- Two components:
  - **Employer Mandate**** – the requirement that employers provide access to "affordable" health coverage to employees or pay nondeductible excise tax penalties.
  - **Individual Mandate** – the requirement that individuals purchase minimum essential health coverage for themselves and their dependents or pay income tax penalties.

****Note**: The employer mandate is explained in this presentation to give full context to the ACA's shared responsibility provisions. However, this mandate does not apply to retiree-only benefits such as those offered through DSRA-BT, and the DSRA-BT is not at risk of paying to tax penalties under the employer mandate.*

The Employer Mandate

- Effective January 1, 2014, all employers with 50+ full-time employees (including part-time equivalents) are required to provide access to affordable health coverage to all full-time employees (those working 30 or more hours per week) or face tax penalties
  - Penalty for failure to offer coverage – $2,000 per FTE (excluding 30); not tax deductible
  - Penalty for offering coverage that is "unaffordable" – $3,000 per FTE who opts out of employer's plan and enrolls in coverage in the state-based exchange IF the employee qualifies for premium tax credits or cost-sharing subsidies

The Individual Mandate

- Beginning January 1, 2014, individuals who do not purchase health coverage for themselves and their tax dependents that is “minimum essential coverage” will be subject to a tax penalty.
- Penalty assessed for each individual, spouse, or tax dependent in the taxpayer’s household.
- The penalty is reported annually and collected with the individual’s federal tax return.
- Calculated and enforced by the IRS.

The Individual Mandate

- Individual “no coverage” penalties
  - 2014: the greater of $95 or 1% of AGI (gross income minus exemptions and deductions)
  - 2015: the greater of $325 or 2% of AGI
  - 2016 and after: the greater of $695 or 2.5% of AGI
- Penalty applies separately for each individual in the household; cut in half for children under 18

What is “minimum essential coverage”?

- Medicare Part A
- Medicaid
- Employer-sponsored group health plan
- Government or church health plan
- Individual insurance policy
- State high risk pool coverage

**Policies offered by DSRA-BT provide minimum essential coverage; members who choose to purchase coverage through DSRA-BT will meet the requirement of the individual mandate and will not be subject to tax penalties.

Public Exchanges: What are they and how will they work?

- Exchanges are state-run marketplaces for individuals and small employers to purchase “qualified health plans” (“QHPs”) effective 1/1/14.
- Insurers who wish to do business in a state will be required to offer at least one qualified health plan in the public exchange.
- Individuals purchasing coverage in the exchange may receive financial assistance for premiums and out-of-pocket expenses through the Insurance Affordability Program
- Eligibility for assistance is based on household income and availability of affordable employer-sponsored coverage.

Functions of a public exchange

- HHS regulations outline the functions that must be provided by an Exchange, and that HHS will require for approval, including the following:
  - certifying, recertifying, and decertifying QHPs;
  - assigning relative quality and price ratings to each QHP offered through the Exchange;
  - providing standardized consumer information on QHPs;
  - creating an electronic calculator that allows consumers to assess the cost of coverage after application of any advanced premium tax credits and cost-sharing reductions;

Functions of a public exchange

- operating a website and toll-free call center providing comparative information on available health plans and allowing eligible individuals to apply for and purchase coverage;
- determining eligibility for the Exchange, tax credits and cost-sharing reductions, public health coverage programs (such as Medicaid and CHIP), and facilitating enrollment of eligible individuals in such programs;
- determining exemptions from the individual mandate and granting approvals relating to hardship or other exemptions; and
- establishing a Navigator program to assist individuals with their health insurance needs.

Can DSRA-BT be a public exchange?

- **No**. Only an exchange operated by the state or federal government can be a public exchange.
- Private "exchanges" are available and could be offered through DSRA-BT (e.g. BCBSM's Glide Path); ***federal tax credits/subsidies are not available through private exchanges***.

Insurance Affordability Program

- Two sources of federal financial assistance:
  - Premium Tax Credits – advance credits to assist with monthly health premium cost.
  - Cost Sharing Reductions – limitations on maximum out-of-pocket expenses (excluding premium) that an individual will be required to pay for health care services received.

Which DSRA-BT members will qualify for premium credits/subsidies?

- Individuals will qualify for premium tax credits if their household income is between 100% and 400% of the Federal Poverty Line ("FPL")
- Cost-sharing subsidies are also available to households with income between 100% and 250% of FPL
- FPL qualification is based on the household's Modified Adjusted Gross Income ("MAGI"), which includes:
  - AGI (gross income minus expenses/deductions) ***plus***
  - Social Security benefits (even if not ordinarily included in gross income) ***plus***
  - Tax exempt interest ***plus***
  - Foreign earned income

Federal Poverty Line – 2013 Income Amounts*

- Single:
  - 100% = $11,490
  - 150% = $17,235
  - 400% FPL = $45,960
- 2 person household:
  - 100% = $15,510
  - 150% = $23,265
  - 400% = $62,040
- Family of 4:
  - 100% = $23,050
  - 150% = $35,325
  - 400% = $94,200

*Source: U.S. Dep't. of Health and Human Services http://www.acf.hhs.gov/programs/ohs/news/2013-hhs-poverty-guidelines

How will IAP (tax credits/subsidies) work?

- Eligibility is determined by the state-based exchange (coordinated eligibility and enrollment system)
- Individual will be able to apply for a QHP in the exchange and any Insurance Affordability Program (tax credit/subsidy) at the same time
- Tax credits are advanced to the individual (through a premium reduction) and then reconciled when taxes are filed
- Cost-sharing reductions are advanced by federal government to insurers
  - At point of service, providers collect a reduced deductible/coinsurance from patient, insurance company reimburses with funds from government subsidy advance, reconciliation between IRS and insurer happens after year end.

Coverage Example #1: Single Coverage*

Joe Member, 63 Years of Age, Single Adult	***From Kaiser Family Foundation (as updated 6.22.10) http://healthreform.kff.org/SubsidyCalculator.aspx***
Joe's Projected 2014 MAGI	$35,000 (304% of FPL)
Joe's **total** health insurance premium projected based on age and region, "silver" level QHP	$10,172 annually ($848/month)
Maximum % of Joe's income that he must pay toward the cost of his premium before receiving federal assistance	9.5%
Amount of Joe's premium tax credit	$6,847 annually ($570 /month)
Amount of premium Joe must pay	$3,325 annually ($277/month)
Joe's maximum out of pocket medical costs (not including premium)	$4,167 annually

Coverage Example #2: Family Coverage*

Jane Retiree, 56 Years of Age, Adult with Spouse and 2 Children	***From Kaiser Family Foundation (as updated 6.22.10) http://healthreform.kff.org/SubsidyCalculator.aspx**
Household's Projected 2014 MAGI	$75,000 (320% of FPL)
Jane's **total** health insurance premium for family coverage, projected based on age and region, "silver" level QHP	$20,372 annually ($1,697/month)
Maximum % of Jane's household income that she must pay toward the premium cost before receiving federal assistance	9.5%
Amount of Jane's premium tax credit	$13,247 annually ($1104/month)
Amount of premium Jane must pay	$7,125 annually ($594/month)
Jane's maximum out of pocket medical costs (not including premium)	$8,333 annually

Determining amount of subsidy

- The amount of premium tax credits available to an individual is calculated based on the second lowest cost ***silver plan*** as defined by the ACA.
- A silver plan under ACA is a plan with an actuarial value of 70%, meaning that the total expected plan payments for essential health benefits are at least 70% of the total cost of care.
- "Metal" tiers for Qualified Health Plans under ACA:
  - Platinum: 90% actuarial value
  - Gold: 80% of actuarial value
  - Silver: 70% of actuarial value
  - Bronze: 60% of actuarial value

Key Fact: Although DSRA-BT uses the same terminology to define its available health coverage offerings, the ACA "metal tiers" are not based on the DSRA-BT gold, silver and bronze plans, and benefit levels could differ.

Coming Soon….

- This presentation is the Board's initial review of the ACA and its impact on DSRA-BT
- Next presentation will explore new plan options available through BCBSM that could benefit DSRA-BT members in 2014
- For more information, visit our website for FAQs about ACA, HCTC and Exchanges

Thank You!