

# PATIENT PROTECTION AND AFFORDABLE CARE ACT

## Summary of Provisions Affecting Employer-Sponsored Insurance

Much of the public discussion about the health reform law signed into law in March 2010 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 many of the 150 million Americans who are covered through an employer-sponsored plan.<sup>1</sup> This summary addresses common questions from unions and employers about the law's impact on employer-sponsored insurance.

### 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 of up to 100 employees can participate when the exchanges open by 2014. (The state has the option to define small employers as 50 employees or less through 2015.) States can choose to expand exchanges to larger businesses beginning in 2017.
- Citizens and legal residents who are not eligible for Medicaid or affordable employer-sponsored insurance may purchase coverage through the exchange. The coverage will be subsidized for individuals in families with income below 400 percent of the Federal Poverty Level (\$43,320 for an individual and \$88,200 for a family of four).
- For purposes of determining eligibility for the exchange, affordable employer-sponsored insurance is defined as requiring an employee contribution of less than 9.5 percent of family income for a plan that covers at least 60 percent of medical costs on average. (The affordability standard also applies to dependents who are eligible to enroll.) If the premium cost to the employee is between 8.0 to 9.5 percent of family income, and the family income is below 400 percent of the Federal Poverty Level, employers must offer a free choice voucher equivalent to the amount the employer would have contributed to job-based coverage for the employee or the family, which the employee may use to purchase an unsubsidized plan through the exchange.
- 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 if the employer requires a contribution greater than 9.5 percent of income or offers a plan that covers less than 60 percent of medical costs on average, then the employee is eligible for the exchange and the employer faces a penalty, beginning in 2014.
  - **Penalties:** Large employers not offering coverage with at least one employee receiving subsidies in the exchange pay \$2,000 multiplied by the number of full-time non-seasonal employees. Large employers offering coverage with at least one employee receiving subsidies in the exchange pay the lesser of \$3,000 multiplied by the number of full-time non-seasonal employees receiving subsidies and \$2,000 multiplied by the total number of full-time non-seasonal employees. The first 30 employees above 50 employees are excluded from the penalties. Employer penalties shall not apply for employees using the free choice voucher.
  - **Definitions:** Large employers are those with at least 50 full-time equivalent employees. Full-time is defined as an average of 30 hours or more with respect to any month. Seasonal is defined as working fewer than 120 days in a calendar year.
- **Waiting periods:** Waiting periods of more than 90 days are banned effective 2014. This ban applies to all plans, including grandfathered plans and self-insured plans.
- **Automatic enrollment:** Employers with more than 200 full-time employees must automatically enroll employees into a plan unless they opt out of coverage.

## What standards must employer-sponsored plans meet?

- The law establishes new standards for employer-sponsored plans, but some plans are exempt from some of the standards. Employer 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. It is not yet clear which changes to plan design will nullify a plan's grandfathered status. Plans covered under Collective Bargaining Agreements must meet the new plan requirements applicable to new employer-sponsored plans by the last expiration date of an agreement related to that coverage. Self-insured plans are exempt from some of the plan requirements, as noted in Table 1 below.<sup>2</sup>

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

	Exchange plan	Grand-fathered plan	New employer-sponsored plan	Self-insured plan
<b>No lifetime or annual limits:</b> Plans are prohibited from limiting the dollar value of benefits effective 6 months after enactment. ‘Restricted’ annual limits are allowed through 2013.	✓	✓	✓	✓
<b>Dependents under age 26:</b> Plans must allow unmarried adult children under age 26 to enroll in a parent’s plan effective 6 months after enactment. Through 2013, adult children may only enroll in a parent’s grandfathered plan if they are ineligible for another employer-sponsored plan.	✓	✓	✓	✓
<b>Plan administrative costs:</b> 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) beginning in 2011.	✓	✓	✓	
<b>Preventive services:</b> Plans must offer first dollar coverage for preventive services effective 6 months after enactment.	✓		✓	✓
<b>Out-of-pocket maximums:</b> Plans must limit out-of-pocket costs to \$5,950 for single coverage and \$11,900 for family coverage (2010 dollars) effective in 2014.	✓		✓	
<b>Pricing:</b> For small group plans, 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.	small group only		small group only	
<b>Deductibles:</b> Small group plans must limit deductibles to \$2,000 for single coverage and \$4,000 for family coverage beginning in 2014.	small group only		small group only	
<b>Minimum services covered:</b> 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.	small group only		small group only	small group only

## 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, 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?

- Contributions to a Flexible Spending Arrangement for medical expenses are limited to \$2,500 beginning in 2013.
- Funds from a Health Reimbursement Arrangement, Flexible Spending Arrangement, Health Savings Account or Medical Savings Account cannot be used as reimbursement for over-the-counter medications not prescribed by a doctor beginning in 2011.
- Distributions from a Health Savings Account or a Medical Savings Account 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 will be available for small businesses with 25 full-time equivalent employees or fewer and average wages of no more than \$50,000 in 2010-2013, 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 in 2010-2013 and up to 50 percent beginning in 2014. In the case of tax-exempt small businesses, the credit will pay 25 percent in 2010-2013 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 beginning 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 health insurance for early retirees?

- Employers that provide health insurance coverage to retirees aged 55-64 can receive reimbursement for 80 percent of claims between \$15,000 and \$90,000 effective 90 days after enactment until the \$5 billion in appropriated funds are expended.

## 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 beginning in March 2013.
- **W-2 reporting:** Employers must report the value of the benefits on each employee's annual Form W-2 beginning in 2011.
- **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 The list of provisions applicable to self-insured plans in Table 1 is based in part on an analysis by Professor Tim Jost, Washington and Lee University School of Law, posted on the O'Neill Institute blog on March 31, 2010: <http://oneillhealthreform.wordpress.com/2010/03/31/how-does-the-health-reform-legislation-affect-self-insured-plans/>.

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