General Affordable Care Act and Exchange Information

What is the Affordable Care Act?
The Affordable Care Act was signed into law in 2010 to expand access to affordable coverage and quality health care services. The law includes several important market reforms, such as expanding dependent coverage to age 26, and establishes a new web-based marketplace where individuals and small employers can comparison shop and purchase insurance. Individuals and small groups shopping in this new marketplace may be eligible for special tax credits created to make insurance more affordable. Lower income individuals may also be able to receive assistance with out-of-pocket costs, such as coinsurance or deductibles. Individuals and large groups who forego purchasing insurance may face penalties for not meeting minimum federal requirements.

- **Expanding access to coverage**
  - Requires U.S. citizens and legal residents to have health insurance or pay a penalty, though some exemptions are allowed.
  - Individuals and families between 133% and 400% of the federal poverty level (FPL) may be eligible for a premium subsidy on a new web-based marketplace, known as the Exchange.

- **Coverage Requirements**
  - **Individuals** without coverage will pay a penalty of $95 or 1% of income – whichever is greater for 2014. Dependents under age 18 will be assessed 50% of the penalty for adults. (By 2016 this penalty increases to the greater of $695 per adult or 2.5% of income.)
  - There is no requirement that **small employers** (fewer than 50 employees) provide coverage to their employees. Small groups who purchase coverage in the small business health options program (SHOP) on the Exchange may be eligible for a Small Business Tax Credit for up to 50% of their contribution to their employees’ premium costs.
  - **Large groups** (50+ FTEs) who do not offer coverage at all will pay a penalty of $2,000 per full time employee, with the first 30 employees exempt from the calculation, if at least one employee receives a subsidy on the Exchange. If coverage is offered but it is unaffordable or doesn’t meet minimum value standards, the penalty is $3000 per employee that receives a subsidy on the Exchange. **Delayed until 2015.**
How will people buy coverage if they don’t have insurance through their employer?

- The ACA creates new online marketplaces for health coverage, known as the Exchange. New York State will operate its own Exchange, which will also serve as an enrollment portal for Medicaid. Telephone and paper enrollment options will also be available. Individuals and families will be able to comparison shop and purchase coverage through these new marketplaces, and may also be eligible for a subsidy to cover a portion of premium costs and possibly to reduce out of pocket costs, such as coinsurance.

Who can buy insurance from the New York State Exchange? How will it work?

- Individuals will need to fill out an application to have income and citizenship verified to determine eligibility for Medicaid or for a premium subsidy. The Exchange will allow comparison shopping for consumers in their geographic area (which for Western New York includes Erie, Niagara, Chautauqua, Allegany, Wyoming, Cattaraugus, Orleans, Genesee, and Livingston counties).
- NYS will offer small businesses coverage choices through the Small Business Health Options Program (SHOP). The state will aggregate payments for the small group and for its employees for insurance companies participating in SHOP.
- Initial enrollment in the individual exchange runs from 10/1/13 through 3/31/14, with coverage beginning 1/1/14 or after (depending on enrollment date). Enrollment for the SHOP begins on 10/1/2013 with coverage beginning on 1/1/14 and will be available on a rolling basis, depending on the small group’s contract renewal date.

How is the Exchange funded?

- New York received approximately $385 million in Federal funds to establish the Exchange. A significant portion of these grants have been used to build a new information technology infrastructure which integrates Medicaid enrollment and eligibility with Exchange operations for individuals and small groups.

How will the subsidies in the Exchange and the small business tax credit be paid for? Are my taxes going up?

- The ACA established several taxes and fees to pay for health care reform initiatives, including the premium subsidies and small business tax credit. While most of these taxes and fees will not appear in your annual tax return, they are likely to increase the cost of your health coverage. The fees most likely to impact your health insurance premium are as follows:
  - Reinsurance fee (Temporary: 2014-2016)
    - Estimated by the Federal government as $5.25 per person monthly (or $63 per person per year)
    - Reinsurance is a tool to help offset high claims costs for insurers, which in turn can keep premiums increasing steeply if an insurer has a large number of very sick members. The fee funding this pool will be collected from all insurers between
2014 and 2016 and used to provide financial assistance to plans whose individual product membership includes higher claims costs.

- Risk adjustment program user fee
  - $1 per person per year
  - While $1 is collected per member per year to fund the administration of this program, the program itself ensures that plans enrolling healthier-than-average individuals will be assessed risk adjustment charges and insurers enrolling sicker-than-average individuals will receive risk adjustment payments. This creates a more level marketplace because there is less incentive for insurers to “cherry pick” healthier members.

- Health insurance tax
  - This tax, estimated to generate $100 billion in revenue over the next decade, will be paid on all fully-insured commercial products, Medicare Advantage, and Medicaid managed care.
  - Actual tax amount will be allocated amongst fully-insured plans nationwide based on total premiums.
  - Could add 2-3% to premiums. $8 billion total to be collected in 2014, increasing each year after.
  - Self-insured products do not have to pay this tax.

- Patient Centered Outcome Research Institute (PCORI)
  - This fee, which will be collected until 2019, funds comparative effectiveness research projects and examines best practices to increase quality of medical care, reduce waste, and remove health disparities.
  - $2 per member 2014, goes up on October 1, 2014 to $2.15
  - Adjusted for expenditures from 2015 to 2019 (when it ends)

What responsibilities do employers have to provide coverage?
- Responsibilities are different for small employers (50 or fewer full time equivalents) compared to large employers (more than 50 full time equivalents). Large employers may face a penalty beginning in 2015 if they do not offer coverage meeting Federal standards. There is no penalty for small employers who do not offer coverage.
- The waiting period for new employees to receive coverage cannot exceed 90 calendar days from the employee’s first day.
Small Group Employers

What is a Small Employer?
- Fewer than 50 FTEs, with full time employees defined as 30 hours per week or more
- In 2016, the definition of small employer will increase to 100 or more FTEs.
- New York permits “eligible” employees to determine group size for rating and purchasing. An employer therefore could be a small group for rating purposes because of the number of eligible employees according to the employer’s definition, but have enough total FTEs to trigger a large employer penalty.
  - EXAMPLE: A small business has 65 employees, all working at least 30 hours per week. 35 of these employees are eligible for insurance through the company because they work 37.5 hours or more per week. If one of the 30 uninsured employees working 30 hours per week (now considered full-time under the ACA) buys coverage on the Exchange and receives a subsidy, the employer will pay a penalty for not offering coverage. The penalty would be 65 – 30 (the first 30 employees are exempt from the penalty calculation) = 35 x $2000 = $70,000

How is the number of FTEs determined?
- According to the ACA, the following factors are used to calculate an employer’s total number of FTEs:
  - Full-time employees – the number of full-time employees is based on an average 30-hour work week.
  - Part-time employees – prorated (hours worked by part-time employees in a month, divided by 120).
  - Seasonal employees – not counted for those working up to 120 days per year.
  - Temporary agency employees – generally counted as an employee of the temporary agency.
  - Franchise employees/common ownership – all employees across the entities are counted in on sum.
- Example of FTE calculation: the Acme Garden Company has a total of 60 employees – 30 full-time (working an average of 30 hours per week), 20 part-time (working 80 hours per month), and 10 seasonal employees (who work 30 hours per week for the 3 summer months). This group would be considered a small employer because it has 43.3 FTEs.
  - 30 full-time
  - 13.3 part-time (20 employees x 80 hours per month ÷ 120 = 13.3)
  - 0 seasonal (not applicable)
  - For a total of 43.3 FTEs

As a small group employer, what are my options for providing coverage?
- Small group employers have options to consider when deciding whether or not to offer healthcare coverage to their employees. Although small group employers will not be penalized for not offering healthcare coverage, there are other considerations to evaluate as part of this
decision such as the impact on employee recruiting, employee productivity, and employee retention. The employer may also be eligible for a small business health tax credit.

- The following options are available to small group employers:
  - Purchase coverage as done today either directly from health plan or through a broker
  - Use the New York State SHOP – part of the NYS Public Exchange for small groups (see below for more details)
  - Use a private exchange
  - Not offer coverage – no penalties
- A new option for small groups in 2014 is the SHOP—the Small Business Health Options Program. The SHOP is operated by NYS and is part of the Public Exchange that will offer coverage choices to small employers in a web portal similar to the one used by individuals. Through SHOP, employers can offer limited or multiple medial-tier options, and can also limit or expand the number of health plans offered.

**What benefits are there for small group employers to buy health insurance coverage through the SHOP?**

- Small group employers may be eligible for a small group health tax credit. Although the small group income tax credit is available currently to small groups offering health insurance coverage, starting in 2014 the small group income tax credit will only be available to small group employers offering health insurance coverage on the SHOP exchange. The credit can be claimed for two consecutive years. In addition to the tax credit, the SHOP will also aggregate all of the billing so each employer only receives one bill and writes one premium check, regardless of what options their employees choose.

**What is a Private Exchange?**

- A Private Exchange is private, online portal for employees of a particular business to select their health coverage. Independent Health has partnered with Bright Choices to offer employers a wide variety of health plans and other personalized benefits such as life insurance, disability insurance, HSA and FSA services. A Private Exchange also provides small businesses with a defined contribution model and also simplifies the enrollment process for HR/benefit administrators. Benefits of a Private Exchange include:
  - Already in existence; Independent Health has partnered with Bright Choices
  - Ability to offer defined contribution and defined benefits to employees
  - Offer additional benefits: life, disability, HSA, FSA, etc.
  - Administrative efficiency – online selection, group billing

**Is the coverage for my small group going to change in 2014?**

- Every small group (and individual) policy sold beginning in 2014 must offer the Essential Health Benefits. These benefits include hospitalization, maternity care, mental health services, pediatric dental care, pediatric vision coverage, and other benefits. Plans will also be available in four “metal tiers” established through the ACA that will determine what level of out of pocket
costs consumers are expected to pay. The metal tiers are determined by a plan’s actuarial value, which is roughly the average percentage of health care costs the insurer pays compared to what the insured member pays. The metal tiers are:

- Bronze: 60% actuarial value (similar to existing high deductible health plans)
- Silver: 70% actuarial value
- Gold: 80% actuarial value
- Platinum: 90% actuarial value (the more traditional health plan with minimal co-pays or cost sharing)

**How will my benefits change in 2014 if I am an individual (also applies to small groups)?**

- The Affordable Care Act detailed 10 Essential Health Benefits which must be covered as part of any small group (and individual) health plan. The Essential Health Benefits are made up of 10 categories of services:
  - Ambulatory Patient Services
  - Emergency Services
  - Hospitalization
  - Maternity and Newborn Care
  - Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment
  - Prescription Drugs
  - Rehabilitative and Habilitative Services and Devices
  - Laboratory Services
  - Preventive and Wellness Services and Chronic Disease Management
  - Pediatric Services, Including Oral and Vision Care

- New York selected the Essential Health Benefits as the template for all individual and small group plans sold in the state to ensure that all of the state mandated benefits are still covered.

**What is the Small Business Tax Credit?**

- The eligibility criteria to qualify for the tax credit for small business are as follows:
  - Businesses with fewer than 25 full time equivalent employees (FTE) for the calendar year are eligible
  - Average annual wages of less than $50,000 per FTE
  - Employer pays at least 50% of the premium cost
  - Tax credit amount (2010-2013):
    - 35% of employer premium payment for small businesses
    - 25% of premiums for non-profits
  - Credit only available through the Exchange (SHOP) after 2014
  - After 2014, the credit is 50% of premium, limited to two years
What small groups are eligible, and how is the tax credit calculated?
- For specific information on eligibility, the IRS has created a website to assist small businesses interested in filing for this tax credit: [http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers](http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers).

Do I have to provide coverage if I own several small companies?
- If a company has multiple affiliates under common ownership, all employees are aggregated to one total number.
  - Example: a parent company has 20 employees, and three affiliated companies have 15 employees each. This total would be aggregated to 65 total employees, and would categorize this employer as a large group.

How are FTEs for multiple affiliates calculated if the business owner has less than 100% ownership in one or more of the affiliates?
- It is unclear based on existing guidance. Independent Health has requested additional clarification from the IRS on this issue.

If I am a sole proprietor, am I still considered a small group?
- No. Beginning in 2014 sole proprietors will be able to purchase individual coverage only.

If a New York-based company has employees who live and work outside of New York, what are the coverage options for the out-of-state employees? Can they use the individual exchange in the state in which they reside?
- Employees who live out of state should be able to use the individual Exchange where they reside. In addition, companies with offices in multiple states may be eligible (based on group size within that state) to enroll in the SHOP in each of those states as a way to provide coverage to their employees.

Will family members whose employer offers coverage through the SHOP be able to choose different coverage through the SHOP?
- Family members cannot choose different products through the SHOP. Different product selections are only available in the individual Exchange.

Large Group Employers

What is a Large Employer?
- A large employer has 50 or more full-time equivalents (FTEs), calculated as a mix of full time, part time and seasonal workers as follows:
  - Full Time (30+ hours per week on average)
  - Part Time (total hours for employees aggregated and divided by 120)
- Seasonal (employees who work fewer than 120 days in a year are not counted toward the large employer threshold, and seasonal employees alone cannot push an employer from small group to large group status)
- In 2016, the definition of large employer will increase to 100 or more full-time equivalents.
- A large employer must provide coverage to all full-time employees and their dependent children up to age 26 (does NOT include spouses)
- Coverage must meet minimum value and affordability standards. Minimum value is defined as a 60% or greater actuarial value. An employer plan is deemed affordable when the employee has to contribute 9.5% or less of their income toward the lowest cost single policy offered (even if purchasing family coverage).

If I am a large employer or a small employer offering health insurance, what is the determination around whether or not insurance is deemed affordable for my employees?
- An employer plan is deemed affordable when the employee has to contribute 9.5% or less of their household income toward a single policy (even if purchasing family coverage). An employer may use an employee’s W-2 form to determine if the coverage offered meets this standard.

If I am a large employer, how do I know that the plan(s) that I am offering are adequate?
- Coverage must meet minimum value and affordability standards. Minimum value is defined as a 60% or greater actuarial value. The Summary of Benefits and Coverage provided by insurers to employer groups will note whether or not a plan meets or exceeds the 60% minimum value threshold. An employer plan is deemed affordable when the employee has to contribute 9.5% or less of their income toward a single policy (even if purchasing family coverage). An employer may use an employee’s W-2 form to determine if the coverage offered meets this standard.

What if my plan does not meet minimum value or is not affordable for all employees?
- If the coverage offered is not affordable for some or all employees or does not meet minimum value employee can purchase coverage through the Exchange and may be eligible for a subsidy. The penalty will be $3,000 for each employee who receives the subsidy.

If I am a large employer and do not offer health insurance coverage, will I have to pay a penalty?
- If no coverage is offered and at least 1 full time employee (30 hours or more per week) receives a subsidy through the Exchange, it triggers the following penalty:
  - (FULL TIME EMPLOYEES – 30) X $2000 ÷ 12 (penalty is assessed monthly)
    - The first 30 full time employees are exempt from the penalty and the penalty is not paid on part time or seasonal workers.
    - EXAMPLE: 75 FT employees – 30 = 45. 45 x $2000 ÷ 12 = $7,500 monthly penalty ($90,000 annually assuming the number of FT employees does not change month to month)
• Penalties also apply to large groups offering insurance if the insurance offered does not meet minimum coverage and does not meet affordability on an employee by employee basis.
  o The monthly penalty for inadequate of unaffordable coverage is the lesser of the following two calculations:
    ▪ $3,000 x [No. of Full Time employees who receive credit for Exchange coverage] ÷ 12
    ▪ $2,000 x [Number of Full Time employees – 30] ÷ 12
• The penalty has been delayed until 2015

If own a company with 300 employees based in Canada, but I have 20 employees in the United States, do I have to pay a penalty if I don’t offer coverage?
  • The penalty only applies to employees working in the United States. Employees based in another country are not included in the penalty calculation. With only 20 employees in the US this employer would be considered a small group not subject to the penalty.

**Individuals**

As an individual, what are my choices for buying coverage?
Individuals have new options related to choosing health care coverage starting in 2014:
  • Purchase coverage through the Exchange, which will be the only way to receive a federal premium subsidy or cost sharing (if eligible based on income)
  • Buy directly from an insurer as is done today
  • Go without insurance coverage and pay a penalty

Are individuals required to buy health insurance?
  • Individuals who do not have health insurance beginning on January 1, 2014 will face a penalty. This penalty is assessed annually on every member of a household who does not have coverage.
    o The penalty (tax) for 2014 is $95 for adults or 1% of income (whichever is higher) and $47.50 for dependents under 18.
    o In 2015, the penalty (tax) is 2% of income or $325 per person.
    o By 2016 the penalty (tax) increases to $695 for adults or 2.5% of income (whichever is higher), or $347.50 for dependents under 18.
    o The penalty is capped at the amount of the lowest cost bronze product available in the Exchange. For an individual in Buffalo in 2014 that is $221. For a family of four it is $630.
Can family members who enroll through the public Exchange able to choose different coverage per family member?
- Yes. Family members can select different options to find the most affordable coverage for their family. For example, a single parent with two children may find it more affordable to enroll in a single policy for their own needs and then enroll their two children in Child Health Plus coverage.

Are there any exemptions from the individual coverage requirement?
- Yes, there are exemptions from the individual penalty for those with a religious conscience exemption, individuals who cannot find coverage with a premium less than 8% of their income (although these people may be able to buy a catastrophic coverage plan), and several specialized groups (e.g. undocumented immigrants, incarcerated individuals, native Americans).

Do I have to buy coverage through the Exchange if I don’t get insurance through my employer?
- No, there will still be options available outside of the Exchange for individuals. However, purchasing coverage through the Exchange will be the only way to access premium subsidies and cost share reductions (if you meet income guidelines).

Am I allowed to buy insurance on the Exchange I have employer coverage but prefer the options in the Exchange?
- An individual who has an offer of coverage from an employer which meets the standards for affordability and minimum value is not able to receive a premium subsidy in the Exchange, though they would still be able to purchase coverage at full cost.

What are the premium and cost sharing subsidies available for individuals shopping on the exchange?
- The premium subsidies will be available on a sliding scale for households with income between 133-400% of the Federal Poverty Level (currently $15,281 to $45,960 for an individual or $31,321 to $94,200 for a family of four). The subsidy will be calculated as a percentage of the second lowest cost Silver plan available in the Exchange. Individuals can then purchase coverage at any metal tier based on their needs and what premium they are able to pay. Households with income below 250% of Federal Poverty Level ($28,725 for an individual or $58,875 for a family of four) will also be eligible for additional cost sharing when they purchase a silver level plan. This cost share reduction will be used to reduce out of pocket health care expenses such as deductibles and coinsurance.

What products will be available for individuals on the Exchange?
- Every individual policy sold beginning in 2014 must offer the Essential Health Benefits. These benefits include hospitalization, maternity care, mental health services, pediatric dental care, pediatric vision coverage, and other benefits. Plans will also be available in four “metal tiers” established through the ACA that will determine what level of out of pocket costs consumers are expected to pay. The metal tiers are determined by a plan’s actuarial value, which is roughly the
average percentage of health care costs the insurer plays compared to what the insured member pays. The metal tiers are:

- Bronze: 60% actuarial value (similar to existing high deductible health plans)
- Silver: 70% actuarial value
- Gold: 80% actuarial value
- Platinum: 90% actuarial value (the more traditional health plan with minimal co-pays or cost sharing)

- For individuals under 30 or where affordable coverage is not available (defined as costing less than 8% of household income) catastrophic coverage will also be available.
- All product options available to adults will also be available for children only at a reduced rate.
- Exchanges may offer separate dental and vision benefits for individuals.

**How do I enroll in coverage through the Exchange?**
- There is a streamlined single application to determine eligibility for Medicaid or Exchange subsidies which can be completed online or on paper. The Federal government estimates it will take approximately 45 minutes for an individual to complete this application and enroll in Exchange coverage online.

**How will my benefits change in 2014 if I am an individual (also applies to small groups)?**
- The Affordable Care Act detailed ten Essential Health Benefits which must be covered as part of any small group or individual health plan. The Essential Health Benefits are made up of ten categories of services:
  - Ambulatory Patient Services
  - Emergency Services
  - Hospitalization
  - Maternity and Newborn Care
  - Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment
  - Prescription Drugs
  - Rehabilitative and Habilitative Services and Devices;
  - Laboratory Services
  - Preventive and Wellness Services and Chronic Disease Management
  - Pediatric Services, Including Oral and Vision Care

- For most members the Essential Health Benefits will simply enhance existing products by covering more services.
- New York selected the Essential Health Benefits as the template for all individual and small group plans sold in the state to ensure that all of the state mandated benefits are still covered.
How will I know what benefits are covered, and what differences there are between plans?

- The Exchange will allow for comparison shopping on the website by allowing consumers to view plans side-by-side to look at benefits, provider networks, and quality ratings.
- Every consumer will receive a Summary of Benefits and Coverage (SBC) upon request or at enrollment which provides an overview of coverage for the most frequently used services. The SBC also comes with a glossary detailing commonly used terms.
- A treatment cost estimator is expected to be available on the Exchange to help consumers decide if the coverage they want to buy will meet their needs.
- Customer service will be available at the Exchange and at individual plans to answer any questions. In addition, a number of organizations—known as Navigators, Non-navigator Assistance Personnel, and Certified Application Counselors—are being created to work with consumers to select the right coverage.

What is the difference between Navigators, Non-navigator Assistance Personnel, and Certified Application Counselors? How do I know which one will be the most help for me to find the right plan?

- Navigators, Non-navigator Assistance Personnel, and Certified Application Counselors will all be trained by New York State to determine eligibility for subsidies or cost reduction assistance and to answer questions which will help consumers to buy coverage that fits their needs.
- Navigators were created directly through the ACA and will be funded by the Exchange. Due to funding limitations, such as an exclusion from receiving any compensation from insurance companies, there will be at least one Navigator per county, but there may not be more than that. To reach as many residents and to be as accessible as possible, New York will certify two additional entities: Non-navigator Assistance Personnel and Certified Application Counselors. Both Non-navigator Assistance Personnel and Certified Application Counselors will be able to help consumers apply for Exchange coverage and will be able to help customers understand the product offerings and benefits available.

How does the Exchange affect COBRA coverage? Are people who are offered COBRA through a former employer able to instead obtain coverage through the individual Exchange?

- COBRA coverage will still exist, but the advance premium tax credit cannot be used to lower the cost of coverage. An individual who loses employer coverage is eligible to purchase individual coverage through the Exchange, where the advance premium tax credit may be available for that individual (depending on household income).

If an individual misses the March 31 enrollment deadline to purchase coverage, can the individual purchase coverage at any time directly from the health plan?

- No. New York does not allow direct purchase of insurance coverage after the federal open enrollment deadline has ended.