SEMA FROM THE HILL

By Stuart Gosswein

Confused About the New Health-Care Law?

Here Are Things SEMA Members Need to Know

Although it was enacted into law in 2010, the Affordable Care Act may continue to be bewildering for many SEMA members. The following article is intended to provide clarity on how the law applies to member companies and their workers and identify threshold issues to consider when speaking with an insurance professional.

SEMA-Member Guide to the Affordable Care Act

The Affordable Care Act (also called Obamacare) is one of the most complex and sweeping laws enacted since the Great Depression. Signed into law in March 2010, the law is being phased in over many years. The cornerstone of the law takes effect January 1, 2014, when individuals are required to have health insurance either through their employer or on their own.

There has been much confusion and misinformation about the law. The following overview provides guidance on how it will generally impact SEMA members.

January 2014 is the deadline for individuals to obtain minimum levels of health insurance. It is also the deadline for larger companies (50 or more employees) to offer coverage or pay a penalty. How the law impacts companies and their workers can be summarized in two questions.

- Does your company offer health insurance?
- Is the size of your company 49 or fewer workers?

If your company is already offering health-care insurance, nothing more may be required to meet the law's January 1 deadline, but here are a couple of items to double check: Ask your insurance carrier to confirm that the policy meets applicable federal and state requirements. Also, if your workers pay a portion of the premium, it must be an "affordable" amount, or you may face a penalty. The definition is a bit complex and is based on the federal poverty level. As a general guide, it is not affordable if it exceeds 9.5% of the worker's household income.

As will be described, a primary mechanism for helping individuals and companies with 50 or fewer workers (and potentially 100 or fewer workers) find affordable coverage is health-care "exchanges." The states and federal government are in the process of setting up these marketplaces to allow employers and individuals to shop for coverage and compare competing plans. The exchanges are scheduled to be operating by January 1, 2014, and employers are expected to have access to the information by October 1, 2013.

The following are brief summaries of the law's major provisions. Below them is a timeline for implementation of the major provisions. Given that the law is being phased in over a number of years and some rules have not yet been written, this report will be periodically updated.

Essential Health Benefits (EHB) Defined

As of 2014, all policies in the individual and small group market must include minimum levels of coverage in

■ **The deadline for individuals to obtain minimal levels of health insurance and for larger companies to offer coverage or pay a penalty is January 1, 2014.**

10 categories deemed to be essential. The categories are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance-use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Exchanges

For years, SEMA lobbied in favor of legislation that would allow small companies to purchase nationwide insurance or bargain collectively across state lines, thereby infusing competition into the marketplace. The Affordable Care Act provides a variation on that approach through "exchanges." Individual states had until February 15, 2013, to indicate whether they would establish their own exchange or defer to a federally run option. Twenty-six states opted out in favor of a federal program.

The exchanges are set to be operational by October 1, 2013, in order to enroll people in coverage that will take effect January 1, 2014. Under the exchange, small businesses and individuals will be offered a menu of private-sector health plans that have been established under common rules regarding the offering and pricing of insurance. The exchange has the ability to pool a large number of potential consumers and thereby help organize a more competitive marketplace, especially if cost is a primary issue.

Consumers will be provided with transparent information to help understand the options and differences between the plans (covered benefits, deductibles, premium costs, etc.). The exchanges will determine eligibility and help enroll small businesses/individuals in appropriate plans. [Note: The federal government is delaying full implementation of its program and the 33 states where it will be running exchanges for one year. During 2014, small businesses in those areas will have only the option of selecting one plan rather than allowing their workers to select from multiple plans.)

Exchanges will be administered by a government agency or a nonprofit organization. Many state exchanges will be open to all businesses with up to 100 employees. (The initial limit for the federal program and federally operated state programs may be 50 or fewer.) Beginning in 2017, states will have the option of allowing companies with more than 100 workers to participate as well.

Quick Hits

When did Obamacare take effect?

It is being phased in over 10 years beginning in 2010, with new requirements and benefits being added every year. The most consequential change occurs January 1, 2014, when individuals are required to obtain minimum levels of insurance on their own or through their employers or the government (Medicare/Medicaid).

Is my company required to offer health insurance?

No for "small" companies (49 or fewer employees). A qualified yes for "large" companies (50 or more employees) as of 2014. There is no mandate to offer insurance; however, a large company will incur a non-deductible $2,000 penalty for every fulltime worker when at least one worker obtains a subsidy from the federal government to purchase an individual plan.

My company already offers insurance. Is that enough?

As of 2014, plans offered by insurance companies will cover at least 10 categories of "minimum essential health benefits," from hospitalization to prescription drugs. For large companies, check with your insurance professional to confirm that your plan meets the requirements or, if not, is a "grandfathered" plan. For small companies, while there is no obligation to provide coverage at any level, the government encourages participation and provides tax credits to very small companies (25 and fewer) to assist.

Can the worker pay a portion of the premium?

Yes, but the worker's portion of the premium cost must be "affordable." It is not affordable if it exceeds 9.5% of the worker's household income. (Verifying affordability may require a complex computation, but there are three employer safe-harbor options for making determinations.) The issue of affordability is generally associated with lower-wage workers. It is consequential, since the company will face a $3,000 penalty for each fulltime worker that

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States may also form regional exchanges or allow more than one exchange to operate in a state as long as each exchange serves a distinct geographic area. The federal government will contract with private insurers to offer at least two national or multi-state plans in each exchange.

There will be four benefit categories of exchange plans, plus a separate catastrophic plan. All of the plans will provide essential health benefits with an out-of-pocket limit equal to limits for Health Savings Accounts (currently $6,250 for individuals and $12,500 for families). The plans will differ in the amount of covered costs: 60% (bronze), 70% (silver), 80% (gold) and 90% (platinum).

Private health insurance exchanges may also appear in the marketplace, operated by a broker, insurer or third-party administrator. The private exchanges are designed to help employers and their workers find plans personalized to their specific health-care needs and budget.

Individual Mandate

For the first time in American history, individuals will be required to obtain "essential minimum coverage" for themselves and their dependents, beginning in 2014. The rationale is to ensure that everyone participates in the system, thereby increasing the risk pool and potentially reducing overall costs.

If individuals do not obtain coverage, a penalty will be assessed in 2014 in the amount of $95 or 1% of annual income, whichever is greater. This penalty will increase in 2015 to $325 or 2% of annual income and again in 2016 to $695 or 2.5% of annual income. Penalties for family coverage will be higher but will not exceed the annual income percentage caps listed above.

After 2016, the penalties increase by a cost-of-living adjustment. The government will provide subsidies for lower-income and unemployed individuals. The Internal Revenue Service (IRS) will be responsible for verification and enforcement of this requirement.

Employer Mandate

The law imposes significant requirements on mid-size and large companies but is less restrictive on small businesses. Employers with 49 or fewer employees are not required to offer health insurance. However, very small companies (25 or fewer employees) are provided tax credits as a mechanism to voluntarily offer coverage.

While there is no direct mandate, companies with 50 or more fulltime (working 130 or more hours per month) or "fulltime equivalent" employees must effectively offer health insurance by 2014, since they will be penalized as soon as any fulltime employee receives a government subsidy under the individual mandate. If the penalty is triggered, the government will impose a fee of $2,000 for all fulltime employees, minus the first 30 fulltime employees. For example, a company with 51 fulltime employees would be assessed a fine of $42,000 annually.

The quick formula for determining "fulltime equivalent" employees is adding the number of fulltime employees (30 hours per week or more equals 130 hours per month) and part-time employee equivalents (total monthly part-time hours divided by a cap of 120 hours). For example, if a company employs 40 fulltime workers and 20 part-timers working an average 20 hours per week or 80 hours per month, the 20 part-timers are the equivalent of 13 fulltimers (20 times 80 divided by 120 equals 13). Thus, the employer has 40 plus 13, equaling 53 fulltime equivalents. (Note: While the number of part-time workers is used to determine whether a company has met the 50 "fulltime equivalent" employee threshold for offering coverage, the $2,000 penalty is imposed only on fulltime employees, not part-time workers.)

Even when offering insurance, a company is exposed to one other potential penalty based on "affordability." If the worker is picking up a portion of the premium cost, it must be affordable. It is not affordable if it exceeds 9.5% of the worker's household income or if the plan does not cover at least 60% of medical costs (a "bronze" plan). Also, deductibles for fully insured small group plans are limited to $2,000 for employee-only coverage and $4,000 for family coverage (thereafter indexed to inflation). Verifying affordability may require a complex computation, but there are three employer safe-harbor options for making determinations.

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obtains a health-care subsidy from the federal government. (The $3,000 penalty is only for the individual worker and is not applied to all fulltime workers. On the other hand, the $2,000 penalty for failure to offer health coverage applies to all fulltime employees.)

What are the exchanges?

Beginning in 2014, companies with 50 or fewer employees (and, in some states, companies with 100 or fewer workers) will be able to purchase health insurance for their employees through exchanges. Exchanges will offer a range of health plans and are intended to infuse competition within the private insurance marketplace. The exchanges will be state-based and offer at least one federal plan. After several years, states will have the option of allowing large companies to participate in the exchange. Some states are deferring to the federal government to operate the exchange in their state. Private health insurance exchanges may also appear in the marketplace, operated by a broker, insurer or third-party administrator.

Am I required to purchase insurance through an exchange?

No. Participating in an exchange—whether state, federal or private—is voluntary. An exchange is intended to help employers and individuals find plans personalized to their specific health-care needs and budget. It is also intended to foster competition between private insurers.

Will premiums continue to skyrocket?

A primary purpose of the law is to expand coverage to all Americans while working within the traditional private insurance, employer-based system. It is also intended to spur competition. Nevertheless, how that will unfold is a great unknown. Insurance costs are expected to continue to rise year to year, especially in the next few years as insurance companies adjust to a new marketplace. Nevertheless, the law includes provisions designed to prevent unreasonable and unexpected premium spikes. There are also many variables on how it applies to an individual company and from state

■ **SEMA continues to work toward meaningful health-care reforms that will help reduce the cost of premiums.**

The issue of affordability is generally associated with lower-wage workers. It is consequential, since the company will face a $3,000 penalty for each individual fulltime worker who obtains a health-care subsidy from the federal government.

The law includes a non-discrimination clause for employer-provided plans. Currently scheduled to begin in 2014, the benefit plan cannot discriminate in eligibility, waiting period, benefits or contributions in favor of highly compensated employees. For example, some executives may receive more generous coverage than other employees as part of a compensation package.

Small-Business Tax Credits

The law provides an immediate tax credit to small employers that purchase insurance if they have no more than 25 employees and average annual wages of less than $50,000. The credit varies according to size, wages and the amount of employer contribution for the premium. Beginning in 2014, small businesses that purchase through an exchange will be eligible for a two-year tax credit, based on firm size and average annual wages.

Taxes

In 2013, a new 0.9% surtax was added to the 1.45% Medicare payroll taxes paid by individuals earning more than $200,000 per year or joint filers earning more than $250,000 per year. An additional 3.8% Medicare tax on investment income from capital gains, interest, dividends, annuities, royalties and rent was imposed on these same individuals/couples. Neither tax is indexed to inflation so the number of people exposed to the tax will increase each year.

In 2013, the threshold for claiming medical expense deductions rose from 7.5% of adjusted gross income to 10%. (The threshold will remain at 7.5% for individuals 65 or older until 2016).

In 2013, contributions to health-care flexible spending arrangements were limited to $2,500. The cap will be indexed to inflation beginning in 2014.

As of January 1, 2014, health insurers are forbidden from turning away people with pre-existing conditions. The federal government is establishing a $25 billion fund to help insurance companies cover the costs of previously uninsured people with

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to state. Some companies that have been paying higher premiums for full coverage could actually see reductions or stable premiums. SEMA will continue to fight to enact additional reforms that are designed to reduce premium costs.

Summary:

Important changes occur January 1, 2014. SEMA recommends that companies review their current health-care strategies and consult with insurance professionals in advance of that date.

SEMA PAC President's Club In the Spotlight

■ **Ron Coleman (left) and Rep. Steve Cohen (D-TN).**

Ron Coleman is the president of COMP Performance Group, headquartered in Memphis, Tennessee. Coleman has been a member of the SEMA PAC President's Club since 2004 and previously served as chairman of the SEMA Board of Directors. He was inducted into the SEMA Hall of Fame in 2000.

"The government is involved in your business every day through regulations, laws and taxes," Coleman said. "Everyone needs a voice in Washington to protect and represent their viewpoint, and SEMA PAC is my way of having my viewpoint heard. I recommend that everyone participate in the PAC to make their voice heard."

For more information on SEMA PAC, contact the SEMA PAC Manager Christian Robinson at 202-783-6007 x20 or christianr@SEMA.org.

Implementation Timeline

2010

- Tax subsidies for very small businesses that provide coverage.
- Children permitted to stay on parents' policies until 26th birthday.
- Lifetime limits on coverage prohibited.
- Preventive Care services provided with no cost sharing.
- Insurance companies barred from denying coverage to children with pre-existing illnesses.
- Rescission of coverage not allowed except for fraud, failure to pay or intentional misrepresentation.
- Essential Health Benefits determined and made mandatory without annual dollar limits or lifetime maximums.
- Coverage of emergency services.
- Access to OB/GYN care.

2011

- Rate Hike Review is implemented, whereby insurers must justify rate hikes over 10% to the state.
- 80/20 rule is implemented, meaning that insurers must spend at least 80% of money on health care or give customers a rebate for the difference starting in 2012.
- Over-the-counter drugs are no longer eligible for reimbursement under FSA.

2012

- Very large employers (250 or more workers) must begin reporting the value of health-care benefits on employees' W-2 statements.
- Summary of benefits and coverage required.
- Plans must cover women's preventive health-care services with no cost sharing.

2013

- A new 0.9% surtax is tacked on to the 1.45% Medicare payroll taxes paid by individuals earning more than $200,000 per year or joint filers earning more than $250,000 per year. An additional 3.8% Medicare tax on investment income from capital gains, interest, dividends, annuities, royalties and rent is imposed on these same individuals/couples. Neither tax is indexed to inflation, so the number of people exposed to the tax will increase each year.
- The threshold for claiming medical-expense deductions rises from 7.5% of adjusted gross income to 10%. (The threshold will remain at 7.5% for individuals 65 or older until 2016).
- Contributions to health-care Flexible Spending Accounts (FSA) are limited to $2,500. The cap will be indexed to inflation beginning in 2014.
- A new 2.3% tax is imposed on medical device manufacturers.

2014

- Small-Business Health Option Programs (SHOP) exchanges for small businesses take effect (if not sooner). Subsidies available to participating small companies based on wages and number of employees. Congress must also shop via the exchanges.
- Large companies (50 or more fulltime and fulltime-equivalent employees) must offer affordable coverage or risk a fine of $2,000 per employee, excluding the first 30 employees.
- Three-year fee starts to be imposed on employers for each person insured under a plan to finance a $25 billion fund to help insurance companies cover the costs of the newly insured with pre-existing conditions. Fee starts at $63 at the end of 2014 but decreases to about $40 in 2015 and $28 in 2016.
- All individuals must now have minimum insurance or pay a penalty (as outlined above).
- Medicaid expands coverage to 17 million low-income individuals (subject to state approval).
- Health plans are prohibited from imposing annual limits on the amount of coverage an individual may receive.
- Benefits must begin by the 91st day.
- Cannot deny coverage based on pre-existing condition, regardless of age.

2015

- Penalty for individuals that don't have minimum insurance rises to $325, capped at greater of $975 per family or 2% of family income.
- Doctor's income is to be based on quality of care not the quantity of care provided.

2016

- Penalty for individuals that don't have minimum insurance rises to $695, capped at the greater of $2,085 per family or 2.5% of family income, and is thereafter tied to inflation.

2017

- Businesses with more than 100 workers may buy coverage through the SHOP exchange, if state permits.
- States have the authority to implement their own plans (e.g., a single-payer plan where state residents are taxed and have coverage, replacing private insurance).

2018

- A 40% excise tax on high-cost health insurance plans takes effect. Paid by insurers, the tax is on the amount in excess of $10,200 for individuals and $27,500 for families.

2020

- Medicare Gap now fully eliminated (instead of just offering rebates to seniors).

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medical problems. The fund will be financed by a three-year fee imposed on employers for each person insured under a plan. The fee will start at $63 at the end of 2014 but will decrease to about $40 in 2015 and $28 in 2016. Some employers are expected to pass along the fee to workers.

Health insurance providers will collectively pay a new tax, starting at $8 billion in 2014 and gradually increasing each year. In turn, the health providers may then pass it along to employers.

As of 2012, very large employers (250 or more workers) must report the value of the health plan coverage they provide on the workers' W-2 forms, which may or may not include COBRA premiums. The requirement is currently optional for smaller employers but will eventually become mandatory. The reporting requirement includes both the employer and employee share of health coverage but excludes dental and vision coverages that are under separate policies. Employer contributions to Health Savings Accounts or worker contributions to Flexible Savings Accounts (FSA) are excluded. However, employer contributions to Health FSA plans may be included if benefits are greater than employee contributions.

Other Provisions

The law imposes a variety of restrictions on the insurance industry. It prohibits individual and group health plans from placing lifetime limits on the dollar value of coverage or annual limits on the dollar value of coverage. It provides dependent coverage for children up to age 26 for all individual and group policies and prohibits pre-existing condition exclusions for children. The law establishes a national high-risk pool to provide health coverage to other individuals with pre-existing conditions. The law provides grants for up to five years to small employers that establish wellness programs and allows companies to offer employee rewards to participate (premium discounts, waivers of cost-sharing requirements, etc.).

Health Insurance Premium Costs

Implementation of the new health-care law has so many complexities and unknown variables that it is nearly impossible to predict its effect on the number-one issue for companies: the cost of health-care premiums. The exchanges are intended to stabilize prices through marketplace competition. However, it remains unclear whether companies and individuals will fully participate in the exchanges and whether the federal and state governments can create data hubs that will be easy for consumers to navigate. The law also contains many other mechanisms designed to reduce costs, such as "accountable care organizations," where primary-care doctors, specialists and hospitals work together to deliver patient services based on value rather than volume.

Educating Americans on all aspects of the new law remains a challenge. SEMA-member companies are encouraged to review their current situations, speak with professionals and determine how to proceed. SEMA is working with a number of other organizations to pursue meaningful reforms that will help reduce the cost of health-care premiums.