How Will the ACA Affect Community Rehabilitation Programs?

Final Report

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While some provisions of the Patient Protection and Affordable Care Act (ACA) affect all employers, many will affect employers in various circumstances differently. These circumstances include the number of full- and part-time workers they employ, their contributions to coverage (if a large employer), the level of benefits their health plans currently cover, and the family incomes of their employees.

The ACA provisions already in place affect both small and large employers as well as health plans available to individuals. Among these provisions are coverage of dependents until age 26, the elimination of lifetime limits on coverage, prohibition of denials and pre-existing conditions for children, standardization of appeals processes, coverage of preventive services, and premium rebates by insurers that fail to pay out in medical benefits at least a minimum percentage of premiums.

In 2012 and 2013, additional changes will take effect, including standardized communication of benefits and the availability of new, nonprofit health plans in at least some geographic markets. Other significant changes, slated to be in place by 2014, will include (1) the rollout of health insurance exchanges for individuals and small groups (re-defined to include groups of up to 100 employees), (2) guaranteed issue and renewal of coverage for individuals and small groups, and (3) rules prohibiting insurers from setting premiums based on health status or claims experience, and from denying coverage for pre-existing conditions.

Starting in 2014, each state will operate two exchanges: an American Health Benefits exchange (often simply called an exchange or an individual exchange) for all legal residents and a Small-Employer Health Options Program (SHOP) exchange for employers with fewer than 100 full-time equivalent (FTE) employees. The SHOP exchanges will offer a choice of plans to small employers and possibly to employees as well.

Also starting in 2014, the tax credit currently available under the ACA to small, low-wage employers that offer coverage will be available only to employers that buy coverage through the SHOP exchange. Low- and middle-income consumers who buy coverage through the individual exchange may qualify for premium assistance and reduced cost sharing if they (1) are not offered affordable employer-sponsored insurance that covers at least minimum essential benefits, (2) are not eligible for Medicaid or another program such as Medicare or veterans' health benefits, and (3) meet certain income requirements. Employers with at least 50 FTE employees might be penalized if they do not offer affordable essential health benefits and any of their employees receives subsidized coverage through an individual exchange.

The ACA substantially expands eligibility for Medicaid by 2014. Most newly eligible people will be adults without dependent children, including many low-wage workers. States may offer newly eligible beneficiaries benchmark coverage, which will include fewer services than the Medicaid coverage provided to most current beneficiaries, but it must provide all essential benefits the ACA also requires of employer-sponsored and individual health insurance plans. Legislation enacted after the ACA changed the way Social Security benefits are included in the calculation of modified adjusted gross income and could affect how many workers become or remain eligible for Medicaid; however, this provision will not affect workers currently eligible through Supplemental Security Income or other disability programs.

Some regulations affecting employers and insurance coverage are still under development. For example, regulations specifying requirements for the essential benefits package have not been finalized. The U.S. Department of Health and Human Services will also issue regulations that may affect the way wage determinations are computed under the Davis-Bacon Act and the Service Contract Act. Until these and other regulations implementing the ACA are proposed and finalized, employers will face some uncertainty regarding the full implications of the law.

Nevertheless, all signs point to significant changes in the landscape for employer-sponsored coverage, and some aspects of the ACA may be especially salient for community rehabilitation programs (CRPs). Specifically, CRPs and other low-wage employers might be asked to enroll more Medicaid participants in their health plans (especially dependents in cases where the employee pays most or all of the additional cost of family coverage). In addition, some low-wage workers might lose their Medicaid coverage and, consequently, their supplemental support services. With many more workers eligible for Medicaid in 2014, more workers may prefer to receive cash wages or other tax-preferred benefits in lieu of health insurance, and some employers might consider cafeteria plans to address their changing need for benefits in this new environment for health coverage. In addition, all employers with as many as 100 employees will have new access to a SHOP exchange, opening new opportunities to offer their employees plan choice.

How Will the ACA Affect Community Rehabilitation Programs?

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) [1] will extend health insurance coverage to millions of working Americans. It has a number of provisions that directly affect all employers that offer coverage; for example, family coverage must include children up to age 26, and preventive services must be covered without cost-sharing. Starting in 2014, larger employers might face penalties if they do not provide affordable coverage to full-time workers. However, the ACA will not require employers with fewer than 50 full-time-equivalent (FTE) workers to offer health insurance to their employees, nor will it penalize them for not offering health insurance.[2]

The most sweeping changes that the ACA will bring about are new opportunities for individuals and small employers to purchase high quality, competitively priced coverage in state-based or regional health insurance exchanges. Low-income individuals will receive subsidies to help them buy coverage in the exchange, if they do not have a qualified offer of coverage from an employer. The ACA will also extend Medicaid eligibility to all low-income adults and children—including many minimum-wage workers—while retaining current eligibility rules for children under age 18 to enroll in the Children's Health Insurance Plan. Finally, small employers will have the chance to select high quality, competitively priced plans in Small-Employer Health Options Program (SHOP) exchanges and to offer their workers choice among plans.

The ACA will affect employers differently depending on the number of full- and part-time workers they employ, their contributions to coverage (if a large employer), the level of benefits that their health plans currently cover, and the family incomes of their employees. Although employers know most of these factors with certainty, they do not know their workers' family incomes—only the wages they pay them. Thus, some of the costs employers will face as the ACA takes effect might be difficult to predict.

This policy brief describes how the ACA will affect employers. We note issues regarding coverage and benefits that employers should watch for as regulations are released spelling out the many details that could affect employers and their workers, including disabled workers employed in community rehabilitation programs (CRPs).

A. Health Insurance Reforms

The ACA requires insurers and employer health plans to make a number of changes to their health benefits. Many of the ACA provisions already in place affect both small and large employers as well as health plans available to individuals.

- **Dependents.** The ACA requires all individuals and group policies with family coverage to allow adult children to remain on the parent's plan until age 26.
- **Limits on coverage.** Individual and group health plans may not place lifetime limits on the dollar value of coverage. The ACA also phases out annual limits on the dollar value of coverage and prohibits them entirely as of 2014.
- **Denials and pre-existing condition exclusions for children.** Insurers may not deny coverage to children based on pre-existing medical conditions or impose pre-existing condition exclusions on coverage for children.

- **Rescissions.** The ACA prohibits insurers from rescinding (that is, retroactively cancelling) coverage except in cases of fraud.
- **Appeals.** Health plans must implement an effective process for allowing consumers to appeal health plan decisions and establish an external review process.
- **Coverage of preventive services.** Health plans must provide coverage without cost sharing (that is, with no deductible, coinsurance, or copayment) for the preventive services recommended by the U.S. Preventive Services Task Force. These preventive services include recommended immunizations; preventive care for infants, children, and adolescents; and additional preventive care and screenings for women.
- **Minimum pay-out for medical benefits and regulatory review of premium increases.** Health plans must report the amount of premium dollars spent on clinical services, quality, and other costs and pay a rebate to consumers if this amount is less than 85 percent of the premium for large-group plans and 80 percent of the premium for individual and small-group plans. Rebates for 2011 will be paid to employers and individuals in mid-2012. The ACA also mandates careful review of proposed premium increases for individual and small-group coverage; federal regulations require the U.S. Department of Health and Human Services (HHS) to review any proposed premium increase that exceeds 10 percent per year.
- **Use of flexible spending and health reimbursement or savings accounts**. Costs for over-the-counter drugs, if not prescribed by a doctor, may not be reimbursed through a health reimbursement account or flexible spending account, nor can they be reimbursed on a tax-free basis through a health savings account or Archer medical savings account (MSA). The ACA also increases the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses—to 20 percent of the amount used.

In 2012 and 2013, additional changes will take effect:

- **Communication of benefits.** The ACA requires private individual and group health plans to provide a uniform summary of benefits and coverage (SBC) to all applicants and enrollees. The purpose of the summary is to help consumers compare coverage options before they enroll and better understand their coverage after they enroll. On February 9, 2012, the HHS issued final regulations and a final template for health plans to use.[3]
- **New nonprofit health plans.** The ACA established a consumer-operated and oriented plan (CO-OP) program to foster the development of nonprofit health insurance plans for individuals and small groups. CO-OPs must be governed by a majority vote of members and be independent of the insurance industry. Any profit made by a CO-OP must be used to lower premiums, improve benefits, or sustain programs intended to enhance the quality of health care for members.[4] CO-OPs are expected to begin opening for enrollment in 2013.

Finally, several major changes will occur in 2014 (coinciding with the rollout of health insurance exchanges for individuals and small groups, as described in the next section):

- **Definition of a small group.** The ACA redefines the small-group market to include groups of up to 100 employees. All regulations and protections that apply to the small-

group market will apply to these larger small groups as well.[5] As described below, these include guaranteed issue and renewal, restrictions on premiums, and the ability to buy coverage in the SHOP exchange. States may defer this change until 2016; most states currently define small groups as those with 2 to 50 employees.

- **Guaranteed access to coverage**. The ACA requires insurers to guarantee issue and renewal of health insurance regardless of health status for all individual and small group applicants.[6] Employers also must ensure employees' access to and renewal of health coverage regardless of their health status, if they are otherwise eligible to participate in the plan.
- **Limits on insurance premiums.** The ACA allows issuers to vary premiums for individuals and small groups, but based only on enrollees' age, geographic area, family composition, and tobacco use. It limits the highest premium for adults to three times the lowest premium for adults, and the highest premium for tobacco users to one and a half times the premium for nonusers.
- **No exclusions for pre-existing conditions.** After January 1, 2014, group plans may not exclude coverage for pre-existing health conditions. For children under age 19, this rule took effect in 2010.

Some individual and employer group plans will be able to meet the requirements of the ACA with relatively few changes if they claim "grandfathered" status. Grandfathered plans must offer preventive services without cost sharing and, if they offer family coverage, they must allow dependents to age 26 to enroll if they do not have employer-sponsored coverage.[7] In addition, grandfathered plans (like nongrandfathered plans) cannot have lifetime caps or annual limits on essential benefits (to be defined in final regulations), and they are subject to ACA's prohibition on rescissions.[8]

A health plan will lose its grandfathered status if it makes any major changes that reduce the value of the plan or, in the case of an insured or self-insured group plan, changes the insurer or plan administrator. Changes that reduce the value of a plan would include increasing cost sharing, raising out-of-pocket limits faster than the rate of medical inflation plus 15 percent, lowering annual coverage limits, imposing new limits on coverage, or eliminating coverage for specific conditions.

B. Health Insurance Exchanges

The ACA requires the development of state-based exchanges, designed to help individuals, families, and small employers buy health insurance. Starting in 2014, each state will operate two exchanges: an American Health Benefits Exchange (often simply called an exchange or an individual exchange) for all legal residents, and a SHOP exchange for employers with fewer than 100 FTE employees. A state may choose to combine the individual and SHOP exchanges, operating them as a single exchange.[9] However, if a state chooses not to establish these exchanges, the ACA requires the federal government to step in and create them.

The ACA allows small-group and individual insurance to be sold outside the individual or SHOP exchanges, but only qualified health plans (QHPs) will be sold in the exchanges. QHPs are private plans that (1) meet the ACA's standards for reporting benefits and quality information to help consumers and employers compare health plans, and (2) undertake certain quality improvement activities. They are subject to federal standards for network adequacy and must include essential community providers, which serve low-income and underserved populations.[10] Both individual and

SHOP exchanges will offer plans in four value tiers (platinum, gold, silver, and bronze) to help consumers and employers compare plans within a tier based on price and quality. [11]

1. Individual Exchanges

Low- and middle-income consumers who buy coverage through the individual exchange may qualify for premium assistance and reduced cost-sharing. Specifically, these consumers are eligible for a premium credit if they:

- Are not offered affordable employer-sponsored insurance that provides essential coverage (that is, covers at least the minimum essential benefits) [12]
- Are not eligible for Medicaid or another program (such as Medicare or veterans' health benefits) that provides essential coverage
- Meet certain income requirements (in general, family income between 138 percent and 400 percent of the federal poverty level [FPL]) [13]

In an individual exchange, both premium assistance and reduced cost-sharing are scaled to income, and they phase out completely at 400 percent of the FPL—about $92,000 for a family of four in 2012. [14] The ACA also authorizes grant funding for "navigators" and community assistance programs to help the millions of people who have never before purchased health insurance understand the eligibility criteria, enrollment process, and available subsidies—or to help them enroll in Medicaid if eligible. [15]

2. SHOP Exchanges

The ACA offers a refundable tax credit to employers with 25 or fewer employees and average FTE wages of $50,000 or less (adjusted for changes in the cost of living) when they contribute at least 50 percent of the premium for group coverage. [16] The credit varies based on employer size and average wage. Under the ACA, a nonprofit employer with average wages less than $50,000 may qualify for a refundable credit in the form of a reduction in the employer's income and Medicare tax withholding and the employer share of Medicare tax on employees' wages (with the credit limited by these amounts). Currently, the maximum credit is 25 percent of employer-paid premiums (for nonprofit establishments with 10 or fewer FTE workers and average wages of less than $25,000), phasing out between 10 to 25 FTE employees and for average wages between $25,000 and $50,000. Starting in 2014, the refundable tax credit will increase, ranging as high as 35 percent of employer-paid premiums for the smallest nonprofit establishments with average wages less than $25,000, and it will be available only in the SHOP exchange for two additional consecutive years. [17] New regulations will define how employers who obtain the tax credit will account for contributions to premiums under the wage and benefits requirements of the Davis-Bacon Act and Direct Service Contract Act.

The SHOP exchanges will offer a choice of plans to small employers and employees as well. They might accommodate small employers that want to establish defined-contribution health plans, which are limited or unavailable in most markets. [18] States must open SHOP exchanges for employers with as many as 50 employees by 2014, and they must admit employers with as many as 100 FTE employees by 2016. States may open the SHOP exchange to still larger employers in (or after) 2017.

C. Shared Responsibility for Employers[19]

Starting in 2014, employers with at least 50 FTE employees might be penalized if (1) they do not offer affordable "essential" health benefits and (2) any of their employees receives subsidized coverage through an individual exchange. If an employee applies for a premium credit in the exchange, HHS will notify the exchange about whether the person is eligible for a premium credit—either because his or her employer does not provide essential coverage or because that coverage is unaffordable. The employer will then pay a penalty for each month the employee is in the exchange and is eligible to receive premium assistance or reduced cost sharing.[20] An appeals process will be put in place to resolve disputes about the determination of a penalty.

In some situations, employers with 50 or more FTE employees might not have to pay penalties. Because the "trigger" for these penalties depends not only on the employer's offer of coverage but on the employee's family income, an employer that does not provide coverage may not be penalized if no full-time employee qualifies for a premium credit in an exchange. Medicaid-eligible employees count toward employer size, but they cannot trigger an employer penalty since they are ineligible for subsidies in the exchange.

Thus, in a workplace where full-time employees receive high wages (so their family incomes are likely to exceed the income limit for a tax credit in the exchange), it is unlikely that a penalty would be triggered. Also in workplaces with low-wage workers who are eligible for Medicaid, Medicare, or veterans' health benefits, it is possible that a penalty would not be triggered because few of their workers would qualify for subsidies in the exchange. Figure 1, developed by the Congressional Research Service, illustrates the circumstances under which an employer may be subject to a penalty under the ACA. We also offer three scenarios illustrating ACA requirements for differently situated employers in a series of text boxes that follow.

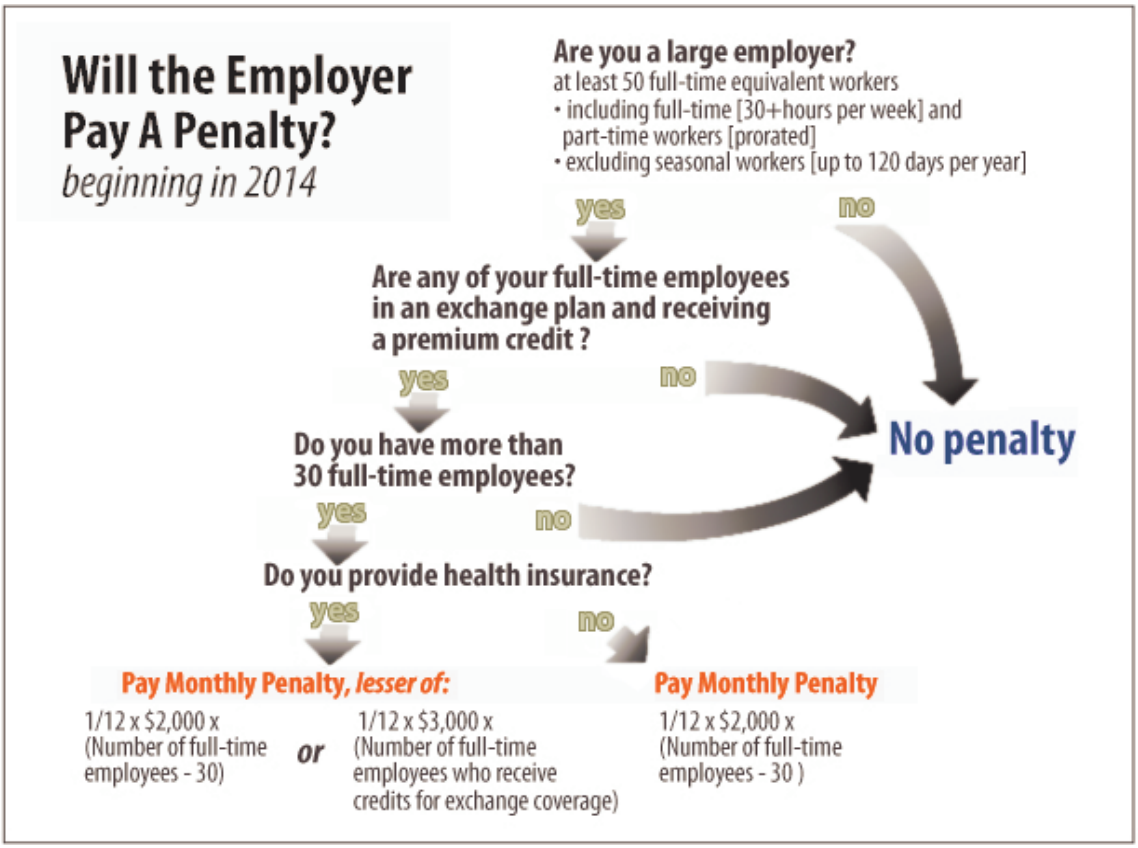
D. Expanded Eligibility for Medicaid and Impact on Medicare

The ACA substantially expands eligibility for Medicaid. By 2014, all legal residents whose household income is less than 138 percent FPL ($15,415 for a single person and $20,879 for a couple in 2012) will be eligible for Medicaid.[21] Most newly eligible people will be adults without dependent children, including many low-wage workers. One recent study estimated that 6 to 12 million adults who currently have employer-sponsored health coverage will become eligible for Medicaid under the ACA.[22]

States need not offer full Medicaid services to these newly eligible beneficiaries, however. Instead, they may offer "benchmark" coverage, which will cover fewer services but provide all essential benefits that are also required in QHPs, and may entail some cost-sharing for covered services.[23] The states cannot charge a premium for this coverage. Although the final regulations for QHPs have not been issued, it is clear that this benchmark coverage will equal or exceed the level of employer-sponsored coverage currently offered by most small or mid-sized employers.

Readers should note that ACA does not affect Supplemental Security Income (SSI) beneficiaries either for the usual eligibility purposes or for 1619 purposes. Social Security Disability Insurance (SSDI) beneficiaries would be eligible for Medicaid during their 24-month waiting period if their household income is less than 138 percent of federal poverty levels ($15,415 for a single person and $20,879 for a couple). Final regulations provide that individuals eligible for Medicare (see Appendix A) can ask to be evaluated for full Medicaid coverage under either pre-ACA rules or the new ACA eligibility rules.[24]

Figure 1. Potential Employer Penalties Under the ACA



Source: Chaikind, Hinda, and Chris L. Peterson. "Summary of Potential Employer Penalties Under the Patient Protection and Affordable Care Act (PPACA)." Washington, DC: Congressional Research Service, June 2, 2010. Available at http://www.ncsl.org/documents/health/EmployerPenalties.pdf]. Accessed January 31, 2012.

E. Status of ACA Regulations That Affect Employers

To implement the reforms required by the ACA, several federal agencies—including HHS, the U.S. Department of Labor (DOL), the Internal Revenue Service (IRS), and the Treasury Department—must develop regulations and guidance. As indicated in Figure 2, some of the regulations affecting employers have already taken effect in the past two years. Other regulations released in March 2012 address how the individual and SHOP exchanges will operate, as well as how states may structure reinsurance and risk adjustment programs to help distribute financial risk across the insurance market. However, some regulations that will guide employers in meeting their responsibilities under the law have not yet been released.

Two rules contained in final regulations released in March 2012 are particularly important for employers. The first rule lays out the procedures that exchanges must follow when making decisions about individual or employer participation in exchanges, [25] as described in Section C. The second rule sets out the procedures and criteria for the new Medicaid eligibility category, low-income adults ages 18 to 65, established under the ACA. [26]

The latter rule should be considered in light of legislation enacted in November 2011 (P.L. 112-56) requiring that Social Security benefits be included in the calculation of modified adjusted gross income (MAGI). [27] In general, disabled workers now eligible for Medicaid will continue to be eligible after 2014, if they are "categorically" eligible for Medicaid through the Supplemental Security Income (SSI) program or another state and federal disability program. Workers in these eligibility categories are not subject to the new MAGI formula for determining Medicaid eligibility. However, the new MAGI formula may cause a small number of workers who now qualify for Medicaid to lose eligibility in 2014.[28] It may also affect workers with higher family incomes, who might lose eligibility for the subsidies in the exchange due to consideration of their Social Security income.

At this writing, regulations specifying requirements for the essential benefits package have not been finalized. In December 2011, HHS issued a bulletin describing the general plan it intends to propose to define essential health benefits under Section 1302 of the ACA. This plan would allow each state to set a benchmark for essential benefits (within the broad categories specified in the ACA) based on the benefits offered in the small-group plan with the largest total enrollment in the state. [29]

In addition, HHS will issue regulations related to the ACA's provisions that amend the Internal Revenue Code and employment rules in the Fair Labor Standards Act. [30] These regulations will define "new" full-time employees (whom employer plans with 200 or more employees must automatically cover) and also "applicable large employers" subject to this requirement. [31] The new rules and guidance may in turn affect the way that wage determinations are computed under the Davis-Bacon Act and the Service Contract Act (SCA). Until these and other rules implementing the ACA are proposed and finalized, employers will face some uncertainty regarding the full implications of the law. [32, 33]

ACA Requirements: Scenario 1 – The CRP has more than 200 workers in different states, and both service and products contracts. Workers are paid with Commensurate and Wage Determination Rate wages.

Because this CRP has more than 30 full time workers, it is subject to the ACA employer responsibility provisions of the ACA and might face a penalty as of January 1, 2014 if it does not offer qualified, affordable coverage to all full time employees. Each state will define an essential benefits package within federal guidelines. Therefore, some of the benefits that constitute qualified coverage might vary from state to state. To be affordable, the employee contribution for health insurance cannot exceed 9.5 percent of the employees' household income, and the insurance plan must pay at least 60 percent of covered health expenses.

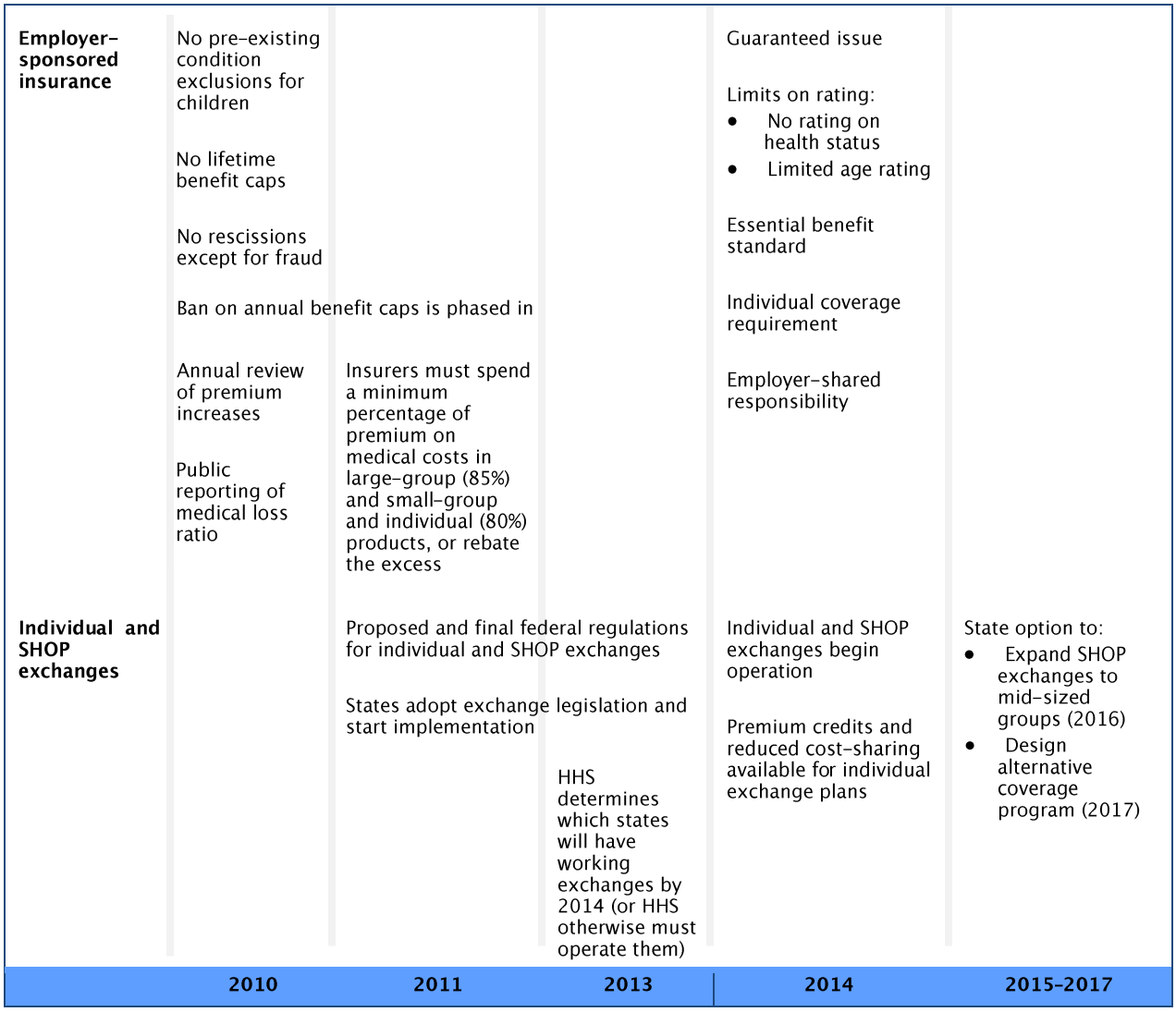
If the CRP does not offer qualified affordable coverage, it would pay a penalty only if a full-time employee approaches the state insurance exchange to buy individual coverage and qualifies for a premium credit—that is, their income is below 400 percent of the federal poverty level. Employees who are eligible for Medicaid do not qualify for premium credits in the exchange.

The size of the penalty will be determined by the number of employees and/or the number of employees who receive premium credits in the exchange. For this CPR, if 10 employees receive tax credits in an exchange, the monthly penalty would be $2,499 (1/12 x $3,000 x 10 employees). New regulations will address whether the ACA might change employers' accounting for contributions to premiums under the Davis-Bacon Act and Direct Service Contract Act.

F. Administrative Requirements for Employers

The ACA requires employers to provide specific information to all employees. First, if employers offer a plan that pays less than 60 percent of the average allowed cost of covered services, they must inform all employees about the state's health insurance exchange by March 1, 2013. They must tell employees how to contact the exchange to obtain assistance, and about the premium tax credits and cost-sharing subsidies that may be available to them. In addition, employers must inform employees that they will forfeit the employer contribution to coverage in the employer plan if they purchase coverage in the exchange.[34] This information must also be provided to new employees when hired. [35]

Figure 2. ACA Timeline for Employer-Sponsored Health Insurance



Source: Mathematica Policy Research.

Large employers with more than 200 full-time employees have additional requirements. Those that offer at least one health benefit plan must automatically enroll new employees and automatically renew enrollment in their current plans. Employees must be given adequate notice and the chance to opt out of coverage in plans in which they were automatically enrolled. [36]

In addition, as of March 1, 2013, employers with at least 50 FTE employees must annually report to the Treasury Department on whether they offer essential coverage, the length of any waiting periods, and the premium and employer contribution for the lowest-cost plan. They must also report the number of full-time employees on their payroll each month during the year and identify the employees enrolled in their plan.[37] The Treasury Department and IRS are currently seeking comments on the draft rules for implementing these new requirements. The final regulations will address some key issues for employers, including specific definitions and possible exceptions or "safe-harbor" provisions for employers regarding the affordability of health coverage. [38]

G. Implications for Employers

Although many of the regulations needed to implement the ACA are yet to be released, all signs point to significant changes in the landscape for employer-sponsored coverage. Some aspects of the ACA may be especially salient for employers of low-wage workers, including CRPs.

ACA Requirements: Scenario 2 – The CRP has less than 100 workers, and both service and products contracts. Most workers are part time and are SSI recipients that receive Medicaid, or they are paid less than minimum wage.

If this CRP has 50 or more full-time-equivalent (FTE) employees, it might be subject to the ACA's employer responsibility provisions beginning in 2014. The ACA defines a full-time employee as one who works at least 30 hours per week (120 hours per month). If this CRP has 30 full time employees, and the remaining 70 employees each work 15 hours per week (60 hours per month), it would have 65 FTE employees—that is, 70 part time employees times 60 hours per month divided by 120 hours (equal to 35 FTEs), plus 30 full time employees.

In this example, the CRP might not be subject to a penalty for not offering qualified, affordable coverage. The formula determining penalties disregards the first 30 full-time employees. With only 30 full-time employees in total, this CRP would not pay a penalty if an employee buys coverage in the exchange and receives a tax credit. However, it could be assessed a penalty if more than 30 employees work full time in a given month and a full-time employee (when not Medicaid eligible) is covered in the exchange and receives a tax credit. New regulations will address whether the ACA might change employers' accounting for contributions to premiums under the Davis-Bacon Act and Direct Service Contract Act.

Because this CRP has less than 100 workers, it might be able to buy coverage for its employees in the state's SHOP exchange as early as 2014, but not later than 2017. SHOP exchanges will offer a range of affordable plans to small employers and also offer employees a choice among plan options.

- **Employers might be asked to enroll more Medicaid participants in employer-sponsored plans.** As discussed earlier, more workers will be eligible for Medicaid in 2014. Most of the currently eligible workers (including people receiving Social Security disability or Supplemental Security Income benefits) will likely continue to be eligible, and if they also have employer-sponsored insurance, Medicaid will remain the secondary payer. Because it is often less costly for Medicaid to pay premiums to enroll workers and their dependents in employer-sponsored coverage when available than to enroll them directly in Medicaid, employers in states that have Medicaid "buy-in" programs for workers with disabilities may be approached to also enroll dependents. Currently, 44 states have some form of buy-in program. [39]

- **Disabled workers who are newly eligible for Medicaid might not receive the support services that SSI-eligible workers have.** New federal rules make it clear that individuals who are eligible for Medicaid as blind or disabled, or who qualify for Medicaid long-term care services and supports, will be able to enroll for such coverage regardless of the new MAGI formula. However, workers with disabilities who enter Medicaid in the new low-income adult eligibility category might not gain access to the support services that current enrollees receive, helping them to participate and remain in the workforce.[40]

- **CRPs can offer their workers plan choice.** The SHOP exchange is intended to offer both employers and workers in groups of fewer than 100 a choice among high-quality health plans. Under final rules issued in March 2012, all SHOP exchanges will allow the employer to pick a plan tier, allowing employees to select among QHPs within the tier. However, the SHOP exchange might also allow alternative options, potentially including employer selection of a single plan (without employee choice), employer selection of plans in each of several tiers, or allowing employees to choose plans across tiers. [41]

- **CRPs might consider providing alternative tax-preferred benefits**. The SCA requires CRPs to provide health and welfare benefits equal to $3.59 per hour, or to pay

cash wages instead. Some CRPs currently allow employees to choose among fringe benefit options or to opt for cash rather than benefits. With many more low-income workers eligible for Medicaid in 2014, more may prefer to receive cash wages or other tax-preferred benefits in lieu of health insurance. Some employers might consider cafeteria plans to address their employees' changing needs for benefits in this new environment. [42]

Although the ACA creates new responsibilities for employers, it creates opportunities for CRPs to review and perhaps redesign their approaches to providing health and welfare benefits. Small CRPs will not be subject to the employer responsibility requirements of the ACA, but will gain access to SHOP exchanges intended to offer small employers and their workers more choice and better value than is available to them currently.

Larger CRPs will need to understand the ACA's new coverage and reporting requirements. In addition, they should be aware of the implications of expanded eligibility for Medicaid for many of their workers as well as the availability of premium and cost-sharing subsidies available to families with modest incomes, including many low-wage workers, if they enroll in individual coverage through an exchange. While failure to cover a Medicaid-eligible worker will not trigger a penalty, failure to cover a subsidy-eligible worker who obtains coverage in an exchange could trigger a penalty. CRPs that employ Medicaid-enrolled workers should be aware of how new federal rules might affect their continued eligibility.

ACA Requirements: Scenario 3 – The CRP has less than 25 employees and only service contracts. Nearly all employees are paid at least minimum wage, and very few receive SSI/SSDI.

Employers with fewer than 50 FTEs are not subject to the employer responsibility provisions of the ACA. However, the CRP would be eligible to participate in the state's SHOP exchange (offering employees a choice of plans) and might also qualify for a refundable tax credit to pay part of the employer's contribution to premiums.

Under the ACA, a nonprofit employer with average wages less than $50,000 may qualify for a refundable credit for part of the employer contribution to premiums. For nonprofit establishments with 10 or fewer FTE workers and average wages of less than $25,000, the current maximum credit is 25 percent. Starting in 2014, the refundable tax credit will range as high as 35 percent for the smallest nonprofit establishments with average wages less than $25,000, and it will be available only in the SHOP exchange for two additional consecutive years.

New regulations will define how employers that obtain the tax credit should account for contributions to premiums under the wage and benefits requirements of the Davis-Bacon Act and Service Contract Act.

Finally, it will be important for all employers, including CRPs, to heed emerging regulation that will define essential benefit requirements for insurance plans in each state. Initially, it is proposed that each state will define its essential benefit based on any of several criteria, such as the benefits offered in the largest small group insurance product in the state. While it is expected that these packages will be quite similar from state to state, future federal regulation might seek to modify essential benefits in order to ensure greater uniformity of essential benefits across states.

Appendix A — Overview of Social Security Disability Insurance and Supplemental Security Income Benefits[1]

Social Security Disability Insurance (SSDI)

The purpose of the SSDI program is to protect workers and their families against the financial hardship that occurs when workers incur a disabling condition that prevents them from working. The basic principle underlying the SSDI program is that workers and their employers (and the self-employed) pay contributions[2] from earnings during working years, and when earnings stop because of a disabling condition, benefits are paid to partially replace the earnings that have been lost. Individuals must meet recency-of-work requirements to receive insured status for SSDI and must meet a strict test of disability: the inability to engage in any work. Benefits are paid based on insured status which means that SSDI is an entitled right, without a means test.

There is a 5-month waiting period after the onset of disability before SSDI benefits can be paid. Health coverage under Medicare begins only after a 24-month waiting period after the month the SSDI beneficiary becomes entitled.

SSDI beneficiaries are entitled to a 9-month trial work period (TWP), during which full benefits are paid regardless of the level of earnings. After the TWP, beneficiaries enter a 36-month extended period of eligibility during which benefits are paid for any month that earnings are below the substantial gainful activity (SGA) level[3]. If at the end of this period the beneficiary is still earning at the SGA level, SSDI benefits are terminated, but Medicare is provided for 8 ½ years from the time the SSDI beneficiary started working.

Supplemental Security Income (SSI)

The purpose of the SSI program is to provide the basic financial support of needy aged, blind and individuals with disabilities. Applicants with disabilities must meet the same strict test of disability as SSDI applicants but without the work and insured status requirements. Generally, SSI eligibility provides categorical eligibility to health coverage under Medicaid (but not Medicare).

SSI is a last-resort source of assistance for those whose income and resources are below specified levels. As a means-tested program benefits are financed from general revenues, and some states supplement the federal benefit. An SSI beneficiary cannot have more than $2,000 in assets (or $3,000 if the individual has an eligible spouse).

The monthly federal benefit rate[4] is reduced dollar-for-dollar by the amount of the individual's countable income, less all applicable exclusions. For example, unearned income is reduced dollar-

[1] This appendix was prepared by the national office of NISH.

[2] These contributions are actually taxes to finance Social Security as authorized under the Internal Revenue Code provisions originally included in the Federal Insurance Contributions Act (FICA) and the Self-Employment Contributions Act (SECA).

[3] The 2012 substantial gainful activity level is $1,010 for non-blind individuals and $1,690 for blind individuals.

[4] The 2012 federal monthly SSI benefit rate is $698.

for-dollar, less a $20 exclusion. The first $65[5] of monthly earnings are excluded from the monthly benefit amount and then the amount is reduced $1 for every $2 that is earned. Even if a SSI beneficiary's monthly benefit is reduced to $0 because of earnings, he or she may continue to receive Medicaid if earnings are under his or her individual state threshold.[6]

[5] $85 would be excluded if the individual has no other income.

[6] State threshold earning amounts range from $27,521 to $$68,132.

Endnotes

[1] The ACA consists of both the Patient Protection and Affordable Care Act (PPACA) and Public Law (P.L.) 111-148, as amended by §1003 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

[2] Full-time employees are defined as those working an average of 30 hours per week or more. Part-time employees are included in the calculation of FTE by dividing their total monthly hours by 120. Seasonal workers who are employed less than 120 days a year are excluded from the calculation. The FTE calculation is applied to the preceding year; for new employers, a determination of employer size is based on whether there is a reasonable expectation that the employer will have at least 50 FTE workers in the current year. See: Lopez, Nancy. "Employer Responsibility under the Affordable Care Act." Available at [http://www.healthreformgps.org/wp-content/uploads/Nancy-Employee-Responsibility-pdf.pdf]. Accessed February 1, 2012.

[3] The ACA's disclosure requirements are effective September 23, 2012. See: HHS. "45 CFR Part 147, Summary of Benefits and Coverage and Uniform Glossary." Available at [http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228.pdf]. Accessed February 15, 2012.

[4] See: Coburn, Andy, Jean Talbot, Erika Ziller, and Zach Gage-Croll. "CO-OP Health Plans: Can They Help Fix Rural America's Health Insurance Markets?" June 2011. Available at [http://www.shadac.org/files/shadac/publications/CO-OPsInRuralMarkets.pdf.] Accessed February 15, 2012.

[5] See: State Health Access Data Assistance Center. "ACA Note: Defining "Small Employer" Under the Affordable Care Act." Available at [http://www.shadac.org/blog/aca-note-defining-%E2%80%9Csmall-employer%E2%80%9D-under-affordable-care-act]. Accessed February 15, 2012.

[6] Since 1997, the Health Insurance Portability and Accountability Act (HIPAA) has required insurers to guarantee the issue and renewal of coverage to small groups (defined as groups of 2 to 50 employees) as well as guarantee the renewal of individual coverage. This ACA provision extends guaranteed issue to individuals and, in effect, also to small groups with as many as 100 employees.

[7] As of January 1, 2014, young adults without employer-sponsored coverage will be able to obtain individual coverage in the exchange. Like older adults, young unemployed or low-income adults may be eligible for premium tax credits, and those who have very low incomes or are unemployed may be eligible for Medicaid. See: HHS. "Young Adults and the Affordable Care Act." Available at [http://www.healthcare.gov/news/factsheets/2011/08/young-adults.html.] Accessed February 13, 2012.

[8] Grandfathered plans are also subject to ACA requirements to develop uniform benefits and coverage documents, and they must report the same financial and other information that is required of non-grandfathered plans. Detailed information about grandfathered health plans is provided in: Fernandez, Bernadette. "Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)." Washington, DC: Congressional Research Service, January 3, 2011. Available at [http://assets.opencrs.com/rpts/R41166_20110103.pdf.] Accessed February 1, 2012.

[9] States that wish to combine their exchanges must demonstrate that the operation of the individual exchange will not be compromised if they do so.

[10] For detailed information on QHPs, see: Hayes, Katherine Jett. "Update: Qualified Health Plans, Reinsurance, Risk Corridors, and Risk Adjustment." July 19, 2011. Available at [http://healthreformgps.org/wp-content/uploads/katherine-exchanges-and-RRR.pdf]. Accessed February 1, 2012.

[11] Each tier will include plans with the same actuarial value, although the specific features of plans within each tier might differ. As defined in the ACA, actuarial value is the measure of the average share of medical spending paid by the plan for a standard population, as opposed to the share paid out of pocket by the consumer. The calculation takes into account various plan features such as cost-sharing (deductibles, co-insurance, co-payments, and out-of-pocket limits) and the services covered by the plan. For example, an actuarial value of 70 percent means that, on average, the plan pays for 70 percent of spending for medical services, and consumers pay the remaining 30 percent out of pocket. In addition to establishing the minimum value of employer-sponsored plans that meet the requirement for essential coverage, the exchanges will use actuarial value to categorize plans by benefit tiers—platinum (90 percent), gold (80 percent), silver (70 percent), or bronze (60 percent)—and to determine the premium and cost-sharing subsidies for low- and moderate-

income individuals and families. See: American Academy of Actuaries. "Issue Brief: Actuarial Value Under the Affordable Care Act, July 2011." Available at [http://www.actuary.org/pdf/health/Actuarial_Value_Issue_Brief_072211.pdf]. Accessed February 13, 2012.

[12] The ACA defines an affordable employer plan as one that (1) requires the employee to contribute no more than 9.5 percent of his or her household income and (2) on average, pays at least 60 percent of covered health care expenses.

[13] In 2011, the federal poverty level was $10,890 for an individual and $22,350 for a household of four.

[14] HHS. "2012 HHS Poverty Guidelines." Available at [http://aspe.hhs.gov/poverty/12poverty.shtml]. Accessed January 30, 2012.

[15] Community Catalyst, a consumer and community advocacy organization, has prepared a description of navigator functions and community assistance programs. See: Community Catalyst. "Navigators: Guiding People Through the Exchange." Available at [http://www.communitycatalyst.org/doc_store/publications/Navigators_June_2011.pdf]. Accessed February 1, 2012.

[16] A small business employer that does not owe tax during the year can carry the credit back or forward to other tax years and still claim a business expense deduction for premiums in excess of the credit. Small tax-exempt employers may claim a refundable tax credit, so may be eligible to receive the credit as a refund even if with no taxable income, if the refundable credit does not exceed the employer's income tax withholding and Medicare tax liability. See: IRS. Small Business Health Care Tax Credit for Small Employers. Available at [http://www.irs.gov/newsroom/article/0,,id=223666,00.html]. Accessed February 21, 2012.

[17] See: Peterson, Chris L. and Hinda Chaikind. Summary of Small Business Health Insurance Tax Credit Under PPACA (P.L. 111-148). Washington, DC: Congressional Research Service, April 5, 2010. Available at [http://www.ncsl.org/documents/health/SBtaxCredits.pdf], accessed March 29, 2012.

[18] In a defined-contribution health plan, the employer selects a portfolio of health plans (possibly any plan available in the SHOP exchange, or in a tier of plans). The employer specifies the contribution that it will make to each health plan in the portfolio, and the employee pays the difference between the premium and the employer's contribution. A defined-contribution plan allows the employer to set health plan costs each year independent of premium growth, and it allows individual employees a choice among health plans.

[19] Sections 1513 and 10106 of the ACA contain the basic requirements for "shared responsibility for employers" with respect to health insurance. ACA §513(a) amends Internal Revenue Code §4908H(c)(4), penalizing large employers that do not offer affordable coverage to workers who receive subsidized coverage in an exchange. In addition to the penalties discussed in this section, the ACA amends the Fair Labor Standards Act (adding Section 18A) to require employers with more than 200 full-time employees to enroll new full-time employees (and renew current employees) automatically in a group health plan, when offered.

[20] Administered by the IRS, the penalty amount will be indexed to changes in premium costs after 2014. See: Chaikind, Hinda, and Chris L. Peterson. "Summary of Potential Employer Penalties under the Patient Protection and Affordable Care Act (PPACA)." Washington, DC: Congressional Research Service, June 2, 2010. Available at [http://www.ncsl.org/documents/health/EmployerPenalties.pdf]. Accessed January 31, 2012.

[21] This is calculated as 133 percent FPL plus a standard 5 percentage-point income disregard. See: State Health Access Data Assistance Center. "When 133 Equals 138—FPL Calculations in the Affordable Care Act, ACA Note." Available at [http://www.shadac.org/blog/aca-note-when-133-equals-138-fpl-calculations-in-affordable-care-act]. Accessed February 10, 2012. For detailed information on eligibility for Medicaid and low-income subsidies in the exchange, see: Henry J. Kaiser Family Foundation. "Focus on Health Reform: Determining Income for Adults Applying for Medicaid and Exchange Coverage Subsidies: How Income Measured with a Prior Tax Return Compares to Current Income." Enrollment Publication #8168. Available at [http://www.kff.org/healthreform/upload/8168.pdf]. Accessed January 20, 2012.

[22] Sommers, Benjamin, Katherine Swartz, and Arnold Epstein. "Policymakers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians Under Health Reform." *Health Affairs*, October 2011. Available at [http://content.healthaffairs.org/content/early/2011/10/24/hlthaff.2011.0413.full.pdf+html]. Accessed February 17, 2012.

[23] As defined in Section 1937 of the Social Security Act [42 U.S.C. 1396u-7], benchmark or equivalent coverage must include at least the required health benefits and pay, on average, 75 percent of the costs of covered services. Other requirements will be developed through the federal rule-making process. The basic types of essential benefits are inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; prescription drugs; mental health services; well-baby and well-child care, including immunizations; and other appropriate preventive services. Vision and hearing services are included in the statutory definition of essential benefits but are not taken into account in determining a plan's actuarial value. Also see: Henry J. Kaiser Foundation. "Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries." Focus on Health Reform, August 2010. Available at [http://www.kff.org/healthreform/upload/8092.pdf]. Accessed April 5, 2012.

[24] See: HHS. "Medicaid Program; Eligiblity Changes Under the Affordable Care Act of 2010." Federal Register, vol. 77, no. 57, March 23, 2012. Available at [http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf]. Accessed May 7, 2012. Also see: Sara Rosenbaum. "Update: Highlights from the Final ACA Medicaid Eligibility Regulations." Health Reform GPS: Navigating Implementation. Available at [http://www.healthreformgps.org/wp-content/uploads/Sara-Medicaid-Final-Rule-PDF.pdf]. Accessed May 7, 2012.

[25] HHS. "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers." *Federal Register*, vol. 77, no. 59, March 27, 2012. Available at [http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf]. Accessed April 5, 2012.

[26] HHS. "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010." *Federal Register*, vol. 77, no. 57, March 23, 2012. Available at [http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf]. Accessed April 5, 2012.

[27] See: P.L. 112-56, Title IV. Available at [http://www.gpo.gov/fdsys/pkg/PLAW-112publ56/pdf/PLAW-112publ56.pdf]. Accessed January 31, 2012. The Congressional Budget and House Joint Committee on Taxation estimated that the inclusion of Social Security income will reduce Medicaid enrollment by 500,000 to 1,000,000 per year, beginning in 2014. People losing Medicaid coverage include some retirees ages 62 to 64 as well as people receiving survivor, disability, and other Social Security benefits. See: Congressional Budget Office Cost Estimate. H.R. 2576, October 14, 2011. Available at [http://www.cbo.gov/ftpdocs/124xx/doc12484/hr2576.pdf]. Accessed January 31, 2012.

[28] If workers who lose Medicaid coverage are also enrolled in employer coverage, the costs of the employer plan (which is the first payer) will be unaffected. If they are eligible for employer coverage but not enrolled, they might newly enroll in the employer plan (presumably with an employer contribution to coverage). Otherwise, they might seek coverage in the individual exchange, and because they are likely to be eligible for a subsidy, the employer would likely be assessed a penalty.

[29] The CMS Essential Health Benefits Bulletin, which includes detailed background information, is available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

[30] See: HHS, CCIIO, CMS. "Affordable Care Act Implementation FAQs—Set 5." Available at [http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs5.html]. Accessed February 15, 2012.

[31] DOL expects to work with stakeholders to ensure that it has the information needed to develop regulations that take into account the practices employers use for auto-enrollment and to solicit the views of a broad range of participants—including employers, workers, and their families. See: HHS, CCIIO, CMS. "Affordable Care Act Implementation FAQs—Set 5." Available at [http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs5.html]. Accessed February 15, 2012.

[32] Cherry, Bekaert & Holland. "The Impact of Health Care Reform on Government Procurement: CB&H Blog." Available at [http://blogs.cbh.com/govcon/?p=1019]. Accessed January 24, 2012.

[33] For example, DOL will need to determine whether the penalties imposed on employers change the way that contribution requirements for health and welfare benefits will be calculated. The method used to calculate SCA obligations in Hawaii illustrates how employer requirements might be viewed under the ACA. Under state law, employers in Hawaii must provide health insurance to most employees. However, the SCA does not allow employers to credit fringe benefits that are required under state law against their health and welfare benefit obligations under the SCA. To address this, DOL calculates the SCA requirement for Hawaii using a method that recognizes employers' obligation to provide health coverage in that state. If the employer responsibility requirements under the ACA were viewed as similar to the coverage mandate in Hawaii, DOL could devise a formula that carves out a minimum benefit that employers must pay for benefits other than health insurance. For employers that do offer affordable qualified benefits, DOL might consider adjusting the health and welfare benefit level to reflect the temporary tax subsidies available to small employers under the ACA.

[34] These provisions are in ACA §1512, which amended the Fair Labor Standards Act of 1930.

[35] To anticipate potential penalties from employees turning to an exchange for coverage, employers might want to obtain certain information from employees who decline employer-sponsored health coverage. For example, employers may want to identify whether these employees have other essential coverage, such as Supplemental Security Income, Medicare, Medicaid, veterans' benefits, or coverage through a family member, that would make them ineligible for premium assistance in an exchange.

[36] See: ACA §1513.

[37] Reporting of other information is also required. The Treasury Department and IRS had issued requests for comments on approaches to the process for implementing the employer responsibility provisions of the ACA. See: IRS. "Notice 2011-36, Request for Comments on Shared Responsibility for Employers Regarding Health Coverage (Section 4980H)." Available at [http://www.irs.gov/pub/irs-drop/n-11-36.pdf]. Accessed February 3, 2012; and IRS. "Notice 2011-73, Request for Comments on Health Coverage Affordability Safe Harbor for Employers (Section 4980H)." Available at [http://www.irs.gov/pub/irs-drop/n-11-73.pdf]. Accessed February 3, 2012.

[38] See: Lopez, Nancy. "Employer Responsibility Under the Affordable Care Act." Available at [http://www.healthreformgps.org/wp-content/uploads/Nancy-Employee-Responsibility-pdf.pdf]. Accessed February 1, 2012.

[39] Personal communication with Annette Shea, health insurance specialist, Centers for Medicare & Medicaid Services, Disabled and Elderly Health Programs Group, Division of Community Systems Transformation, February 1, 2012.

[40] See: Consortium for Citizens with Disabilities. "Regarding: CMS-2349-P." October 31, 2011. Available at [http://www.c-c-d.org/task_forces/health/Medicaid_eligilibility_NPRM_comments.pdf]. Accessed February 15, 2012. New York has also raised concerns about the interaction of the state's Medicaid Buy-in for Working People with Disabilities program and benchmark coverage and the proposed rules of Medicaid eligibility. See: State of New York, Department of Health. "Comments Regarding Exchange Functions in the Individual Market, Eligibility Determinations, and Exchange Standards for Employers; Medicaid Program Eligibility Changes Under ACA, and Health Insurance Premium Tax Credit—Released 8/17/11." Available at [http://www.healthcarereform.ny.gov/docs/comments_august_2011_exchange_functions_proposed_rule.pdf]. Accessed February 15, 2012.

[41] HHS. "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers." *Federal Register*, vol. 77, no. 59, March 27, 2012. Available at [http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf]. Accessed April 5, 2012.

[42] The IRS defines a cafeteria plan as a separate written plan maintained by an employer that meets the requirements of Section 125 of the Internal Revenue Code. A cafeteria plan allows participants to receive certain benefits on a pretax basis and to choose from at least one taxable benefit (such as cash) and one qualified benefit, including accident and health benefits, adoption assistance, dependent care assistance, group-term life insurance coverage, and a health savings account. See: IRS. "FAQs for Government Entities Regarding Cafeteria Plans." Available at [http://www.irs.gov/govt/fslg/article/0,,id=112720,00.html]. Accessed February 1, 2012.