A Union of Professionals
AFT Center for Collective Bargaining

UPDATE ON AFFORDABLE HEALTHCARE

Frequently Asked Questions About the Affordable Care Act

Individual Mandate

Q. *Will I have to have insurance in 2014 or pay a penalty?*
A. Probably. With some exceptions, most people will be required to have insurance. Those who are uninsured will have to pay a penalty. The penalty will be the greater of:

- A percentage of income. The penalty will be 1% for 2014, increasing to 2.5% by 2016; OR
- A flat dollar amount per person. The penalty starts at $95 in 2014 and increases to $695 in 2016.

In either case, the penalty will not exceed the average premium of a bronze plan in the exchange.

The requirement to have insurance is satisfied by coverage such as employer-sponsored insurance, employer-sponsored retiree coverage, Medicare, Medicaid, TriCare or individual plans purchased in an exchange or elsewhere.

Premium Subsidies in the Exchanges

Federal premium tax credits (subsidies) can help some low- and moderate-income people buy insurance in the exchanges in 2014.

Q. *Who can benefit from exchange subsidies?*
A. In general, only people without health coverage through their employer (or through Medicare, Medicaid or other qualifying coverage) and whose household income is 100% - 400% of the federal poverty level (FPL) are qualified for subsidized coverage in the exchanges.

However, there is one exception that may help low wage workers with expensive self-only coverage through their employer:

- If your share of the self-only premium in your employer's plan is more than 9.5% of household income, then you may still be eligible for subsidized coverage in the exchange.

Example: You are a single person earning $20,000 per year (which is less than 200% of the poverty level in 2012). You pay $160 per month toward the premium for the self-only healthcare coverage you receive through your employer.

Because $160 per month ($1,920 per year) is more than 9.5% of your income, you can drop out of your employer's plan and enroll in subsidized coverage in the exchange.

Q. *My self-only coverage isn't that expensive, but my family plan costs more than 9.5% of my income. Can I drop out of my employer's plan and get a subsidy on the exchange?*
A. No. Your employer-sponsored coverage is considered affordable if your share of the premium for self-only coverage costs less than 9.5% of your household income. This is true even if your family coverage is very expensive. Premium tax credits in the exchange are not available to people with access to "affordable" employer-sponsored coverage.

Copyright © American Federation of Teachers, AFL-CIO (AFT) 2013. Permission is hereby granted to AFT state and local affiliates to reproduce and distribute copies of this work for nonprofit educational purposes, providing the copies are distributed at or below cost, and the author, source and copyright notice are included on each copy. Any distribution of such materials by third parties who are outside of the AFT or its affiliates is prohibited without first receiving the express written permission of the AFT.

Q. *I have "affordable" self-only coverage through work, but my kids and spouse are uninsured. Can they get a premium subsidy on the exchange?*
A. If employer-sponsored coverage is NOT offered to the spouse and kids, then yes (assuming they are otherwise eligible for a subsidy). Employers are not penalized for failing to offer health coverage to the spouse of a full-time employee.

If your employer offers coverage to you and your children, and your share of the self-only premium is "affordable," then your children are not eligible for a premium tax credit because they have access to employer-sponsored coverage.

Q. *How do the subsidies work?*
A. There will be a maximum dollar amount that people will have to pay for premiums based on their household income. The subsidy will cover the amount of the premium that exceeds that maximum.[1] The subsidy is based on the second-lowest-cost silver plan offered in their area. If you choose a plan that is cheaper then that silver plan, you will pay less for it.

Q. *I'm on Medicare. Can I buy insurance through the exchange and get a premium tax credit?*
A. No. The exchange premium tax credits are not available to those on Medicare or Medicaid, because those programs are already subsidized.

Employer Penalties

Q. *Does the Affordable Care Act require employers to provide health insurance?*
A. No, but starting in 2014, certain large (defined as having more than 50 full-time equivalent employees) employers are subject to penalties if they do not offer coverage to full-time employees, or if the coverage they provide is inadequate or unaffordable.[2]

Penalties may apply to large employers who:

- Do not offer coverage, or who
- Offer coverage that is
    - Unaffordable (employee premium contribution for self-only coverage for the employer's lowest-cost plan exceeds 9.5% of household income), OR
    - Inadequate (does not cover at least 60% of costs)

The penalties apply to large employers who have at least one full-time employee receiving a subsidy (premium tax credit) in the exchange.

Part-time Employees

Q. *The employer penalties only apply if the employer fails to offer coverage to full-time employees. How does the Affordable Care Act define "full-time" employees for this purpose?*
A. The act defines full time as working at least 30 hours per week for the purpose of the employer penalty.

Employers can calculate their number of full-time (at least 30 hours per week) employees monthly, or may use a "look-back measurement method" to determine full-time status.

[1] For more information on the amount of the subsidies, see http://www.ncsl.org/documents/health/HlthInsPremCredits.pdf.
[2] Hinda Chaikind and Chris L. Peterson, Summary of Potential Employer Penalties Under the Patient Protection and Affordable Care Ace (PPACA), Congressional Research Service, May 14, 2010.

If using the "look-back" method, employers can choose a measurement period that is anywhere from three months to twelve months long. If the employee averaged 30 hours per week or more during the measurement period, the employee would be considered full time for a subsequent "stability" period. Conversely, if the employee were considered part time during the measurement period, he or she would be considered part time during the stability period. The stability period would generally be the greater of six months or the length of the measurement period.

Q. *What about part-time employees who only work during the school year?*
A. Employers cannot use the summer break to unfairly characterize a full-time school year employee as part time.

For ongoing employees of "educational organizations" who have an "employment break period" of at least four weeks (such as during the summer), employers using the "look back" method must either:

- Calculate average hours worked per week excluding the break period, OR
- Treat the employee as having worked their average weekly hours during the "employment break" period

Q. *What about contingent faculty members?*
A. Several institutions have cut contingent faculty courseloads and blamed the cuts on the ACA penalties for failing to provide insurance. This is contrary to the spirit of the law.

The U.S. Department of the Treasury recently wrote that employers of adjunct faculty…must use a reasonable method for crediting hours of service." The rules also say that "it would not be a reasonable method of crediting hours…in the case of an instructor, such as an adjunct faculty member, to take into account only classroom or other instruction time and not other hours that are necessary to perform the employee's duties, such as class preparation time."

In short, unless more specific regulations come out, colleges and universities are allowed to decide for themselves whether any contingent faculty work thirty or more hours per week, as long as the institution claims its standard is "reasonable," and considers time spent working outside the classroom.

The January 2, 2013, *Federal Register* excerpted above is the only official guidance on adjuncts or contingent faculty anywhere in the ACA or federal regulations related to ACA implementation. Federal regulators have not determined an equivalency between credit hours taught and hours worked per week.

Definition of "Small employer"

Q. *How does the law define "small employer"?*
A. Different provisions of the Affordable Care Act define "small employer" differently:[3]

Employers who do not have at least 50 full-time equivalent employees are not subject to penalties for not providing coverage, or for providing inadequate (covers less than 60% or expenses) or unaffordable (self-only coverage costs more than 9.5% of employee's household income) coverage.

[3] http://healthreform.kff.org/timeline.aspx; http://www.healthcare.gov/glossary/e/employer.html.

Employers with 100 or fewer employees will be eligible to buy group plans in the exchanges in 2014 if states permit them to. However, states have the option of continuing to define small groups as up to 50 until 2016. Most states are defining a small employer as up to 50 for this purpose.

Employers with 25 or fewer FTEs may be eligible for the small business health insurance tax credit. Other provisions of the Affordable Care Act may define large and small employers differently.[4]

Excise Tax

Q. *I know that the excise tax on high cost plans takes effect in 2018. How is "high cost" calculated?*
A. For 2018, "high cost" is defined as $10,200 for an individual plan, and $27,500 for a family plan. For retirees and those in certain high-risk occupations, the threshold amounts are $11,850 and $30,950.

Q. *Will those threshold amounts be indexed?*
A. Yes. In 2018, there will be a one-time "catch-up" adjustment based on how much the premiums have increased for the federal employees' standard Blue Cross/Blue Shield plan.[5] In 2019, the threshold amounts will be indexed to the Consumer Price Index (CPI) plus 1%. In 2020 and thereafter, those amounts will simply be indexed to the CPI.[6]

Q. *Does $10,200 for an individual plan or $27,500 for a family plan only take into account the employer's contribution?*
A. No. The threshold amount is the total cost of the plans, regardless of how much of the cost the employer pays.

Q. *Are vision and dental included in the price of the plan?*
A. Vision and dental coverage can be "carved out" or excluded from the calculation, if they are separate, stand-alone policies. Consider carving out your vision and dental coverage before 2018.

Q. *Is prescription coverage included in the price of the plan?*
A. Yes.[7]

Q. *Who is responsible for paying the excise tax?*
A. The Affordable Care Act (PPACA Sec. 9001) makes it clear that the employee is not responsible for the tax. [8] The Kaiser Family Foundation says "The tax will be levied on insurers and self-insured employers, not directly on employees" (kff.org). However, watch for employers attempting to pass the cost along to employees.

---

[4] *Federal Register*, December 1, 2010: http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf.

[5] PPACA Title IX, Subtitle A, Sec. 9001, IRS Code 4980I (b) (3)(C)(ii), and David McSweeny et. al. *Avoiding a Head-on Collision with the Cadillac Tax*, Benefits and Compensation Digest, Vol. 47, No. 10 October 2010. For 2011, the annual rates for the basic Federal BC/BS plan are $5441.76 for an individual; $12,743.64 for a family.

[6] http://docs.house.gov/energycommerce/section_by_section.pdf.

[7] *How Your Health Insurance Will Change*, smartmoney.com; PPACA Title IX, Subtitle A, Sec. 9001, IRS Code 4980I (b) (3)(C)(ii).

[8] Patient Protection and Affordable Care Act.

Mental Health Services

Q. *Does the restriction on annual limits and the abolition of lifetime limits apply to mental health coverage?*
A. Yes, for plan years beginning on or after September 23, 2010. Mental health services (as well as substance abuse services) are now considered "essential health services." This means that the prohibitions against excluding children (in 2010) and adults (in 2014) from coverage due to a pre-existing condition apply to those with pre-existing mental health conditions. It also means that the health plans offered through the exchanges (in 2014) must cover mental health services.[9]

Retiree Healthcare

Q. *What does healthcare reform mean for early retirees?*
A. If early retirees are enrolled in the same plan as active employees, the Act treats them the same as the other enrollees.

Also, the Affordable Care Act provided for an Early Retiree Reinsurance Program (ERRP), which gave federal money to employers to defray the cost of insuring early retirees. The fund is no longer taking applications. You can find a list of ERRP recipients here:
http://cciio.cms.gov/resources/files/early_retiree_reinsurance_program_disbursements_through_june_10_2011.pdf.

Q. *Our employer wants to take retirees out of the active employees' insurance plan and place them in their own retiree-only plan. What are the implications of this?*
A. The healthcare reforms of the Affordable Care Act do not apply to "stand-alone retiree-only plans."[10] Therefore, separating retirees from the active employees would mean that the retirees lose the protections of the Affordable Care Act. In 2014, early retirees will be able to buy individual plans through the exchanges.

Q. *Our employer no longer offers health coverage to pre-Medicare retirees. Doe s the Affordable Care Act affect those early retirees?*
A. Starting in 2014, pre-Medicare retirees will be able to purchase health insurance in the exchanges and will not be denied coverage due to a pre-existing condition. Early retirees may receive exchange subsidies if they are income eligible.

[9] *The Affordable Care Act & Mental Health: An Update*, by Pamela S. Hyde, www.healthcare.gov; Mercer update on healthcare reform, ©2011 Mercer LLC.
[10] http://www.healthcare.gov/news/blog/index_17.html; "Health Care Reform Mandates Do Not Apply to Retiree-Only Plans," Seyfarth & Shaw, seyfarth.com; Aon Consulting Alert, June 16, 2010.