Time-Sensitive Issues for Pools and Pool Members: Implementation of the Affordable Care Act
May 9, 2013, 12:30pm ET

Speakers:

Shared Responsibility: John L. Barlament, Attorney & Partner, Quarles & Brady, LLP

Provider Fee Issues: Geoffrey L. Beauchamp, Esq., General Counsel, Delaware Valley Health Insurance Trust

H.R. 1076: Susan Smith, Executive Director, TML Intergovernmental Employee Benefits Pool; Erin Sweeney, Counsel, Dickstein Shapiro; and Robert Mangas, Partner, Dickstein Shapiro
Time-Sensitive Issues for Pools and Pool Members:

Health Care Reform’s “Pay or Play” Rule

John Barlament
Quarles & Brady LLP
john.barlament@quarles.com
414.277.5727
Seven Steps to Understanding Pay or Play

1. Understand general Pay or Play Rule concepts
2. Is the employer a “large employer”? 
3. Will any employees receive federally-subsidized Exchange coverage? 
4. Does the employer offer minimum essential coverage under an employer plan? 
5. Does the plan provide minimum value? 
6. Is the plan’s coverage affordable and offered to all full-time employees? 
7. If applicable, calculate and pay the penalty
Step 1: Understand General Rules

- Technically employers not “required” to provide health plan coverage to any employees (even “full-time” employees)
  - But, can face a tax penalty if fail to do so

- Rule generally applies beginning 1/1/2014
  - But, to determine “full-time” status of an employee, may need to measure in 2013
  - Can be a delayed effective date for some non-calendar year plans

- Generally must offer (to avoid penalty) health plan coverage to full-time employees and children (but not spouses)
**Possible Penalties**

- **No Offer Penalty:** If employer does not offer minimum essential coverage:
  - $2,000 (annual, but calculated on monthly basis) tax per full-time employee, if at least one full-time employee obtains federally-subsidized Exchange coverage
  - Calculated after first 30 employees; 5% de minimis

- **Unaffordable Coverage Penalty:** If employer does offer minimum essential coverage but at least one full-time employee obtains federally-subsidized Exchange coverage:
  - Tax is lesser of $3,000 per subsidized full-time employee, or $2,000 per all full-time employees (annual, but calculated on monthly basis)
Step 2: Is the Employer a Large Employer?

- Check if employer has at least 50 full-time (including full-time equivalent (FTE)) employees during preceding calendar year
- For purposes of determining whether the rule applies, a “full-time” employee is an individual with 30+ “hours of service” per week
Step 3: Will Employees Receive Subsidized Exchange Coverage?

- Exchange is generally a marketplace for individuals and small employers (later, large employers) to obtain health insurance
- Affordable Care Act (“ACA”) provides federal subsidies to help pay for health insurance coverage or to reduce certain health plan costs
Step 3: Will Employees Receive Subsidized Exchange Coverage?

- Always possible for an employer (with help from insurer / TPA) to design health plan so employer never faces Pay or Play Rule penalty
  - But may require plan design changes and employer must follow three requirements
  - (a) Offer “Minimum Essential Coverage” under an “eligible employer-sponsored plan” to all its full-time employees (and, perhaps, dependents) who are eligible for subsidized Exchange coverage
  - (b) Ensure employer’s plan provides “Minimum Value”
  - (c) Ensure employee’s share of premium for self-only coverage for employer’s lowest-cost, Minimum Value plan is “Affordable”

- Steps 4 – 6 discuss each point
Step 4: Offer Minimum Essential Coverage?

- Nearly all “major medical” plan coverage will be “minimum essential coverage”
- Note that to “offer” coverage, must allow employee to enroll / disenroll at least once per year
Step 5: Does Plan Provide Minimum Value?

- “Minimum value” looks like a complicated definition, but vast majority of plans expected to pass the test
- Can input plan information to an online calculator and obtain result
Step 6: Is Plan Coverage Affordable?

- Employee can obtain subsidized Exchange coverage if income at least 100% of federal poverty level (“FPL”) and not more than 400% FPL (about $92,000 today for a family of four) and either:
  - No Minimum Value or
  - Costs Too Much: Employee’s share of premium for employee portion of “self-only” coverage for employer’s lowest-cost coverage that provides minimum value > 9.5% of employee’s “household income”

- IRS: Employers allowed to use W-2 wages or two other “safe harbors”
Step 6: Is Plan Coverage Affordable?

- See Pay or Play Guide, Step 6(b), for safe harbors:
  - W-2
  - Rate of Pay
  - Federal Poverty Line
Step 7: Determine Who is a “Full-Time” Employee?

- Generally divide employees into different categories
  - Ongoing Employee
  - New Employees
  - New, Full-Time Employee
  - New, Variable Hour Employee
  - New, Seasonal Employee
  - Part-Time Employees
    - Term not used in Pay or Play Rule guidance, but is used in March 18, 2013 90-day waiting period regulation
  - Transitional Employee (our term, not an IRS term)
Step 7: Ongoing Employees

- Employer selects Standard Measurement Period
  - 3-12 month period in which employer will determine whether employee has worked on average 30 hours per week
  - Employer chooses when it starts and ends

- If Ongoing Employee is a full-time employee, he is “protected” and remains full-time employee during subsequent Stability Period
  - Stability Period must be at least 6 consecutive calendar months
    - Leads to awkward results if 3-month Measurement Period selected
    - Stability Period generally cannot be shorter than Standard Measurement Period

- Start of Stability Period can be delayed for up-to-90-day Administrative Period
  - Allows employer to calculate employee’s hours, answer questions from employees, collect materials from employee, etc.
Step 7: Ongoing Employees

Illustration of Full-Time Employee Time Periods

In this example, assume Employer uses a 12-Month, October 15-based Standard Measurement Period. Employer also uses a 12-Month Stability Period and 2½ month Administrative Period. Assume Employer hired Alex the Employee as a full-time employee in 2007 and Alex has worked continuously since then as a full-time employee of Employer.

1/1/2014 to 10/15/2014

1/1/2015 to 10/14/2015

1/1/2016 to 12/31/2016

- Standard Measurement Period – Alex’s hours during this time are measured
- Administrative Period – Employer checks to see if Alex is still full-time. If so, Employer offers coverage to Alex
- Stability Period – If Alex enrolls for coverage, Alex continues to be covered during this time
Step 7: New Employees Expected to be Full-Time

- No Pay or Play Rule penalty if employer offers health plan coverage at or before conclusion of employee’s initial three full calendar months of employment
Step 7: New, Variable Hour Employee

- Usually Variable Hour and Seasonal Employees treated the same
- Technically, Variable Hour Employee involves New Employee with uncertain future hours (not known if will average 30 hours/week)
- Employer measures full-time status using “Initial” Measurement Period (not a “Standard” Measurement Period)
  - Also a period between 3 – 12 months
  - Employers may want shorter period (e.g., 11 months) due to special rule (discussed later)
Step 7: New, Variable Hour Employee

Illustration of New, Variable Hour Employee (No Administrative Period)

For New Employees, the Employer uses an initial Measurement Period which begins on the first day of employment and ends 12 months later. Employer also uses a 12-Month Stability Period and no Administrative Period. Assume Employer hired Betty the Employee as a Variable Hour Employee on April 10, 2014.

Betty’s Initial Measurement Period – Employer checks to see if Betty is full-time.

Betty’s Stability Period – If Betty enrolls for coverage effective 4/10/2015, Betty is covered during this time, until her Stability Period ends after 12 months (here, April 9, 2016).
Step 7: New, Variable Hour Employee

- For Variable Hour Employee, employer can “split” Administrative Period
- Helpful to make dates “easier” (e.g., start counting as of first of month)
- However, special rule: combined Initial Measurement Period and Administrative Period may not extend beyond last day of first calendar month beginning on or after one-year anniversary of employee’s start date
  - Totals, at most, 13 months and a fraction of a month
  - Prevents employer from having 12-month Measurement Period and 90-day Administrative Period
- See examples in Guide
Step 7: New, Variable Hour Employee

- If Variable Hour Employee not treated as full-time during Initial Measurement Period, employer can treat employee as not “full-time” for a “Limited” Stability Period

- Limited Stability Period:
  - Must not be longer than one month longer than the Initial Measurement Period
  - Must not exceed remainder of Standard Measurement Period (and any associated Administrative Period) in which Initial Measurement Period ends
  - Appears to be designed to allow employee to “re-qualify” quickly for full-time status
Step 7: New, Variable Hour Employee

Illustration of New, Variable Hour Employee (Limited Stability Period)

In this example, assume Employer uses a 12-Month, October 15-based Standard Measurement Period for Ongoing Employees. For New Employees, the Initial Measurement Period begins on the first day of employment and ends 12 months later. An Administrative Period is used for these New, Variable Hour Employees, where the Period runs until the end of the month after the Initial Measurement Period ends. For Ongoing Employees, Employer uses a 12-Month Stability Period which begins on January 1 and a 2½ - month Administrative Period. Assume Employer hired Carol the Employee as a Variable Hour Employee on May 10, 2015. Assume Carol only averages 28 hours during the Initial Measurement Period of May 10, 2015 – May 9, 2016, but 30.0 hours during the 10/15/2015 – 10/14/2016 Standard Measurement Period.

Thus, the net effect is that:
- Carol is not offered coverage from the start date (May 10, 2015) through all of 2016.
- Because Carol was not deemed full-time during her unique Initial Measurement Period, Carol receives another chance to qualify for full-time status. Employer must count the hours Carol worked from October 15, 2015 – October 14, 2016 (the Standard Measurement Period which applies to Ongoing Employees – even though Carol is not an Ongoing Employee as of the start of that Standard Measurement Period).
- Although Employer may want to “lock in” Carol as a Part-Time Employee who is not eligible for plan coverage from July 1, 2016 – June 30, 2017 (the typical 12 months) Employer cannot do this. Carol’s average of 30 hours during the overlapping Standard Measurement Period of October 15, 2015 – October 14, 2016 “controls.” Carol becomes a Full-Time Employee on January 1, 2017 and receives plan coverage.
Step 7: Seasonal Employees

- Under prior IRS guidance (Notice 2012-17) appeared Seasonal Employees could never be deemed “full-time” (even if working 30+ hours)
- Now, key seems to be length of Initial Measurement Period (and Administrative Period) selected by employer
  - Long periods will prevent Seasonal Employees from being “full-time”
- E.g., Little Ski Hill has a 3-month Initial Measurement Period from 11/15/2014 – 2/14/2015. Administrative Period lasts until first of month following end of Initial Measurement Period.
  - Little Ski Hill hires Ted on 11/15, who works 60 hours per week entire time
  - Ted’s Initial Measurement Period ends 2/14/2015
  - Ted’s Administrative Period ends 2/28/2015
  - Ted seems to be “full-time” as of 3/1/2015 (before he terminates employment on 3/15)
Step 7: Rehired Employees

- What if employee has a period of no service then returns to service?
- If break was “long enough” prior hours ignored and employee is a “New” employee
  - 26 weeks
  - If less than 26 weeks, apply rule of parity (at least 4 week break; compare break period to prior work period)
- Special rules for counting hours if break due to unpaid FMLA leave, USERRA leave or jury duty
- Special rule for educational organization
- If special rule applies, ignore weeks with zero hours or provide “credited” hours
- See examples in Guide, pp. 40 - 44
Practical Considerations

- Will almost certainly require insurers / TPAs / employers to make some plan changes
  - E.g., if employer sets eligibility using “expected to work 30+ hours per week”, have Pay or Play Rule risk
  - Thus, many employers may choose to “sync up” eligibility provisions with Pay or Play Rule
    - Not legally required, but only way to “guarantee” no Pay or Play Rule risk
    - Perhaps could rely on 5% de minimis exception
  - Also, new COBRA-like rules for late / short payments (and possible COBRA changes)
Practical Considerations

- For employer with calendar year plan, “easiest” solution is to have:
  - 6-month Measurement Period from, e.g., April 15 – October 14, 2013
  - 2.5-month Administrative Period from October 15, 2013 – December 31, 2013
  - 12-month Stability Period from January 1, 2014 – December 31, 2014
Questions?

Thank you for attending!

John Barlament, Partner
Quarles & Brady LLP
411 E. Wisconsin Avenue
Milwaukee, WI  53202
(414) 277-5727
John.Barlament@quarles.com
www.quarles.com
ASSOCIATION OF
GOVERNMENTAL RISK POOLS

The Affordable Care Act
Annual Health Insurance Providers Fee

Geoffrey L. Beauchamp, Esq.
General Counsel
Delaware Valley Health Insurance Trust
719 Dresher Road
Horsham, PA  19044-2205
(267) 803- 5715
gbeauchamp@dvit.com

Date:  May 9, 2013
The ACA Annual Insurance Providers Fee

Section 9010 of the ACA provides as follows:

• Each covered entity *engaged in the business of providing health insurance* shall pay to the [Treasury] Secretary...beginning after 2013 a fee in an amount determined under subsection (b).

• The fee is due in any calendar year on the date determined by the [Treasury] Secretary, but in no event later than September 30 of each calendar year.

(Emphasis added). *See Section 9010 (a)(1) & (2), ACA.*
Types Of Insurance
Subject To The Annual Fee

• Broadly applicable to “health insurance”, the fee applies to all medical/Rx benefits and certain other benefits that are excepted from ACA requirements such as dental, vision, and retiree health insurance.

• Net premiums from accident, disability, long-term care, group specified disease and Medicare Supplemental insurance are exempt from the annual fee, as are a wide variety of other insurance coverages.

• The proposed rules equate the definition of “health insurance” with “health insurance coverage” in Section 9832 of the IRS Code.

See 9010 (a), (b) & (h)(3), ACA; Section 9832 (c)(1)(A) & (B), IRS Code.
With respect to each covered entity, the fee for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as:

- The covered entity’s net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, bears to:

- The aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year.

(Emphasis added). See Section 9010 (b)(1)(A) & (B), ACA.
How The Annual Fee Is Determined

- The net premiums that “are taken into account” during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

  Not more than $25 million............0%
  More than $25 million, but not
  more than $50 million...............50%
  More than $50 million...............100%

See Section 9010 (b)(2), ACA.
How The Annual Fee Is Determined

• Thus, the first $25 million in net premiums and 50% of the net premiums between $25 and $50 million will **not** be taken into account in determining the annual fee.

• For annual net premiums of $100 million, $62.5 million will therefore be “taken into account” in determining the annual fee.

• Section 9010 of the ACA does not define “net premiums”, but the proposed rules do.
Amount Of The Annual Fee

- For calendar years beginning before 2019, the “applicable amount” will be determined in accordance with the following table:

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Applicable Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$8 Billion</td>
</tr>
<tr>
<td>2015</td>
<td>$11.3 Billion</td>
</tr>
<tr>
<td>2016</td>
<td>$11.3 Billion</td>
</tr>
<tr>
<td>2017</td>
<td>$13.9 Billion</td>
</tr>
<tr>
<td>2018</td>
<td>$14.3 Billion</td>
</tr>
</tbody>
</table>

- For years after 2018, the applicable amount shall be the amount for the preceding calendar year increased by the rate of premium growth... for such preceding calendar year. (Emphasis added). See Section 9010 (e)(1) & (2), ACA.
The ratio for each covered entity (their annual net premiums/total U.S. net premiums) is multiplied by the applicable amounts described on the preceding page for calendar years 2014 through 2018, which are then increased by the rate of premium growth year over year.

Thus, the annual fee payable by a covered entity is roughly tied to its share of the U.S. insurance market as measured in total net premiums.

See Section 9010 (b), (c) & (e), ACA.
Assessment And Payment Of the Annual Fee

• Each covered entity must report its net premiums not later than the date determined by the [Treasury] Secretary following the end of any calendar year for which the annual fee is assessed. Under the proposed rules, that date is May 1. Significant penalties are imposed for failure to report or failure to accurately report the covered entity’s net premiums.

• The IRS will calculate the amount of each covered entity’s fee for any calendar year and in so doing shall determine that entity’s annual net premiums on the basis of reports submitted by the covered entity and any other sources of information available to the IRS.

See Section 9010 (b)(3) & (g), ACA.
Assessment And Payment Of the Annual Fee

• If more than one person is liable for the payment of the annual fee, all such persons “shall be jointly and severally liable for the payment of such fee”.

*See Section 9010 (c)(4), ACA.*
The “Covered Entities”

• A “Covered Entity” is broadly defined as “any entity which provides health insurance for any United States health risk”.
• The following are excluded:
  - Any employer to the extent that it self-insures its employees’ health risks;
  - Any governmental entity;
  - Certain nonprofit corporations; and
  - Any entity described in Section 501(c)(9) of the IRS Code and which is established “by an entity (other than by an employer or employers) for purposes of providing healthcare benefits. (e.g., VEBAs, student health insurance).

(Emphasis added) See Section 9010 (c)(2)(A)-(D), ACA.
The Proposed Rules

• On March 1, 2013 the Treasury Department and the IRS issued proposed rules for the annual insurance providers fee for which comments are due by no later than June 3, 2013, as are requests to speak at the public hearing scheduled for 10:00 a.m. on Friday, June 21, 2013 at the IRS headquarters in Washington, D.C.

• The proposed rules provide a definition of “health insurance” and further define what constitutes a “Covered Entity” and those entities which are excluded from that definition.

• If finalized as written, the proposed rules would arguably make public entity health pools and trusts subject to the annual insurance providers fee.

Definition Of “Health Insurance”

• As already noted, the proposed rules equate the definition of “health insurance” with the definition of “health insurance coverage” in the IRS Code:

  Benefits consisting of medical care (provided directly, through insurance, reimbursement, or otherwise) under any hospital or medical service, policy or certificate, hospital or medical service plan, contract or health maintenance organization contract offered by a health insurance issuer.

Definition Of “Health Insurance”

• A laundry list of insurance coverages are excluded from the definition of “health insurance” under the proposed rules (e.g., accident, disability, automobile, workers compensation, etc.). See 78 Fed. Reg. 14,038 & 14,043.
Definition of “Net Premiums”

• The proposed rules define the term “net premiums written” as:
  
  [P]remiums written, including reinsurance premiums written, reduced by ceding commissions and medical loss ratio (MLR) rebates with respect to the data year (the calendar year immediately before the “fee year”).


• This definition strongly suggests that it should apply only to commercial health insurers.
The “Covered Entity” Rules

• The proposed rules further define “Covered Entity” as:
  - A health insurance issuer within the meaning of Section 9832(b)(2) of the IRS Code. (e.g., insurance company, service or insurance organization subject to state insurance laws);
  - A health maintenance organization within the meaning of Section 9832(b)(3) of the IRS Code;
  - An insurance company that is, or would be, subject to tax under Part I or II of subchapter L of the IRS Code, but for the entity being exempt under Section 501(a) of the Code;
The “Covered Entity” Rules

- An insurer that provides health insurance under Medicare Advantage, Medicare Part D or Medicaid; or

• If public entity health pools are deemed to be MEWAs, they do not fall within the specific DOL regulation referenced above and therefore may be “covered entities”.
The “MEWA” Issue

• The proposed rules adopt the definition of a “MEWA” from Section 3(40) of ERISA, which is:

  An employee welfare benefit plan, or any other arrangement (other than employee welfare benefit plan) which is established and maintained for the purpose of offering or providing any benefit described in paragraph 1 [welfare benefit plans] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or arrangement that is established or maintained:

  - Under or pursuant to one or more collective bargaining agreements
  - By a rural electorate cooperative; or
  - By a rural telephone cooperative association.

The “MEWA” Issue

- Because many public entity health pools operate like MEWAs – and are commonly “not fully-insured” – this issue bears close scrutiny and requires further clarification from the government.

- A “governmental plan” is defined in ERISA and the IRS Code as follows: “A plan established and maintained for its employees by the Government of the United States, by the government of any state or political subdivision thereof, or by any agency or instrumentality of any of the foregoing…”

- Because the “governmental plans” sponsored by public entity health pools are expressly excluded from ERISA, the reference to MEWAs in the proposed rules arguably only applies to such arrangements adopted by private employers with ERISA plans.

The “MEWA” Issue

• The March 1, 2013 final DOL rules imposing MEWA reporting requirements expressly exempt “a group health plan not subject to ERISA, including a governmental plan”. The same is true for the MEWA registration requirement in Section 6606 of the ACA. Imposing the annual fee upon public MEWAs as “covered entities” is therefore inconsistent with the current regulatory regime.

• Even if public entity health pools are “covered entities” because they are “non-fully insured MEWAs”, they may still fall within the “self-insured employer” or “governmental entity” exclusions.

The “Self-Insured Employer” Exclusion

• A “self-insured employer” is defined in the proposed rules as “any employer that sponsors a self-insured medical reimbursement plan” (i.e. self-funded health plan) within the meaning of section 1.105-11 (b)(1)(i) and (ii) of the Income Tax Regulations. These regulations state that a self-insured plan may use a third party administrator and still be considered “self-insured” if there is “no shifting of risk to the third party”.

The “Self-Insured Employer” Exclusion

• A “self-insured plan” is also defined in the IRS Code as self-insurance coverage where “any portion of such coverage is provided other than through an insurance policy”. See 26 U.S.C. §4376(c).

• Public entity health pool participants self-insure or self-fund their employee benefits by agreeing to jointly fund their respective governmental plans through the health pool.

• The “self-insured” or “self-funded” nature of health pool participants’ benefit plans is further bolstered by a trust agreement or by-laws that not only affirms their self-insured status, but allows the imposition of assessments upon pool participants to fund any deficits.
The “Governmental Entity” Exclusion

• The proposed rules further refine the “governmental entity” exclusion in Section 9010(c) by stating that a “governmental entity” includes any “political subdivision of any state”, but also states that such an entity does not include “instrumentalities of a governmental entity” within the meaning of IRS Revenue Ruling 57-128, 1957-1 C.B. 311.

• The 1957 Revenue Ruling addressed the tax exempt status (for federal employment tax purposes) of an association organized and operated by the heads of various states’ insurance departments for the uniform administration of state insurance laws. In conferring a tax exemption upon this association as an “instrumentality” of its state participants, the IRS applied a six (6) factor test.
The “Governmental Entity” Exclusion

• Many public entity health pools have obtained tax exemptions under the IRS Code because they satisfy a multi-factor test virtually identical to the one used in the 1957 Revenue Ruling.

• There is no compelling policy reason to tax public entity health pools as if they were engaged in the “business of providing insurance”, when they are tax exempt just like their public entity participants and serve an essential governmental function.
The “Governmental Entity” Exclusion

- The IRS acknowledged that this is a legitimate issue, and invited comments “on the type of instrumentalities, if any, who would be considered covered entities under the general definition and the extent to which they would qualify for exclusions consistent with the statute”.

- In that regard, the IRS stated that any governmental instrumentalities that “provide health insurance” may still qualify under the “self-insured employer exclusion or the exclusion for certain nonprofit corporations”. While the first exclusion is readily applicable to public entity health pools, the second is not.
Conclusions And Recommendations

• AGRiP should submit comments on behalf of its health pool members making the following points, among others:
  - Provide background information about AGRiP and its membership;
  - Explain the unique nature of public entity health benefit pools under state law and how they are markedly different from commercial health insurers;
  - Argue that the “not-fully insured” MEWAs referenced in Section 9010 of the ACA and the proposed rules should be limited to those established by private employers with ERISA-covered plans. Those with taxpayer funded governmental plans should be exempt from the annual insurance providers fee.
Conclusions And Recommendations

- Imposition of the annual fee upon public entity health pools as “governmental instrumentalities” is contrary to Section 9010 of the ACA precisely because those pools are “not engage in the business of providing insurance” nor are they regulated as commercial health insurance companies;

- The way “net premiums” are defined, calculated and reported is uniquely suited to commercial insurers, and not public entity health pools;

- Public entity health pools should not be subject to the fee where they are solely comprised of – and controlled by – political subdivisions that are themselves “governmental entities”;
Conclusions And Recommendations

- Sound public policy also requires that public entity health pools be treated no differently than their public entity participants; and
- The school districts and municipalities that participate in public entity health pools nevertheless fall within the “self-insured employer” exclusion and therefore should not be required to pay the annual insurance providers fee.

• AGRiP’s comments should be accompanied by recommended revisions to the proposed rules that would exempt public entity health pools from the annual health insurance providers fee.
AGRIP/NLC RISC Association Webcast

Explaining H.R.1076: Hall-Thornberry-Cotton legislation To Assist Municipalities
Municipalities and Health Care

- Municipalities are the fourth largest employer in the United States.

- Eighty-six percent of all cities and towns provide health insurance for their employees and their families.

- Cities and towns spend $87B/yr. for healthcare for their employees, retirees, and families.

- Approximately 17% of the employer’s budgets are health benefits for employees, retirees, and families.
Under PPACA, **employers with fewer than 50 employees** that participate in benefit pools have incentives to leave those pools and send their employees to statewide Exchanges.

![Graph showing current pool coverage vs exchange coverage under PPACA for a family of four with $42,000 income.](image-url)
PPACA Tax Credits and Cost Sharing

- PPACA is designed to **limit premium costs** on a sliding scale based on income, from **2% of income (133% FPL)** to **9.5% of income (400% FPL)**.

- PPACA is designed to **limit out-of-pocket (OOP) costs** (deductibles or copayments) on a sliding scale based on income, with a dollar amount based on **an actuarial value (AV) ranging from 70% (for 250-400% FPL)** to **94% (100-150% FPL)**.

- Amounts above these caps are offset by premium tax credit and cost sharing payments paid directly to health plan issuers in statewide exchanges.
Potential Modification to PPACA

- Many State authorized benefits pools provide health care coverage at **costs well below the national average.**

- It would be **less costly to the federal government to provide individuals in the existing benefit pools with the same subsidies as the Exchanges** and let them remain in the pools.

- It would **also be less costly to political subdivisions** to keep employees and their families in existing pools.

- According to Congressional staff, this issue was not thoroughly considered when PPACA was drafted.
If a Political Subdivision Pool can show that its alternative will —

- provide coverage that is **at least as comprehensive as the “essential health benefits”** requirements of PPACA;
- provide **cost sharing protections** at least as generous as PPACA; and
- **save money for the federal government** compared to the Exchange,

Then a Political Subdivision Pool is entitled to a **“Pass Through of Funding”** that is equal to the aggregate amount of premium tax credits and cost sharing reductions that would have been paid to participants in the pool had they otherwise entered the statewide exchange.

Political Subdivision Health Benefit Pools could **apply directly to HHS** for pass through of funding approval.
How Can You Help?

➤ Review the Hall legislation (H.R. 1076).

➤ If you expect your health coverage to be competitive with the exchange plans, evaluate whether you would pursue an application to HHS as provided under the bill.

➤ If the answer is yes, draft a letter in support of the bill to send to Rep. Hall.

➤ Contact your U.S. House Members directly.
Have a Great Day!

Susan Smith  (512) 719-6780  susan.smith@tmliebp.org
Rob Mangas  (202) 420-2241  mangasr@dsmo.com
Erin Sweeney  (202) 420-3477  sweeneeye@dsmo.com
Thank you for joining us! Please direct any questions or comments to:

Jessica Tripoli
Member Services and Education Specialist
AGRIp
jtripoli@agrip.org