How the Affordable Care Act Affects Small Businesses and Individuals

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Small Businesses

- **No Financial Requirements for Small Businesses:** the ACA imposes no financial requirements for small businesses to contribute to their employees' health insurance.
    - However, beginning in 2014, larger employers with more than 50 full-time employees ("FTEs") who do not offer coverage face a penalty of $2,000 per FTE (excluding the first 30 FTEs) if at least one FTE receives a government subsidy to buy coverage on the exchange.
- **Small Business Health Care Tax Credit:**
    - This new tax credit helps small businesses and small tax-exempt organizations afford the cost of covering their employees. It encourages small businesses to offer health coverage for the first time or maintain their current coverage.
    - To qualify, an employer must: (1) cover at least 50% of the cost of health insurance for employees; (2) not have more than 25 full-time equivalent employees; and (3) have annual wages of less than $50,000.
    - Credits became available in 2010, covering up to 35% of the employer's contribution to health insurance coverage; on January 1, 2014, this will increase to 50%.
- **Requirement for All Small Employers Providing Coverage:**
    - Small employers must limit waiting periods to no more than 90 days.
    - They must eliminate lifetime and annual benefit limits.
    - Small employers offering dependent coverage must offer that coverage to workers' adult children up to age 26 (no obligation that they contribute to that coverage).
    - Beginning 6 months after enactment, pre-existing condition exclusion periods for children were banned.
- **Requirements for Plans Sold in Small Group Market:** (except grandfathered plans)
    - These plans must meet the essential benefit requirements ("EHBs").[1]
    - These plans must be rated consistent with rating limits (i.e. 3:1 for family structure, geography and age bands and 1.5:1 for tobacco use).
    - They must limit deductibles to $2,000 for single coverage and $4,000 for family coverage
    - Annual cost sharing must be limited to current Health Savings Account limits; in 2010, this was $5,959 for single coverage and $11,900 for family coverage.
- **Grandfathered Plans:**
    - Small employers already offering health coverage can continue to provide such coverage to their workers, with current policies being "grandfathered," or exempt from most of the law's regulatory reforms and the essential benefits requirements.

[1] The ACA defines essential health benefits to "include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care."

- However, if an employer ends a grandfathered policy, new coverage bought on small group markets is subject to the regulatory reforms and benefit minimums.

- **Small Business Health Options Program ("SHOP") Exchanges:**
  - Beginning in 2014, businesses with up to 100 employees can use state-based SHOP exchanges to purchase coverage.
  - SHOP exchanges utilize a premium rate review process and setting standards for how much insurance companies can spend on administrative costs (i.e. the medical loss ratio).

Individuals

- **Individual Mandate:** in 2014, all individuals must have health insurance (with exceptions).
  - Those without coverage must pay a yearly financial penalty (greater of $695 per person, up to a maximum of $2,085 per family, or 2.5% of household income, phased-in from 2014-2016).
  - Exceptions: religious exceptions; American Indians; those uninsured for under 3 months; those for whom the lowest cost health plan exceeds 8% of income; individuals with income below the tax filing threshold ($9,350 for individuals, $18,700 for married couples in 2009).
- **Health Insurance Exchanges:** individuals without access to affordable employer coverage will be able to purchase qualified health plans ("QHP") through a health insurance exchange.
  - Exchanges, at minimum, will: certify QHPs; require certain public disclosures (e.g. claims payment policies; periodic financial disclosures; data on enrollment, denied claims, rating practices; information on cost sharing and payments for out-of-network coverage; enrollee rights); require QHPs make available timely information about the cost sharing for specific items or services; assign ratings to each plan based on the relative quality and price of their benefits (e.g. Bronze plans pay for 60% of plan costs, Gold plans pay for 80%).
  - QHPs are certified; provide EHBs[2]; are offered by licensed health insurers who are in good standing, offer at least one QHP in the silver and gold levels, and agree to charge the same premium rate for each QHP whether or not the plan is purchased on the exchange or through an agent; are renewable; and adhere to the rating limitations.
  - Subsidies for premiums will be offered as refundable and advanced tax credits starting 2014 for individuals and families with incomes from 133% to 400% of the federal poverty level.
- **Catastrophic Plan:** low cost plans available to those up to age 30 or to those exempt from mandate.
- **No Pre-Existing Coverage Exclusions:** beginning six months from enactment, health plans may not exclude coverage of pre-existing conditions for children; provision applies to adults in 2014.
- **No Lifetime/Annual Limits:** insurers can no longer set lifetime or annual limits on health plans.
- **Free Prevention Benefits:** all new health plans must offer prevention and wellness benefits; out-of-pocket expenses are eliminated for these services in public and private plans.
- **Medicare Changes:**
  - Closes the Medicare Part D drug benefit coverage gap; provides $250 rebate check for any Medicare beneficiary hitting the donut hole in 2010; in 2011 seniors in the donut hole can get a 50% discount on brand-name drugs. By 2020 the donut hole will be filled.
  - As of 2011, those enrolled in Medicare can receive a free, annual wellness visit and have all out-of-pocket expenses waived for preventative care.
- **Medicaid Expansion:** Medicaid will be expanded to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) for all individuals under age 65.
- **Pre-Existing Condition Insurance Plan ("PCIP") or High Risk Pools:** those who cannot get insurance due to pre-existing conditions (e.g. cancer, diabetes) may join the PCIP; PCIP ends in 2014, when government-regulated exchanges start operating.
  - States may run their own PCIPs with federal funding or have their residents use a federal PCIP run by the federal government.

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[2] Id.

- Limits on out-of-pocket expenses for those in the PCIP are $5,950 per year for an individual and $11,900 per year for a family.
- Older people cannot be charged more than 4 times what younger persons are charged.
- In May 2011, HHS offered a plan to make it easier for Americans to enroll in the PCIP. Premiums for the federally-administered PCIP will drop by up to 40% in 18 states and eligibility standards will be eased in 23 states and DC (e.g. applicants for a PCIP need only provide a clinician's note and no longer must wait for an insurance denial letter); later in 2011, HHS will begin paying agents/brokers who unite eligible individuals with a PCIP.