The Affordable Care Act and Its Effect on Employers: 2015 Update

February 2015

The Patient Protection and Affordable Care Act of 2010 (ACA) is designed to expand coverage to millions of Americans, yet it largely preserves the system of employer-sponsored health insurance (ESI) that covers a majority of Americans. Nevertheless, the ACA includes several provisions that directly affect employers and can influence their decisions about whether to offer coverage. Before many of the ACA's provisions began in 2014, CHRT published separate issue briefs examining the key provisions for small employers,[1] along with those affecting midsize and large employers.[2] In addition, CHRT has published briefs on ACA taxes,[3] premiums, and cost-sharing for employers and their workers.[4]

This brief will summarize recent trends in employer coverage and provide an update on certain key provisions that have faced implementation challenges.[5] Several provisions of relevance to employers have faced significant delays or changes as the ACA has been implemented.

Michigan Employer-Based Coverage Trends

Although the prevalence of employer coverage has declined over the last decade, the majority of Michigan residents still rely on their employer for health insurance. As of 2013, 60 percent of residents received ESI coverage, down from 65 percent in 2008.[6] Small firms still comprise the vast majority of private-sector employers in Michigan, as almost three out of every four employers have fewer than 50 employees (Figure 1). While large firms with 1,000 or more employees only represent 13 percent of total firms, they employ nearly 45 percent of Michigan workers.[7]

The Center for Healthcare Research & Transformation (CHRT) illuminates best practices and opportunities for improving health policy and practice. Based at the University of Michigan, CHRT is a non-profit partnership between U-M and Blue Cross Blue Shield of Michigan designed to promote evidence-based care delivery, improve population health, and expand access to care.

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[1] Brandon Hemmings, Rachel Waldinger, Joshua Fangmeier, and Marianne Udow-Phillips. The ACA and Its Effects on Small Employers (Ann Arbor, MI: Center for Healthcare Research & Transformation, May 2013).
2 Joshua Fangmeier and Marianne Udow-Phillips. The Affordable Care Act and Its Effects on Midsize and Large Employers (Ann Arbor, MI: Center for Healthcare Research & Transformation, October 2011).
3 Brandon Hemmings, Joshua Fangmeier, and Marianne Udow-Phillips. The Impact of ACA Taxes and Fees (Ann Arbor, MI: Center for Healthcare Research & Transformation, October 2011).
4 Brandon Hemmings and Marianne Udow-Phillips. Employee Cost-Sharing for Health Insurance in Michigan. Cover Michigan 2013. (Ann Arbor, MI: Center for Healthcare Research & Transformation, September 2013).
5 Statistics and figures on employer trends were derived from published tables of the Medical Expenditure Panel Survey, Insurance Component (MEPS-IC).
6 SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.
7 Medical Expenditure Panel Survey. Table II.B.1.a(2013).
http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2013/tiib1a.htm

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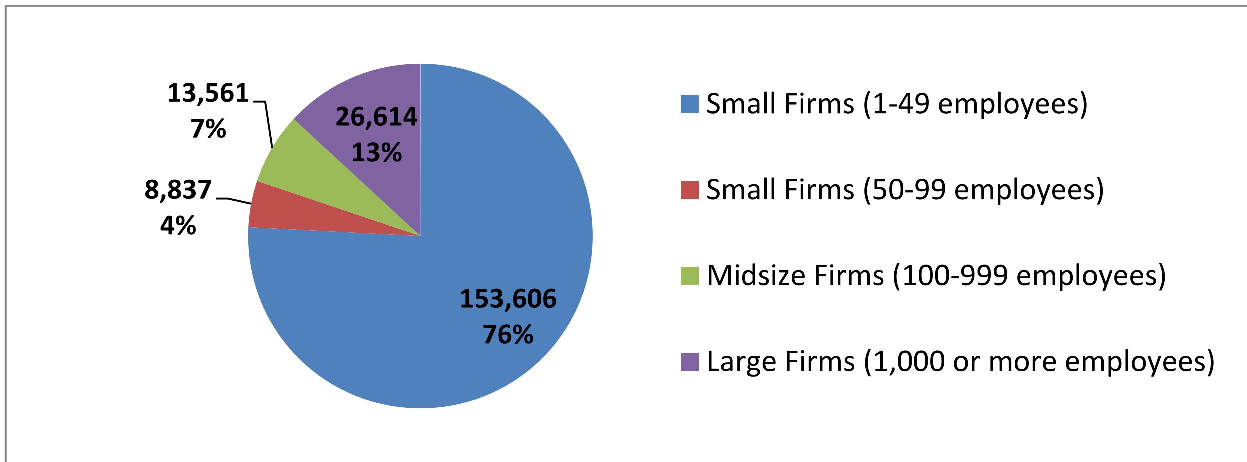
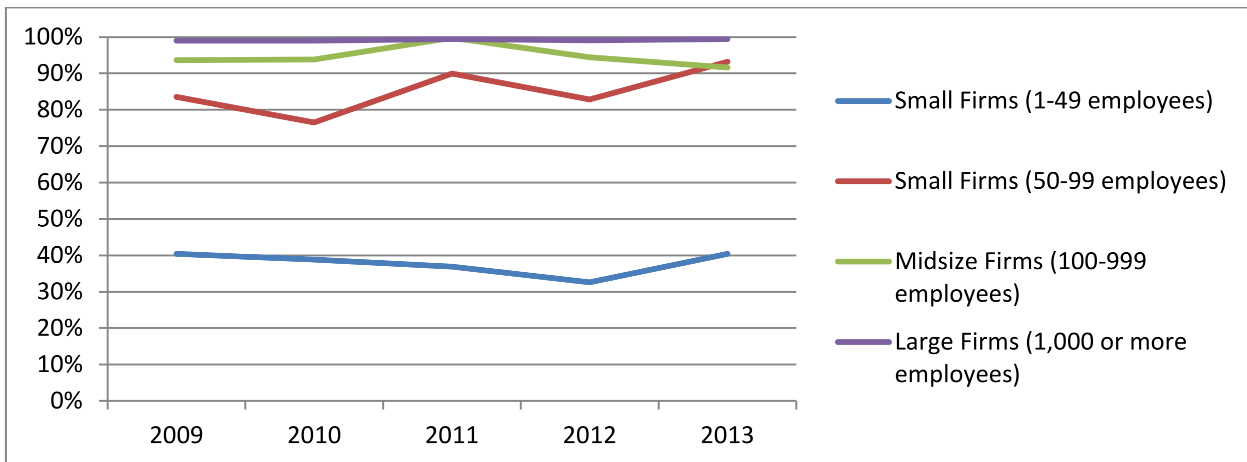
Distinguishing employers by their number of employees is important for two reasons: small firms have historically been much less likely to offer health insurance, and the ACA applies specific provisions to employers based on their count of full-time employees or equivalents. Among firms that offer coverage, large firms also tend to offer more generous coverage than smaller ones.

Figure 1: Michigan Private-Sector Establishments by Firm Size, 2013



Small firms with fewer than 50 workers have historically been less likely to offer coverage to their workers than larger firms. In Michigan, their offer rate fell considerably between 2001 and 2012, from 60 percent to 33 percent,[8] but in 2013 the offer rate actually increased significantly to 40 percent (Figure 2). By comparison, offer rates nationally remained steady at 35 percent from 2012 to 2013. It is not yet clear what caused this increase in Michigan or whether it marks the beginning of a reversal of the erosion of small employer coverage. Firms with 50 to 99 workers have had offer rates of at least 75 percent, and well over 90 percent of firms with 100 to 1,000 employees offer coverage. Consistent with national rates, virtually all firms with more than 1,000 workers offer coverage in Michigan.

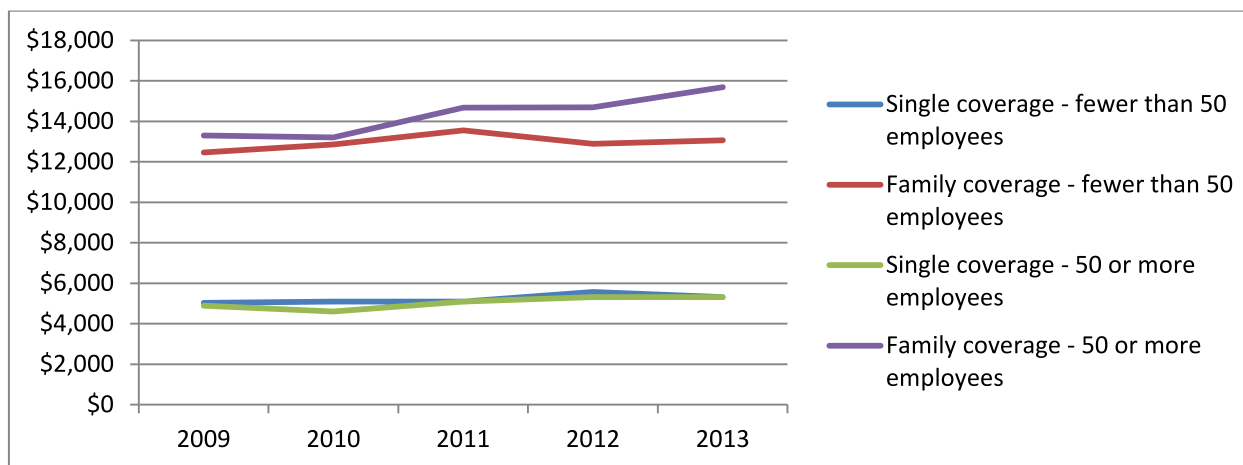
Figure 2: Percent of Michigan Private-Sector Establishments that Offer Health Insurance by Firm Size, 2009–2013



[8] Hemmings, Brandon; et al. May 2013.

Among Michigan employers offering coverage, total premiums from 2009 to 2013, including both employer and employee contributions, grew faster for employers with 50 or more employees than for smaller employers (Figure 3). The average annual premium increase for employees at large firms enrolled in family coverage was 4.1 percent, compared to only 1.2 percent for smaller businesses. Average rate increases were similar for single (employee-only) coverage enrollees across small and large employers. Regardless of plan type, relative premium increases in Michigan were below the national averages.

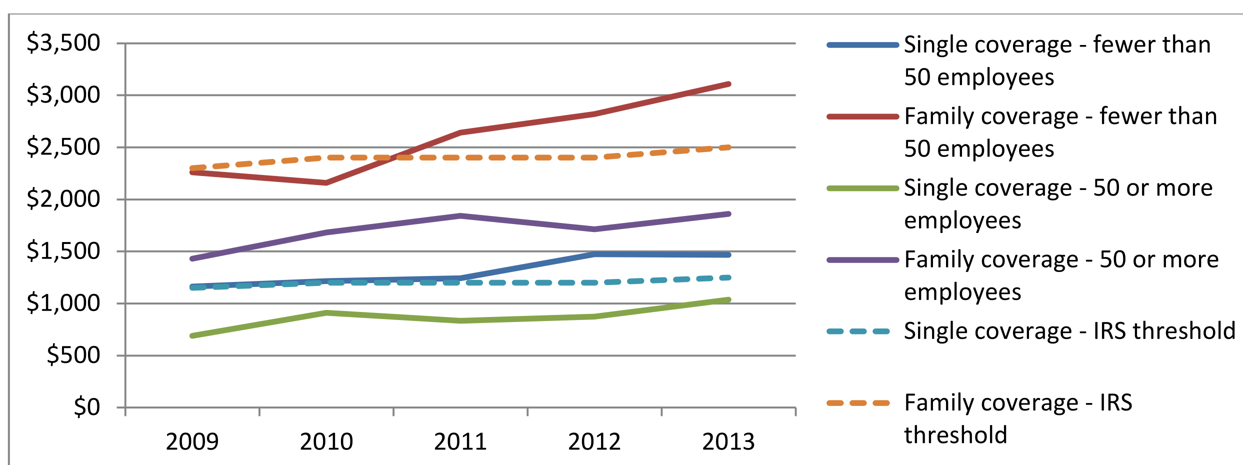
Figure 3: Average Total Premium per Michigan Enrolled Employee by Firm Size and Coverage Type, 2009–2013



Smaller employers that offer coverage have experienced slower average premium growth, in part due to selecting plans with higher deductible levels. From 2009 to 2013, the average family deductible for small employers increased 8 percent annually, and the average deductibles for both single and family coverage are now above the Internal Revenue Service (IRS) thresholds for a high-deductible health plan (Figure 4).[9] While larger employers have also seen deductibles increase, they continue to remain below IRS thresholds. Overall, deductibles in Michigan continue to remain below the national averages.

[9] The Internal Revenue Service (IRS) sets deductible thresholds to define high-deductible health plans (HDHPs). In 2013, the IRS defined HDHPs as plans with deductibles of at least $1,250 for individual coverage and $2,500 for family coverage. See http://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx (accessed 1/18/15).

Figure 4: Average Deductible per Michigan Enrolled Employee by Firm Size and Coverage Type, 2009–2013



Notable Changes to ACA Employer Provisions

Since the ACA was passed into law in March 2010, several of its provisions have experienced delays, changes, or even repeal due to subsequent legislation or regulatory decisions made during implementation of the law.[10] Many of these changes affect employers, who have been strategically planning for these provisions and assessing how the law will affect their workforce and, ultimately, their profitability.

These changes have not occurred without controversy, as opponents of the ACA charge that the federal government is acting outside the law, while supporters state that many of these changes are only temporary delays to smooth implementation.[11] Regardless, employers have had to adapt to these changes, especially for the following five provisions that have seen considerable alteration or delay. A table summarizing these provisions is included in the Appendix.

Employer Mandate (ACA §1513, IRC §4980H)

To encourage firms to offer affordable coverage to their workers, the ACA penalizes firms with 50 or more full-time equivalent (FTE) workers that do not meet certain standards of coverage. The employer mandate includes two types of potential penalties. First, firms that do not offer coverage to 95 percent of eligible workers and dependents face a penalty of $2,000 per full-time worker after the first 30 workers.[12] Second, firms that offer coverage are penalized $3,000 for each worker who receives a tax credit from the marketplace because their coverage offer is inadequate or unaffordable.[13] Total penalty amounts for the second penalty cannot exceed the total possible penalty amount for the first (not offering coverage at all).

[10] David Nather and Susan Levine. March 25, 2014. *A Brief History of Obamacare Delays*. Politico. http://www.politico.com/story/2014/03/obamacare-affordable-care-act-105036.html (accessed 1/18/15); Lisa Klinger. October 9, 2013. *Delayed ACA Provisions*. Leavitt Group. https://news.leavitt.com/health-care- reform/delayed-aca-provisions/ (accessed 1/18/15).

[11] Timothy Stoltzfus Jost and Simon Lazarus. May 22, 2014. *Obama's ACA Delays—Breaking the Law or Making It Work?* New England Journal of Medicine 370: 1970–71. http://www.nejm.org/doi/full/10.1056/NEJMp1403294 (accessed 1/18/15).

[12] The ACA defines a full-time worker as an employee working 30 hours or more per week.

[13] The ACA defines adequate coverage as plans with an actuarial value of at least 60 percent and affordable coverage as plans with employee premiums of less than 9.5 percent of household income.

The employer mandate was scheduled to begin in 2014, but on July 9, 2013, the IRS issued a notice that the mandate was delayed until 2015 due to issues in the development of necessary reporting systems.[14] On February 10, 2014, the federal government issued final rules for the employer mandate.[15] These rules stated that employers with 50 to 99 FTEs would receive an additional year before the mandate takes effect in 2016. Notably, the vast majority of Michigan employers of this approximate size already offered coverage in 2013 (Figure 2).

According to the final rules, employers with 100 or more FTEs will face penalties in 2015 if they do not offer coverage to 70 percent of their full-time workers and dependents, or if their employees receive a tax credit from the marketplace. In 2016, potential penalties apply to employers with 50 or more FTEs and the threshold for offering coverage rises to the original 95 percent.

Automatic Enrollment of New Employees (ACA §1511)

The ACA includes a new automatic enrollment requirement for employers with more than 200 full-time employees who offer coverage. New employees at these applicable firms will be automatically enrolled in the health plan with the lowest employee premium contribution if they do not make an active plan selection. Current employees can also be maintained in available coverage, but employees can still opt out of ESI coverage if they choose. Since many firms require workers to actively enroll, this provision could increase the share of workers who enroll in ESI coverage. In 2010, 16.4 percent of eligible workers did not enroll in coverage that was offered to them by their employer, and this is most prevalent among younger workers.[16]

The ACA does not specify an effective date for this provision. In December 2010, the Department of Labor issued a guidance which specified that the automatic enrollment requirement would not take effect until regulations have been promulgated.[17] A subsequent bulletin in February 2012 stated that automatic enrollment would not take effect until 2015 at the earliest.[18] At this time, federal regulations for this provision have not been released, and it is unclear when this provision will take effect.

Nondiscrimination Rules (ACA §1001, PHSA §2716)

Prior to the passage of the ACA, employers who self-insured coverage for their workers were subject to rules that prohibited them from offering richer benefits to highly compensated individuals at their company. The ACA extends similar rules to employers who are fully insured (purchase coverage from an insurer). Financial penalties for employers violating this provision are substantial, as employers may be penalized up to $100 per day per employee discriminated against.

Employers originally prepared for this provision to take effect in 2014. However, the IRS issued interim guidance in December 2010 stating that the nondiscrimination rules on fully insured employers would not begin until the

[14] Internal Revenue Service. July 2013. *Notice 2013-45*. http://www.irs.gov/pub/irs-drop/n-13-45.PDF (accessed 1/18/15).

[15] Lisa Klinger. February 18, 2014. *Specifics on "Play or Pay" Final Rules for Large Employers*. Leavitt Group. https://news.leavitt.com/health-care-reform/specifics-final-regs-employer-mandate-one-year-delay-smaller-employers-requirements-eased-larger-employers/ (accessed 1/18/15).

[16] Paul Fronstin. April 2012. *Employment-Based Health Benefits: Trends in Access and Coverage, 1997-2010*. EBRI Issue Brief 370. http://www.ebri.org/pdf/briefspdf/EBRI_IB_04-2012_No370_HI-Trends.pdf (accessed 1/18/15).

[17] U.S. Department of Labor. December 2010. *FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation*. December 2010. http://www.dol.gov/ebsa/faqs/faq-aca5.html (accessed 1/18/15).

[18] Centers for Medicare & Medicaid Services. February 9, 2012. *Frequently-Asked-Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods*. http://www.cms.gov/CCIIO/Resources/Files/Downloads/employer_faq_bulletin_2_9_12_final.pdf (accessed 1/18/15).

plan year after regulations have been promulgated.[19] At this time, no such rules have been released, so it is unclear when this provision of the ACA will become effective.

SHOP Marketplace (ACA §1311)

In 2014, the Small Business Health Options Program (SHOP) marketplace was launched (administered by either the state, the federal government, or through a federal-state partnership). The SHOP marketplace is intended to spread administrative cost and pool risk across multiple small employers.[20] In addition, since 2014, the ACA's small employer tax credit is only available to firms that purchase coverage through the SHOP marketplace. For 2014 and 2015, nearly all states limited enrollment in the SHOP marketplace to employers with 50 or fewer workers.[21]

Like other provisions of the ACA, the federally operated SHOP marketplace delayed certain features for 2014. Specifically, the federal government delayed online enrollment, premium aggregation, and employee choice until at least 2015. Employers could still enroll their employees in SHOP plans via traditional methods, such as through agents, brokers, or directly with an insurer. Beginning in 2015, premium aggregation allows employers to receive one bill from the SHOP marketplace rather than multiple bills from separate insurers.[22]

The employee choice model allows employers to select a level of coverage (bronze, silver, gold, etc.) and then allows employees to select an insurer and specific plan within that level. For 2014, employers who used the federal SHOP marketplace could only select a single plan for all employees. However, the Centers for Medicare & Medicaid Services (CMS) gave states that use the federal SHOP marketplace the option of implementing employee choice for 2015.[23] In June 2014, Michigan joined 17 other states in delaying the employee choice model for another year until 2016.[24] Some insurers argue that the employee choice model will lead to adverse selection, if higher-risk employees disproportionately choose more comprehensive coverage than lower-risk employees.[25] This could result in higher rates for the entire small group risk pool. It remains to be seen how the delay of these features has affected enrollment in Michigan's SHOP marketplace.

Out-of-Pocket Maximum (ACA §1302(c))

In 2014, the ACA required all non-grandfathered private health plans to have a standard out-of-pocket maximum, regardless of employer size or whether an employer is fully or self-insured. For 2014, the maximum limits were

[19] Internal Revenue Service. December 2010. *Notice 2011-1*. http://www.irs.gov/pub/irs-drop/n-11-01.pdf (accessed 1/18/15).

[20] Under the Affordable Care Act, all ACA compliant small group plans within a state, both on and off the SHOP marketplace, are part of a single risk pool for rate setting purposes.

[21] Only the District of Columbia chose to expand their definition of small employer to firms with 100 or fewer workers. In 2016, all states must adopt this definition.

[22] Centers for Medicare & Medicaid Services. March 14, 2014. *2015 Letter to Issuers in the Federally-facilitated Marketplaces*. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf (accessed 1/18/15).

[23] Centers for Medicare & Medicaid Services. May 2014. *2015 Transition to Employee Choice*. http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html

[24] Michigan Department of Insurance and Financial Services. June 2, 2014. *2015 Transition to Employee Choice*. http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/MI_Recommendation_Form_for_the_2015_Transition_to_Employee_Choice_FINAL.pdf (accessed 1/18/15).

[25] Sarah Dash and Kevin W. Lucia. September 18, 2014. *Health Policy Brief: Employee Choice.* Health Affairs. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=125 (accessed 2/11/15).

defined as $6,350 for individual coverage and $12,700 for family coverage and are adjusted annually.[26] The out-of-pocket maximum includes member cost-sharing liabilities such as deductibles, co-payments, and co-insurance.

In February 2013, the Department of Labor released guidance allowing a one-year delay of this provision for certain employers for the first plan year beginning on or after January 1, 2014.[27] Employers who used separate vendors for medical and pharmacy benefits and who had an out-of-pocket limit on pharmacy costs qualified for this transitional relief. Employers who did not have an out-of-pocket limit on pharmacy costs did not qualify. This delay was made in response to industry concerns about the difficulty of coordinating benefits across multiple vendor systems. However, the overall effect of this delay was expected to be limited.[28]

Employers who qualified for the delay could implement separate out-of-pocket limits for medical and pharmacy benefits. Therefore, members enrolled in these plans could have experienced effective total out-of-pocket limits of $25,400 for family coverage in 2014. However, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits employers from applying separate limits for medical and mental health or substance abuse services.

Conclusion

Although the ACA includes many provisions that affect employers, employer-sponsored insurance will likely continue to cover a majority of non-elderly Americans. The Congressional Budget Office projects that the ACA will lead to a 5 percent reduction in ESI coverage in 2020, as some firms drop coverage and some workers forgo ESI for other coverage options.[29] However, employer trends will likely vary across states and may be sensitive to future implementation of ACA provisions. While certain provisions, such as the employer mandate, have been temporarily delayed, the future of the automatic enrollment and nondiscrimination rules seems uncertain. All of these issues are worthy of continued monitoring as ACA implementation continues.

[26] For 2015, the limits are $6,600 for individual coverage and $13,200 for family coverage.

[27] U.S. Department of Labor. February 2013. *FAQs about Affordable Care Act Implementation Part XII*. http://www.dol.gov/ebsa/faqs/faq-aca12.html (accessed 1/18/15).

[28] Stephen Miller. August 20, 2013. *For 2014, Out-of-Pocket Cap May Exclude Stand-Alone Drug Plans*. Society for Human Resource Management. http://www.shrm.org/hrdisciplines/benefits/articles/pages/out-of-pocket-cap-delay.aspx (accessed 1/18/15).

[29] Congressional Budget Office. April 2014. *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act*. http://www.cbo.gov/publication/45231 (accessed 1/18/15).

Appendix

ACA Provision	Original Policy	Revised Policy
Employer Mandate (ACA §1513, IRC §4980H)	Beginning in 2014, employers with 50 or more FTEs face penalties if they do not offer coverage to 95 percent of full-time workers and dependents or if employees receive a tax credit from the marketplace.	Penalties were delayed for one year for all employers. Mandate scheduled to be implemented with the following timeline: 2015: Employers with 100 or more FTEs face penalties if they do not offer coverage to 70 percent of full-time workers and dependents or if employees receive a tax credit from the marketplace. Employers with 50 to 99 FTEs receive one year of additional delay. 2016: Employers with 50 or more FTEs face penalties if they do not offer coverage to 95 percent of full-time workers and dependents or if employees receive a tax credit from the marketplace.
Automatic Enrollment of New Employees (ACA §1511)	Employers with 200 or more full-time employees who offer coverage must automatically enroll new employees in the lowest-cost plan if that employee does not make an active selection. The ACA does not specify when this provision should take effect.	The federal government issued a bulletin that this provision will not be enforced until regulations have been promulgated. No regulations have yet been published, so it is unclear when this provision will take effect.
Nondiscrimination Rules (ACA §1001, PHSA §2716)	Beginning in 2014, fully insured employers who offer richer benefits to highly compensated individuals within their company could face penalties.	The federal government issued interim guidance that this provision would begin for plan years after regulations have been promulgated. No regulations have yet been published, so it is unclear when this provision will take effect.
SHOP Marketplace (ACA §1311)	Beginning in 2014, SHOP was designed to facilitate online enrollment for small employers and include features, such as premium aggregation and employee choice.	The federal government issued notices that online enrollment in the federal SHOP marketplace was delayed until 2015. In addition, the premium aggregation and employee choice features were not be available until 2015. Michigan chose to delay employee choice for another year until 2016.
Out-of-Pocket Maximum (ACA §1302(c))	Beginning in 2014, out-of-pocket limits cannot exceed $6,350 for single coverage and $12,700 for family coverage, regardless of employer size. These amounts are adjusted annually.	For the 2014 plan year, the Department of Labor issued guidance that employers with separate vendors for medical and pharmacy benefits could operate separate out-of-pocket limits, if they implemented such limits on pharmacy benefits prior to 2014. For the 2015 plan year, these employers must implement unified out-of-pocket limits.

Authors: Joshua Fangmeier, MPP and Marianne Udow-Phillips.