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Implications of the ACA for Exempt Organizations

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The Affordable Care Act (ACA)[1] has generated a variety of new legal developments affecting tax-exempt organizations. The primary impact is on exempt organizations as employers. Those with 100 or more full-time employees or equivalents will be subject to the employer "play or pay" penalty starting in 2015, and those with 50 or more in 2016 and later. Exempt organizations will want to understand the new premium tax credit, the individual coverage requirement, and the employer play or pay requirement that were enacted as part of the ACA so that they can appreciate the consequences for exempt organizations as employers and for the populations served by organizations with a social service mission.

Premium Tax Credit

The premium tax credit was enacted as section 36B of the Internal Revenue Code (the "Code"). It is available to subsidize the cost of health coverage for certain individuals who have enrolled through one of the new health insurance exchanges, also known as the "Health Insurance Marketplaces."

Exchanges. The exchanges provide a way that individuals can purchase coverage for themselves and their families, and small businesses can offer coverage to their employees. The rules governing the exchanges are intended to standardize the health plans that are offered to make each exchange an organized and competitive marketplace.[2] The ACA requires each state to establish an exchange for both individuals and small businesses (businesses with less than 100 employees) by January 1, 2014.[3] In each state that did not establish an exchange, the Federal Government operates an exchange to serve that state. Exchanges run by the U.S. Department of Health and Human Services ("HHS") are called Federally-facilitated exchanges or Federally-facilitated marketplaces.[4] Although states that did not establish an exchange for 2014 had the opportunity to establish an exchange for 2015, no new states have instituted exchanges.

A state exchange must be a state-established nonprofit entity or government agency.[5] States were required to submit plans (called Blueprints) to establish an exchange by November 16, 2012, for the 2014 plan year, and HHS was required to approve the state's

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[1] The ACA was enacted in two parts. The Patient Protection and Affordable Care Act (PPACA) was enacted as Public Law 111-148 on March 23, 2010. The Health Care Reconciliation Act of 2010 (HCERA) was enacted as Public Law 111-152 on March 30, 2010.

[2] 42 U.S.C. § 18031(b) (2011).

[3] 45 C.F.R. § 155.20.

[4] 45 C.F.R. § 155.105(f).

[5] 42 U.S.C. 18031(d)(1); 45 C.F.R. § 155.100.

exchange by January 1, 2013, in order for it to begin operation in the fall of 2013 and offer health coverage beginning January 1, 2014. The statute allows states to participate in regional exchanges in conjunction with other states or establish subsidiary exchanges within the state, provided the exchanges satisfy the requirements established in the Federal Regulations. To date, no states have availed themselves of these options. Once approved by HHS, an exchange is subject to periodic review by HHS for ongoing compliance with the requirements.

For 2015, fourteen states are running state-based exchanges. Three states have state exchanges that are using the federal IT platform and enrolling individuals in coverage through healthcare.gov. Seven states are running Partnership Exchanges, in which HHS runs core eligibility and enrollment functions and the state may perform the plan management function, the consumer assistance function, or both. Twenty-seven states defaulted to a Federally-facilitated exchange.

Exchanges are permitted to offer only qualified health plans which must meet a series of requirements set forth in §1311(c) of the ACA. These requirements include: (1) satisfying marketing requirements so as not to discourage enrollment by individuals with significant health needs; (2) ensuring a sufficient choice of providers and providing information to enrollees and applicants on the availability of in-network and out-of-network providers; (3) including essential community providers within health plan networks, where available, to serve low-income, underserved individuals; (4) being accredited with respect to local performance on clinical quality measures and other performance measures; (5) implementing a quality improvement strategy; (6) using a uniform enrollment form for applicants to enroll in Qualified Health Plans ("QHPs") offered through the exchange; and (7) utilizing the standard format established to present health benefit plan options.

In addition, each QHP must offer an "essential health benefits package" that includes: (1) "essential health benefits," (2) a limit on cost-sharing and deductibles in accordance with the ACA, and (3) a level of coverage that satisfies one of four actuarial thresholds.[6] "Essential health benefits" generally include coverage for ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse care, prescription drugs, rehabilitative services, laboratory services, preventative and wellness services, and pediatric care. HHS's approach allows states to choose a "benchmark" plan from among four options established in the Regulations to define what constitutes essential health benefits for insured coverage in that state. As part of the essential benefits package, QHPs must also follow annual limits on cost-sharing and deductibles, as established by HHS. For example, the deductible of a health plan offered to an individual in the small group market must not exceed $2,050 for 2014. States may also require participating health plans to offer additional health benefits.

Finally, QHPs must offer health plans with coverage satisfying the requirements of either bronze, silver, gold, or platinum levels of coverage, as defined by the ACA. Bronze-level plans must cover 60% of the projected total cost of benefits provided under the plan for a standard population. (This percentage of projected costs is called the actuarial value.) Silver-level plans provide 70%, gold-level plans provide 80%, and platinum-level plans provide 90%.

[6] 45 C.F.R. § 156.115; § 156.130;§ 156.140.

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