# Important Information Regarding the Affordable Care Act

The effective date of Health Care Reform (the Patient Protection and Affordable Care Act—ACA) for the National Roofers Union and Employers Joint Health and Welfare Fund was June 1, 2011. Since then, the Trustees have taken steps to ensure that the **Plan** conforms to what the law requires. The Trustees have not had to address, however, what the law might require of individual **plan participants** and of contributing **employers**.

Next year, the insurance "exchanges" contemplated by the ACA are supposed to be up and running. The Trustees understand that individuals will be receiving information about these exchanges not only from their employers (as required by the law) but from the exchanges themselves, as well as from advertisers promoting health insurance products. They believe that this information may be confusing to individuals (and employers) that may have always relied on the Fund for health benefits. Indeed, a "model" form of the exchange notice for use by employers has been published by the regulators. It appears to be designed for use by employers that offer (and administer) one plan for all employees. Construction industry employers, and other employers with collective bargaining agreements covering "units" of employees—sometimes several different units—seemingly would have to customize the notice for each group, or put together an amalgamation of information that would definitely be confusing.

Because of all of the uncertainty, the Trustees have directed that this correspondence be provided to all **participants** and to all **contributing employers**. It is intended to express, in a question and answer format, the Trustees' **current** understanding of how the coverage provided by the Fund fits into the scheme of the ACA's health reform regulations.

## Individual Mandate and the Exchanges

**Q: What does the law require of individuals?**

**A:** A specific section of the Internal Revenue Code states the mandate that has been the subject of controversy. Basically, that section requires that effective January 1, 2014, all individuals must secure "minimum essential coverage" health insurance for themselves and family members. The failure to do so subjects the individuals to tax penalties that escalate on into the future to as much as 2 ½ % of household income. The coverage required is measured by the calendar month, and the tax penalties are for each month that the coverage is not in place.

**Q: Are there exemptions?**

**A:** There are some exemptions to the IRS mandate to secure coverage. Certain individuals with bona fide religious objections are exempt, as are illegal aliens and incarcerated persons. There are also exemptions relating to household income levels and to the affordability of coverage. Under the affordability rules, an individual is exempt from paying the penalty if premium payments to obtain coverage exceed 8% of household income.

**Q: What is an insurance exchange?**

**A:** To facilitate a ready marketplace for obtaining this kind of individual and family coverage[1], the law establishes "exchanges" for each state that will identify insurance policies, at various benefit levels, that are made available from insurance companies operating on the exchange.

**Q: What will be offered on the exchange?**

**A:** There is a requirement that each of the policies offered on an exchange cover a basic platform of benefits (called "essential benefits"). There is also a requirement that each policy be summarized in an eight (8) page comparison document called a "summary of benefits and coverage" (SBC). The idea is to allow individuals to compare the policies, and their costs, and to make informed decisions when buying health insurance.

**Q: Is there financial assistance available to individuals who purchase policies on the exchange?**

**A:** Depending on family income, individuals who purchase insurance policies on one of these exchanges may be eligible for tax credits against the cost of the coverage, and certain cost sharing reductions with respect to claims made under the policies. However, these subsidies will most likely not be available to participants because of the coverage available through this plan.

## Employer Shared Responsibility Mandate and the Exchanges

**Q: Are employers required to provide health insurance coverage to employees?**

**A:** Not exactly. The law generally requires employers that regularly employ more than 50 full-time employees or full-time employee "equivalents" (full-time means 30 hours or more per week) to "share" the financial responsibility for health insurance coverage secured through an exchange. Under these provisions, if such an employer does not offer eligible health insurance coverage to full-time employees, and one of these employees secures a policy through the exchange (and receives a premium tax credit or cost sharing reduction for doing so), the employer will be liable for a "shared responsibility" fee. There is **no** obligation under the ACA for small employers (under the

1 And small employer coverage, as well. See the discussion of "SHOPS" on the following page.

50 full-time employee/equivalent level) to provide health benefits coverage to employees. So, if an employer has over 50 full-time employees/full-time equivalents, it must offer "affordable" coverage that provides a "minimum value" or pay a penalty.

**Q: Can employers be subsidized for providing coverage?**
**A:** They can be, but only small employers, and only for 2014 to 2016. Small employers who employ fewer than 25 full-time employees can be eligible for their own tax credits for providing health insurance to employees under another Internal Revenue Code section. Unfortunately, the rules do not allow any credit for an employer contributing to the Fund, since it presently self-insures its coverage and does not buy health insurance from some carrier.

**Q: Do employers have any ability to use the exchanges?**
**A:** Each state will be required to establish Small Business Health Options Programs ("SHOPs") on their exchange. The concept is a one-stop "SHOP" for purchasing health insurance products for employees. Employers eligible for the SHOP will be able to elect levels of coverage (platinum, gold, silver or bronze) and the particular insured health plans to make available. Apparently, the SHOP will administer billing and collection of premiums from employers, as well. In a collective bargaining setting, an employer would have to bargain and reach agreement with the employees' representative before covering employees in this way.

## Trust Fund Coverage

**Q: Does the health insurance coverage provided by the Fund satisfy an individual's responsibility to obtain health coverage?**
**A:** It seems clear to the Trustees that, since the Fund's Plan of benefits covers the employee and family members, and since the ACA treats employer-provided coverage (like the Plan) as "minimum essential coverage," each month of coverage earned by an individual employee will satisfy the individual mandate for that month.

**Q: Why would someone purchase insurance on the exchange when they have Fund coverage?**
**A:** They wouldn't, unless Fund coverage ran out and that was a viable option. Individuals certainly can't receive a premium tax credit, nor cost reduction, if they have been offered employer-provided health benefit coverage (like the Fund Plan) that is "affordable" to the employee (coverage for the employee and dependent children costs less than 9½% of income) and which provides what is called "minimum value" (that is, it reimburses 60% or more of the allowable expenses incurred under the plan). The Trustees believe that the Fund Plan would be considered affordable (since all contributions come from the employers—there is no additional cost to employees). They also believe that the Plan provides value well in excess of the "minimum" that is required. [Note: This affordability test is separate from the affordability test under the individual mandate.]

Since coverage under the Fund depends on the number of work hours an individual has, and since not all construction industry employment is regular, gaps in Fund coverage will necessarily occur. What do those gaps mean under the mandate? As the Trustees understand it, short-term gaps in coverage under the Fund (up to three months) will not lead to individual penalties. Gaps longer than that, however, will result in potential tax liability to the individual for the entire time period of the gap.

**Q: Will the Fund be available on any exchange?**
**A:** It will not. The Fund's Plan is not an insurance product available in any marketplace. It is required to produce an SBC comparison document, however. Plan participants should receive one by the start of the next plan year—June 1st, 2013.

**Q: What if an individual chooses to self-pay to continue Fund Coverage?**
**A:** For many years, the Fund has offered self-payment rights to individuals who lose Fund benefit coverage. Since the mid-1980s, that right to self-pay for extensions of coverage has been codified in federal law (COBRA), and the rules now permit as many as 18 months of family coverage tailing off of the last month of employee coverage provided by the hour bank. Individuals who lose coverage under the Fund can certainly self-pay for benefits and satisfy their individual obligation to secure coverage. Presumably, such individuals could also obtain coverage from an exchange for any month for which there is a gap. Depending on income levels, Medicaid coverage might also be available.

**Q: Does the health insurance coverage provided by the Fund satisfy an employer's obligations under ACA?**
**A:** As noted, small employers don't have an obligation under the ACA. Large employers do, and it seems clear to the Trustees that the Fund coverage will not cause those employers to incur any shared responsibility fee *with respect to participants in the Fund*. Because the kind of coverage provided by any particular employer to employees other than those covered by the Plan is unknown to the Fund, it is impossible to tell whether any large employer is at risk for the fee. No fee should ever be generated with respect to an individual participant in the Fund, however.

The Trustees will try to update the information available relating to how the Fund coverage fits into the scheme of the ACA. In the meantime, they hope that the information set forth above is helpful. ■