

# The Affordable Care Act and the IAFF

January 2014



## PRIMER #1

*The Affordable Care Act  
Key Elements Affecting IAFF Members*

## **Introduction**

For generations, leaders at all levels of this union have recognized the value of obtaining high quality health insurance. In both jurisdictions that allow collective bargaining and those that do not, IAFF leadership has fought for top quality health insurance for our members and their families as one way to protect them from dangers encountered on the job. In many cases, securing decent health coverage has come at the expense of sacrificing wages and other benefits.

However, the level and quality of health care and covered benefits vary greatly across the nation for all workers, including the members of this union. And still tens of millions do not have any health care coverage at all.

The United States currently spends far more on health care than any other industrialized nation. Americans spend twice as much as most other countries on patient care, yet we have a higher rate of preventable deaths from illnesses. The high cost of health care strains family budgets, imposes burdens on employers, and exacerbates fiscal problems for both the federal and state government. IAFF members have felt the effects of this high cost at both the bargaining table, and in shrinking local government budgets.

Historically, there have also been some other critical problems with the health system in the U.S. For example, insurance companies were able to deny coverage to some based on pre-existing conditions. Caps on the amount of care that was covered meant people were being tossed off their insurance while battling tough diseases and injuries, which is when people needed their insurance the most. Many indigent and uninsured Americans rely on 9-1-1 services and emergency room visits as their primary form of health care, which is inefficient, expensive and a drain on both fire-based EMS and emergency department resources. And the list could go on.

Over the past few years, a great debate has been waged about how to “fix” the health care delivery and payment system in this country. Policymakers, employers and interest groups on both the left and right began to propose overhauling the nation’s health care system.

Rather than completely overhaul the nation’s health care structure, the Patient Protection and Affordable Care Act (PPACA), often referred to as the ACA or “Obamacare” was passed and signed into law.

Authors of the ACA attempted to build upon our current system that relies largely on employer-provided health care. The intent of the Act is to retain the parts of the current system that work, while imposing new requirements that fill in the gaps. Because of this piecemeal approach, the law is cumbersome, complex and can be very confusing. Not surprisingly, since its passage, the ACA has been the primary target of all kinds of heated political rhetoric – some of it lies, some half-truths, and some actual facts.

From the beginning of the debate, the IAFF has been very clear about our position -- *do no harm to our members*.

While the law was being considered, we fought hard and were able to kill a number of bad proposals, however, we didn’t win every battle. And as a result, there are some negative impacts from the ACA on IAFF members.

While the IAFF continues to push for legislative and policy solutions to the problems with the law, we are also working with our affiliates to assure that you are positioned to address these challenges.

This document is the first in what will be a series of summary “primers” on the effects of the ACA, or “the Act” on our members. Our goal is to help separate the myths from the facts, and provide what you really need to know about the ACA.

That said, the political rhetoric surrounding the law is fierce, and while there are some clear benefits to the law, a number of serious problems with the implementation of the law have been widely reported through the media. This has led to a very volatile situation on Capitol Hill and in some states.

Because of the complexity of the law and the confusion surrounding many of its provisions, there have already been some changes made to the Act. There will likely be more changes and regulations issued. As those developments occur, we will provide additional updates.



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## How the Affordable Care Act Works

The ACA has three primary goals: expand access to health insurance, protect patients against arbitrary actions by insurance companies and reduce costs. It attempts to achieve these goals in various ways.

### Expanding access

The ACA utilizes a variety of tools in an attempt to provide health insurance to more Americans. While many people receive health coverage through their employer, there are many that are not offered health coverage, even if employed.

The Act addresses this problem by requiring every employer (private and public) with 50 or more full-time employees plus full-time equivalent employees (which are explained below, because like everything else in this law it's confusing) to offer health insurance to its workers - a rule which is known as the "employer mandate." This provision has been delayed and now kicks in January of 2015.

The size of your employer is determined by how many employees are employed by your entire municipality. So, even if our members are broken off into a separate health plan, to determine whether the employer mandate applies, you have to count all of the full-time employees in the jurisdiction. That's because the language in the ACA refers to employers, not to health plans.

The Act also ensures that dependents under age 26 can be covered on their parents' health plans – a major benefit enhancement of the ACA. And it expands access to Medicaid for more working families in certain states whose income falls below certain levels and it provides subsidies to low income workers who do not qualify for Medicaid and have to buy their own insurance.

The most controversial provision of the Act requires most Americans who are not covered by employer-provided insurance or a government program to purchase health insurance on their own. This requirement is referred to as "the individual mandate." While early on there was a lot of dispute about whether this provision violates the Constitution of the United States, the U.S. Supreme Court ruled in June 2012 that this provision is in fact constitutional.

To make insurance more affordable and accessible, the ACA established new health care marketplaces, known as "exchanges," where individuals are now able to compare different plans and levels of coverage so they can purchase health insurance and receive government subsidies if they are eligible. The main "exchange," [www.healthcare.gov](http://www.healthcare.gov), has been the epicenter of the failed launch of this new law by the federal government that has been widely publicized. There are also a number of state-level exchanges. While some of those state exchanges have also experienced problems, many are reportedly operating well.

In order for plans to be eligible to be on the exchanges, they must provide coverage for an Essential Health Benefits (EHB) package in 10 benefit categories. The 10 benefit categories required by the EHB are: 1.) ambulatory patient services, 2.) emergency care, 3.) hospitalization, 4.) laboratory services, 5.) maternity and newborn care, 6.) mental health and substance abuse services, 7.) prescription drugs, 8.) rehabilitative and habilitative services and devices, 9.) preventative and wellness services/chronic disease management, and 10.) pediatric services, including oral and vision care. While the law requires coverage for these broad categories, each state determines which specific services must be covered.

Also important is that in 2013 these requirements only applied to plans on the exchanges and plans covering 50 or fewer employees. Beginning in 2016, some states are mandating that the 10 requirements apply to plans covering 100 or fewer employees, and starting in 2016 the law says that the 100 or fewer

employees limit applies to all states. You will need to check how your state is handling the phase in from 50 to 100. However, by 2016, all health plans covering 100 or fewer employees will have to provide coverage for the 10 EHBs.

*NOTE: To make this even more confusing, in the case of the Essential Health Benefits, the law distinguishes which plans must include the 10 benefits based on how many employees are covered by the health care plan. In the case of “mandatory coverage,” which is described a few paragraphs earlier, the Act distinguishes which employers must provide coverage based on the number of full-time and full-time equivalent employees that are employed by the jurisdiction. These types of inconsistencies add to the confusion surrounding implementation of the law, but they are critical to understanding how it will affect our members.*

In most cases, the benefits available on the exchanges are less generous (and likely less costly to employers) than those plans covering the overwhelming majority of our members today. We are already seeing cases of IAFF employers attempting to cease coverage for their employees and transition them onto the exchanges (while usually providing a “stipend” to the employee to pay for at least part of the health benefit) to reap those savings – particularly for retirees. We will deal with this potential issue in later updates so that local leaders can be prepared to defend retaining their employer provided coverage (for active members and, where applicable, for retirees).

In the private sector, some employers are utilizing a provision of the law to avoid providing health insurance to their employees by transitioning them to part-time status. The law requires *large* employers to offer affordable health insurance to their employees who work 30+ hours per week. Regrettably, there is evidence that some businesses are skirting the law by scheduling workers to less than 30 hours per week. In addition to not providing health coverage, this practice obviously reduces a worker’s weekly wage and diminishes their standard of living. It is one of the more troubling unintended consequences of the ACA.

In fall of 2013, the White House came under fire over the cancellation of a large number of health insurance policies in the individual market. While in the course of normal business, insurance companies have cancelled plans in favor of pushing people to new/different plans, the cancellations occurring this fall were played up by those who oppose the ACA to be a direct result of ACA provisions. In response to the growing controversy, the Obama administration will exempt those losing their coverage because it does not comply with ACA rules. These individuals will be allowed to buy “catastrophic” insurance; usually reserved for those under the age of 30 or opt out completely without the fear of fines. As of mid-December 2013 the insurance cancellation issue will affect fewer than 500,000 individuals.

In late 2013, there was also significant concern and speculation in the press about how volunteer fire departments would be affected by the ACA, and specifically by the employer mandate. Some commented that volunteer fire fighters might be treated as “employees,” and the resulting obligation to offer health insurance coverage or pay a tax penalty would be a crippling expense that would force many volunteer and hybrid fire departments to close. To address these concerns, the Internal Revenue Service (IRS) on January 10, 2014, issued a statement that its “forthcoming final regulations relating to employer-shared responsibility generally will not require volunteer hours of bona fide volunteer fire fighters and volunteer emergency medical personnel at governmental or tax-exempt organizations to be counted when determining full-time employees (or full-time equivalents).”

### Insurance Reforms

One of the driving forces behind health care reform was the need to address abuses by health insurance companies. A drumbeat of news reports about insurance companies denying coverage for those with

legitimate health care needs helped create the atmosphere for reform efforts that eventually led to passage of the ACA.

The law addresses many of these issues by preventing insurance companies from denying coverage for people with preexisting conditions or imposing lifetime limits on people with chronic health problems.

This was a major issue for those attempting to purchase insurance on the individual market prior to the Act becoming law. Simply put, people were denied access to insurance coverage.

In most group plans covering IAFF members and their dependents, the issue of preexisting condition was not a problem. However, many plans did impose a lifetime maximum. The ACA ends that limitation.

The ACA also requires insurers to spend at least a certain percentage of the income they receive from premiums on health care services. This figure is often called the *medical loss ratio*, and the minimum is 80 percent in the individual and small group market and 85 percent in the large group market.

### Cost Containment

Although many observers believe the ACA does not do enough to reduce runaway health care inflation, the Act does include a number of cost containment provisions. It is too soon to know if these changes will have an impact on reducing costs over the long term for our members.

Perhaps the most significant cost containment provision is simply the expansion of access to health care. It is estimated that the current cost of providing medical treatment to those without insurance (many of whom currently use 9-1-1 and emergency room care for all of their medical needs) is \$1,000 for each health insurance policy issued in the U.S. Expanding access to insurance should reduce these costs.

Other provisions attempt to reduce cost by promoting more competition among insurance companies and placing more emphasis on preventive medicine. The Act also creates a new mechanism to reduce Medicare reimbursement formulas and funds research into the most cost-effective way to treat patients and deliver health care services.

One of the most watched aspects of the new law is whether enough of the younger and healthier of the uninsured population sign up for care. Those younger people are generally healthier and less costly for insurance companies to cover, and that reduced cost to the insurance companies was supposed to help pay for all of the older, more fragile of the uninsured population that is expected to sign up for insurance under the new law. If not enough of the younger population sign up, the cost balance will be thrown off. The outcome of that is unpredictable, but would likely mean higher premiums for all – which would be bad for cost containment.

### Pay Fors

One of the most contentious topics surrounding the ACA was identifying revenue sources necessary to pay for the expanded benefits. The ACA includes a variety of fees and taxes, some of which have a negative impact on IAFF members.

Notably, the Act imposes fees on both employers who refuse to offer health care to their workers and on individuals who refuse to purchase health care. The Act also imposes new taxes and fees on insurance companies, self-insured plans, medical device manufacturers and an assortment of other providers.

If you are an active fire fighter receiving employer-provided insurance, your current coverage should not be interrupted, but that doesn't mean it won't change.

The law places a value on employer-sponsored insurance and thus works to preserve this tradition through penalties to keep employees insured. The penalty provision is part of the employer mandate which requires employers with 50 or more full-time plus full-time equivalent employees to offer health insurance or pay a penalty. The penalties range from \$2,000 to \$3,000 for each full-time employee, depending on the circumstances.

Below are some key points that will be used to determine whether an employer would face penalties:

- Employers with 50 or more full-time plus full-time equivalent employees face penalties if they do not provide adequate coverage.
- To avoid penalties, health insurance must be “qualified” meaning that it covers at least 60 percent of the employee's cost on average.
- To avoid penalties, the employee's required contribution to health insurance coverage must not exceed 9.5 percent of the employees income.

The scenarios for how the penalties are applied are very complex. For a more comprehensive understanding of the employer penalties with different employee scenarios please click [here](#).

### What the Act Means for Jurisdictions Covering IAFF Members

How the jurisdictions employing our members will react to the new law is very unpredictable.

Many employers where no collective agreement was in place could have stopped coverage prior to the passage of the ACA without penalty. But most employers of IAFF members maintained coverage, so now that there is a penalty to drop coverage, employers have a disincentive to drop insurance coverage completely.

But, again, that doesn't mean they won't attempt to use the ACA to decrease the cost to the jurisdiction. In fact, a number of jurisdictions have already reported changes to (or attempt by their employers to change) their plans based on their employers' interpretation of the ACA.

Since the ACA does NOT mandate that the employer provides coverage to spouses or retirees, there is already evidence that employers will attempt to stop providing coverage to those groups. However, if health care is included in your collective bargaining agreement, employers will need to return to the bargaining table to make any changes in your health coverage (unless your jurisdiction is subject to an emergency manager provision or bankruptcy, which in many cases usurps many rights and protections in collective agreements).

Some elected officials may call for abolishing employer health care in favor of purchasing coverage on the exchanges. Although unlikely, you may need to defend your health care plan by explaining its value and popularity, and by reminding lawmakers that health care coverage for fire fighters is critical because of the dangerous work you do. Understanding how the enrollment process works and the benefits of the exchange in your state may prove useful information to have at your disposal.

### Grandfathered Plans

The ACA exempts most health plans that existed on March 23, 2010 (the day the law was enacted) and have not made certain types of changes from some of the law's consumer protections. These plans are

called “grandfathered” health plans and there is a possibility that you and your plan may qualify for this exemption. To find out, simply check your plan information starting with the first plan or policy year beginning on or after September 23, 2010: health plans must disclose if they are grandfathered plans in all related materials that describe their health benefits. You can also check with your health plan’s administrator. (Note that your plan may be grandfathered even if you joined the group more recently than 2010).

If your plan is a grandfathered plan, it is not required to comply with *some* of the protections found within the ACA. Below is a list of provisions that DO and DO NOT apply to grandfathered plans:

The following ACA provisions DO apply to grandfathered plans:

- End lifetime limits on coverage.
- End arbitrary cancellations of health coverage.
- Must cover adult children up to age 26.
- Provide a Summary of Benefits and Coverage (a short, easy-to-understand summary of what a plan covers and costs.)
- Pre-existing conditions cannot be used to deny coverage in the group health insurance market (the only exception is grandfathered *individual* health plans)

The following ACA provisions DO NOT apply to grandfathered plans:

- Cover preventive care for free.
- Guarantee your right to appeal.
- Protect your choice of doctors and access to emergency care.
- Be held accountable through Rate Review for excessive premium increases.

In order to avoid these additional rules, many health plans are choosing to preserve their grandfathered status as long as possible. However, any number of factors may cause a plan to decide grandfathered status is no longer worth maintaining. For instance, a plan may wish to increase members’ co-insurance obligation; such a change would cause the plan to lose grandfathered status.

### **Pre-Medicare Retirees**

Retired members face a unique set of circumstances when it comes to their health care, due to the fact that the overwhelming majority of our members retire before Medicare eligibility. While some retirees maintain the same level of coverage as active duty fire fighters, others lose coverage or are required to pick up a much larger portion of their premiums if they want to remain on the group plan. As the cost of health care continues to grow, more employers are discontinuing retiree health coverage or increasing the retiree’s share of the premium.

Retirees who do not have access to care after they leave the job and those who can’t afford to maintain their current coverage will have a new option to obtain coverage through the network of health care exchanges. This is a major benefit for many IAFF retirees who are without current or sufficient coverage.

The IAFF has long advocated for our retired members to have access to quality and affordable health care, and the exchanges will provide that avenue in many respects. Affiliates should determine whether this aspect of the ACA would benefit their retirees.

On the other hand, some retirees who previously continued to receive comprehensive health coverage from their employer even after they left the job may now see their employer attempt to push them onto the exchanges, where coverage may not be as good and the cost may be higher.

If you choose to purchase health care through an exchange, the federal government may provide you with subsidies to assist in purchasing your health insurance. These subsidies are based on various income threshold requirements. In other words, depending on how much income you earn, the government will provide you with a tax credit to help pay for coverage through an exchange. While the vast majority of people's incomes will be determined by their salary, you can click [here](#) for a full list of sources that will determine income levels for subsidy eligibility.

These credits are available to individuals and families who are earning 100-400 percent of the federal poverty line. However, if you do not qualify for these subsidies, the exchanges will still provide insurance options.

To better understand the exchanges, subsidies and plans offered within, use this helpful "[subsidy calculator](#)" created by the Kaiser Family Foundation to find out what subsidies, if any, would be offered at various income levels.

The ACA offers another option for pre-Medicare eligible retirees by expanding access to Medicaid. Starting in 2014, individuals under 65 with an income at 133 percent or below the federal poverty level will be eligible for Medicaid.

Because Medicaid is a state-run program, each state decides whether to accept federal funding for this purpose. So, this new benefit may not be available to all retired IAFF members. The new law expands Medicaid (in participating states) while streamlining and simplifying the application process. Go to the Medicaid.gov [website](#) to learn how the new Medicaid improvements work. Many long-time retirees whose pensions do not have cost-of-living escalators may benefit from this provision. Affiliates should determine if this option is appropriate for any of their current or former members.

Use this chart to determine subsidies available on state exchanges and expanded access to Medicaid.

Household Size	100 percent	133 percent	150 percent	200 percent	300 percent	400 percent
1	\$11,490	\$15,282	\$17,235	\$22,980	\$34,470	\$45,960
2	15,510	20,628	23,265	31,020	46,530	62,040
3	19,530	25,975	29,295	39,060	58,590	78,120
4	23,550	31,322	35,325	47,100	70,650	94,200
5	27,570	36,668	41,355	55,140	82,710	110,280
6	31,590	42,015	47,385	63,180	94,770	126,360
7	35,610	47,361	53,415	71,220	106,830	142,440
8	39,630	52,708	59,445	79,260	118,890	158,520

Also, thanks to an administrative fix, insurance companies will be able to continue providing coverage to their customers on the individual market (which may include retired members) until January 1, 2015 without adhering to the Essential Health Benefit (EHB) rules. After that date, insurance companies will have to provide plans that include EHBs, which may affect the plans of some of our retirees.

### **Self-Insured Plans**

Virtually all of our affiliates are covered by health plans that are either fully insured, self-funded, self-administered or a hybrid of these plan types. Some health plans are fully administered and controlled by insurers who collect premiums paid by the employer and then pay out claims based on the benefits in the employee's plan. These are traditional, *fully-insured plans* in which insurance companies assume the financial risk of paying for necessary health coverage.

However, some affiliates have their healthcare needs covered by arrangements other than fully-insured plans. For municipal *self-funded plans*, the employer/local government takes the place of the insurer by taking on the financial risk of covering the costs of any medical claim by employees. For the local union *self-administered plans*, the union or a trust established by the union receives a finite sum of money from the employer/local government, and the union (or trust) itself bears the financial risk of paying for its members healthcare needs. In either of these alternative arrangements, a third party administrator (TPA), in many cases an insurance company, may handle claims administration, processing, etc., but the jurisdiction, the union, or the trust assumes the risk and responsibility to pay the claims.

Unfortunately, under the ACA, municipal self-funded plans and union self-administered plans will face a number of negative impacts, administrative requirements and fees.

It is important to know what these changes will look like and how they will affect IAFF members as the local and the employer interact throughout the year and during the collective bargaining process.

Along with a number of fees – that are explained in more detail in the following section – there is one additional problem with how the ACA affects self-municipal funded plans and union self-administered plans. As the law stands currently, these plans will not have access to the premium tax credits and cost-sharing reductions that are provided to other health plans. Without these subsidies, the fear is that such plans will be comparatively more expensive for union workers, forcing them off of their current benefit plans or into the exchanges. The IAFF has and is working vigorously to fix the subsidy issue and fees associated with self-insured and self-administered plans.

### **Taxes and Fees**

#### Patient-Centered Outcome Research Institute (PCORI) Fee

The PCORI fee will be collected to help pay for the institute that was authorized by Congress to provide evidence-based research that is intended to help people make informed health care decisions.

<b>How much will this cost?</b>	\$2 per covered life between 10/1/2013 to 9/30/2014; from 10/1/2014 to 9/30/2019 it will be equal to the sum of the prior year, plus health care inflation.
<b>Who is responsible for paying this fee?</b>	The fee is to be paid by health insurance issuers or, for self-insured plans, by the plan sponsor. It applies to both grandfathered and non-grandfathered plans.

Reinsurance Fee (“belly button tax”)

A temporary fee, technically referred to as the Transitional Reinsurance Program Assessment Fee, will be required to be collected for every insured life (every “belly button”) to help stabilize premiums for insurers providing high-cost coverage to the individual market. This issue has been a major source of contention between organized labor and the Obama administration.

The decision to implement the tax was done through the Department of Health and Human Services (HHS). It is particularly troublesome since non-profit plans and their members are paying this tax to subsidize for-profit companies. Frankly, it is corporate welfare. The IAFF is working with other unions and our allies in Congress to address this issue.

<b>How much will this cost?</b>	Funded over a three-year period, the assessment will cost \$63 per individual enrolled in 2014. That cost is expected to decrease in subsequent years, as the fee is designed to raise a total of \$12 billion in 2014, \$8 billion in 2015 and \$5 billion in 2016.
<b>Who is responsible for paying this fee?</b>	Health insurance issuers, or “TPAs on behalf of self-insured group health plans,” will be responsible for paying this fee. It applies to both grandfathered and non-grandfathered plans.

The IAFF and other labor unions have lobbied aggressively to have the Administration eliminate the fee and in response to our efforts the White House has issued a proposed rule change that would do the following:

- Exempt certain self-insured, self-administered plans from the fee for the final two years.
- Alter the timing of the payments, splitting them into two – one payment at the beginning of the calendar year, and one at the end.
- Clarify that fee payments are required only once with respect to the same covered life and that the fee would not unfairly target covered lives that receive supplemental insurance from other sources.

The IAFF will continue to advocate for the elimination of the fee while the rule goes through the traditional comment period process.

The Excise Tax – or “Cadillac Tax”

Perhaps the most troubling provision of the ACA for our members is the *Excise Tax on High-Cost Coverage*, more commonly referred to as the “Cadillac Tax.” Beginning in 2018, employer-based health plans will have to pay a 40 percent tax on the part of each premium that exceeds a certain cap (considering the share of the premiums paid by the employee, as well as the share paid by the employer). In 2018, these caps will be set at \$10,200 for individual coverage and \$27,500 for a family of four. Premiums associated with dental or vision coverage do not apply to these caps.

So, if an individual plan is valued at \$11,200 (not including vision/dental), a 40 percent tax on the amount above the cap (in this case \$1,000) would be applied. (\$11,200 cost of plan – \$10,200 ACA cap = \$1,000 x .40 = \$400 tax.)

Although the tax has been nicknamed the “Cadillac Tax,” it would more appropriately be called the “Chevy Tax” since the premium cap would affect many basic health plans that do not have luxury

features. And each year, more and more plans will bump up against the cap. The thresholds are set to increase each year based on the consumer price index (CPI), but health care costs traditionally rise much faster than inflation. A Johns Hopkins study estimated that while only 16 percent of plans will be affected by the tax in 2018, that figure could grow to 75 percent by the year 2030.

Since the insurance companies will be responsible for paying the tax, we can only speculate how those insurers will respond to this onerous 40 percent excise tax on amounts above the threshold. We believe that insurance companies will either cut coverage to avoid the fee by reducing benefits or requiring higher co-pays and deductibles, or the fee will be passed through to the employer and potentially even to our members, which is unacceptable.

### High Risk Occupations

The ACA allows for higher caps for plans covering employees in high-risk professions (including fire fighting). These new caps will be bumped up to \$11,850 for individuals and \$30,950 for a family of four. Unfortunately the “high risk” bump-up is not as simple or inclusive as it seems.

According to the law, in order to take advantage of the higher caps, the “majority of employees” in the health plan must be in high-risk professions or retirees. This means that plans covering just fire and police would be eligible for the higher caps; however those members that are covered by health plans that include other municipal employees may not be covered by the higher caps.

### The Future of the Cadillac Tax

Early versions of the ACA imposed a direct tax on workers on the total value of their health benefits. The IAFF led the opposition to this tax, and was successful in derailing it.

Needing to replace the revenue that would have been generated by taxing health benefits, ACA supporters came up with the idea of taxing insurance companies that sell high cost policies. The IAFF opposed this alternative as well, and succeeded in dramatically reducing its impact by delaying the implementation to 2018 and increasing the thresholds (see the caps above).

The IAFF remains strongly committed to repealing or reforming the excise tax. *We believe that the tax (along with a number of the other fees and taxes mentioned earlier) directly contradict President Obama’s pledge that “if you like your health care you can keep it.”*

While the first option is to completely repeal the tax, the IAFF is also exploring options that would lessen its impact. Possible reforms include:

- Pro-rate the high-risk occupation threshold for plans that cover high-risk workers who comprise less than 50 percent of all employees. Such plans would qualify for a partial increase in the cap.
- Reform how the caps are indexed by using health care inflation, GDP or CPI + 1 percent.
- Decrease the amount of the tax.
- Push back the effective date (currently set for January 1, 2018).
- Increase the caps for high value plans.
- Increase the high-risk caps.

### The Tax Exclusion for Employer Sponsored Health Insurance (ESI)

The majority of Americans with health care coverage are receiving it from their employer. This popular system has been around for nearly 100 years and has served as the backbone for providing effective health coverage to millions of middle class American workers. One of the things that make this system so popular is that benefits provided by the employer are not counted as taxable income to the employee and, similarly, employee contributions toward their health care premiums are made on a pre-tax basis.

IAFF members especially benefit from this tax break because health plans for our members are typically more costly and cover more benefits due to the high-risk nature of the profession. In fact, our affiliates many times forgo higher salaries to increase or keep their existing health benefits – placing a high value on the need for quality and comprehensive coverage.

As noted earlier, there have been repeated attempts to severely alter or even eliminate this tax exclusion. The 2008 presidential election, the 2010 health care debate, and the current fight to reform the tax code have provided opportunities for political candidates and elected officials to push for drastically altering the health care tax exclusion. So far, the IAFF has fought and won every attempt to protect this important tax benefit and will continue to do so now and in the future.

### The Exchanges... ACA and Private Exchanges

The ACA was designed to allow people without employer-provided health insurance to purchase health care through a health care exchange, also known as a health care marketplace. Similar to travel websites like Kayak or Orbitz, these exchanges are supposed to enable shoppers to easily compare the cost of insurance offered by different companies, though implementation in the first few months has been poor, and many shoppers have experienced difficulty. Plans are presented in four categories – bronze, silver, gold and platinum – and consumers are able to use a price calculator to see if they qualify for subsidies.

Under the ACA, the job of setting up these exchanges falls to the states. In states that have declined to create exchanges, people will be able to participate in the federal exchange, which is HealthCare.gov.

Those receiving affordable health care through their employers are **NOT** eligible for tax subsidies to help with the cost of coverage purchased on the exchange.

Separate from the ACA's exchanges are private/corporate health care exchanges. These "exchanges" act similarly to the state exchanges. They are managed insurance marketplaces where multiple carriers compete by offering employees a choice of fully-insured group plans. The goal is to increase competition, bring down prices and provide better services, just like the state exchanges. This model is independent from the ACA and will not affect how the state exchanges are operated, nor will participants in private exchanges be eligible for tax subsidies.

### Emergency Medical Services

The impact of the ACA on EMS delivery and services has the potential to be significant. Generally speaking, the ACA aims to reduce the use of unnecessary EMS services by increasing the number of insured Americans and increasing the health of the population by incentivizing preventive health care. Although call loads may increase initially, non-emergency calls are expected to level off and reduce over time as the uninsured portion of the population who uses 9-1-1 for all of their health care needs shrinks. In light of these changes, the ACA may offer new opportunities for EMS providers, as well.

The Act also extended Medicare bonus payments for ground ambulance services. For 2013 those payments were set at 2 percent for transports originating in urban areas, 3 percent for transports originating in rural areas, and 22.6 percent for transports originating in super-rural areas. These same bonus payment levels have been subsequently extended through January 1, 2014. The bonus payments have proven critical to covering costs; their expiration in 2014 may lead some providers to cut funding for life-saving equipment, training, or personnel.

Finally, the Act imposes a 2.3 percent tax on medical devices costing more than \$100; the tax took effect January 1, 2013. Although the tax is levied on manufacturers, EMS providers should expect that the additional cost will be passed onto them during purchase, which may affect the budgets of departments.

### **Benefits Audits**

Because the ACA represents an extremely complex change in the rules of the American health care system, and because many of its provisions go into effect at the start of 2014, now is a good time for IAFF affiliates to consider re-examining their health plans and prescription plans through the use of a benefits audit, claims audit, or cost analysis. Doing so may require a Freedom of Information Act (FOIA) request if the local government is unwilling to turn over the relevant claims/cost data voluntarily. Claims audits can be useful tools to help a local affiliate determine what methods can be used to control costs and lessen the burden on our members and their families.

### **Conclusion**

For over a generation, employers have tried to shift costs, diminish benefits and control health care through cafeteria plans, managed care, prescription formularies, and other programs to regulate care and reduce costs. The ACA is simply another challenge.

The ACA will increase the number of Americans with access to affordable health insurance and includes protections for people against some abuses by insurance companies, but it does have significant problems. IAFF affiliate leaders must be educated and prepared to respond.

On the national level, the IAFF will continue to lobby for reform of the provisions that negatively or unfairly impact our members and their plans, and we will continue to provide you with the information and tools you need to represent our members on the frontlines.