In March 2010, President Obama signed the $940 billion comprehensive health care reconciliation package known as the Patient Protection and Affordable Care Act (PPACA). A second piece, a reconciliation measure (HR 4872) to make adjustments to PPACA, was formally adopted March 25 and signed by the president on March 30. In June 2012, the U.S. Supreme Court upheld most of the law’s constitutionality.

PPACA incorporates adjustments to the Senate-passed legislation based largely on the proposals submitted by President Obama. It maintains proposals to create health insurance exchanges and to provide tax credits to qualifying individuals and small businesses, including nonprofits, for purchasing health insurance.

Health care reform affects nonprofits directly, both as service providers and as employers.

The goal of this publication is to inform nonprofits about the health care law as it affects them, both as employers and as service providers to those that may be directly affected by the legislation’s individual provisions.

Nonprofits as Employers
- In 2009, the latest year of record, 80% of larger nonprofits provided health care benefits to their employees, while 71% of nonprofits with 50 employees or fewer did. Over half of all respondents reported that rising health care costs represented a significant organizational challenge, according to a 2010 Johns Hopkins study.
- Since 2001, health insurance costs for small firms have increased 119 percent, according to the National Small Business Association.

Nonprofits as Service Providers
- Nonprofits, particularly those that deliver health and human services, incur substantial costs associated with serving the more than 48 million Americans who do not have health care coverage, as well as the millions of other individuals and families whose health coverage is insufficient to cover the costs of care and prevention.
- Benefit and workforce reductions due to rising health care costs greatly diminishes the ability of nonprofit organizations to deliver programs and vital services to communities and individuals in need.

FOR MORE INFORMATION
Visit [http://www.coloradononprofits.org/](http://www.coloradononprofits.org/) for more information, as well as state and federal policy information a schedule of upcoming trainings.
Nonprofits as Employers

The Small Employer Health Insurance Tax Credit ........................................... 3

Employer Responsibility to Offer Affordable Health Care .................................. 4

Changes to Flexible Spending Accounts (FSAs) ............................................. 4

Health Benefit Exchanges (HBEs) ........................................................................ 5

Employer Reporting Requirements under PPACA ........................................... 6

Employer Information Sharing Requirements .................................................... 7

Nonprofits as Service Providers

Government Subsidies for Purchasing Insurance ............................................... 8

Medicaid Expansion ............................................................................................. 8

Guaranteed Issue and Renewal ............................................................................ 9

State High-Risk Pools and the Pre-Existing Condition Insurance Plan (PCIP) ....... 9

Coverage of Pre-Existing Conditions for Children .......................................... 10

Keeping Young Adults on Their Parents’ Plans ............................................... 10

No Lifetime or Annual Limits on Coverage ....................................................... 11

Access to Emergency Room Services .............................................................. 11

End of Rescission of Coverage ........................................................................ 11

Individual Requirement to Purchase Health Insurance .................................... 12

Health Benefit Exchanges (HBEs) ..................................................................... 13

The ‘Essential Health Benefits Package’ ............................................................ 14

Insurance Companies Reporting “Medical Loss Ratio” (MLR) and Rebates ...... 15

Changes to Medicare: Medicare Advantage ..................................................... 16

Changes to Medicare: Reducing Hospital payments and increasing savings .... 17
The Small Employer Health Insurance Tax Credit  
*Effective: Currently*

Small employers that pay for health care premiums for their employees can claim payroll tax credits. To qualify, employers must meet the following criteria:

- Pay at least 50% of employee premiums
- Have 25 employees or fewer
- Have average wages of less than $50,000

If an employer has more than ten full-time employees (FTEs), or average payroll in excess of $25,000, the amount of the credit is reduced from the maximum amount based on a particular sliding scale.

For nonprofits, the schedule of credits is as follows:

- 2010-13: Up to 25 percent of qualified health costs (35% for for-profits)
- 2014-onward: Up to 35 percent of qualified costs for purchases of coverage through an exchange (50% for for-profits)

Beginning in 2014, credits are available to employers purchasing employee coverage through health insurance exchanges. The credit will only be available to employers for two consecutive years after 2013. Employees would still receive full credit for taxes withheld from their pay.

**LEARN MORE**

- [Calculate your tax credit](#) at Small Business Majority’s website
- Learn more about [how the small employer tax credit works](#) from Independent Sector
- View the [timeline for Colorado employers](#) from Colorado.gov
NONPROFITS AS EMPLOYERS

Employer Responsibility to Offer Affordable Health Care
Effective: 2014

Beginning in 2014, large employers must offer health insurance options that employees can afford, and those plans must offer a certain minimum value of benefits.

Employers with 50 or more employees will be required to either offer health insurance that pays at least 60 percent of employee premiums or pay a fee to help cover the cost of making insurance affordable to their employees through a Health Benefit Exchange.

For coverage to be affordable, the employee’s share cannot exceed 9.5 percent of the employee’s household income. The legislation exempts the first 30 workers from employers’ payment calculations. The fee schedule works as follows:

- If the employer does not offer coverage, there will be a $2,000 fee per employee.
- If the employer does offer coverage, but has employees which are eligible for federal subsidies (see page 8), or, if coverage requires that the employee pay more than 9.5% of household income, there will be a $3,000 fee per eligible employee.

Plans in existence on or before March 23, 2010 are considered ‘grandfathered plans’ for the purposes of the Affordable Care Act. Large employers with grandfathered plans are still required to adhere to employer responsibility provisions; their coverage is considered as being the minimum essential coverage.

Changes to Flexible Spending Accounts (FSAs)
Effective: 2013

Beginning in 2013, tax-free Flexible Spending Accounts (FSAs) will be capped at $2,500 per plan year. An FSA can only cover qualified care and services (such as doctor & dental visits, and prescriptions) that are not covered under a traditional health plan. Currently, the cap on FSAs is generally set by employers.

LEARN MORE

- View the flowchart explaining employer penalties from Kaiser Family Foundation
- Read more about large employer responsibility from Department of Health and Human Services
- Read a definition and summary of changes to FSAs from the Health Foundation of Greater Cincinnati
- View the timeline for Colorado employers from Colorado.gov
Health Benefit Exchanges (HBEs)
Effective: 2014

HBEs are online markets where individuals and small businesses can buy lower-cost health insurance as a part of a larger purchasing pool. The Affordable Care Act mandates that HBEs be established and run by state government agencies or a nonprofit organization.

- Once HBEs become operational, all employers with fewer than 100 employees will be eligible to participate, and individuals with incomes between 133 and 400 percent of the Federal Poverty Level (FPL) will be eligible to receive cost-sharing subsidies in HBEs.
- Although the Affordable Care Act defines “small business” as an entity employing 100 or fewer workers, states (like Colorado) have the option (until 2016) to define “small business” as an employer with 50 or fewer employees.
- Starting in 2017, states may allow larger companies (those with more than 100 employees) to participate in HBEs.

Eligible small businesses can “shop” for health insurance through the Small Business Health Options Program (SHOP) set up within Health Benefit Exchanges. SHOPs use economies of scale in setting plan rates; this feature allows small businesses to access rates that were previously available only to larger employers. SHOPs also allow small employers to offer and select multiple Qualified Health Plans (QHPs) to their employees, while writing out a single monthly check to the Health Benefit Exchange.

Each state’s HBE must establish a website designed to help individuals and small businesses shop for QHPs, which are health plans that meet minimum federal and certification standards established by each separate state Exchange. If states do not create an HBE by the end of 2013, they will become part of a federal exchange.

LEARN MORE

- Visit Colorado’s Health Benefit Exchange, opening for business in 2013
- Learn more about the Small Business Health Options Program (SHOP) from American Cancer Society
- View the timeline for Colorado employers from Colorado.gov
Nonprofits as Employers

Employer Reporting Requirements under PPACA
*Effective: for 2012 W-2 filings (issued in Jan 2013)*

The Affordable Care Act places new requirements for W-2 reporting. This reporting is optional in 2011, but is required for 2012 W-2s (issued in January 2013). Specifically, employers must report the cost of coverage under an employer-sponsored group health plan on their W-2 (for informational purposes, not taxation). The amount reported generally covers the amount paid by the employer as well as the portion paid by the employee.

For employers who issue less than 250 Forms W-2 within a calendar year, this reporting requirement is optional.

**LEARN MORE**

- Read the IRS explanation of W-2 reporting for 2012 filings and onward
- View the timeline for Colorado employers from Colorado.gov
Employer Information Sharing Requirements
Effective: 2013

The Affordable Care Act makes amendments to the Fair Labor Standards Act (FLSA) by adding, among other provisions, a requirement that employers make their employees aware of several items related to their health care options.

- Employers must notify employees of the existence of Health Benefit Exchanges.
- Employers must notify employees that if they purchase a plan on their own through the Health Benefit Exchange, they may lose their employer’s contributions to health benefits offered through their workplace.
- If the employer plan does not meet the minimum standard of a Qualified Health Plan (if it does not cover at least 60% of expenses), the employer must make that known to employees, and also let them know that they may be eligible for a premium tax credit and cost-sharing reduction if they purchase a plan through a Health Benefit Exchange.

LEARN MORE

➔ Scan the list of employer compliance rules from Martindale, which includes the information-sharing provision for 2013

➔ View the timeline for Colorado employers from Colorado.gov
NONPROFITS AS SERVICE PROVIDERS

Government Subsidies for Purchasing Insurance

*Effective: 2014*

Lower- and middle-income Americans may receive subsidies from the government to assist them in purchasing health insurance. Those eligible for subsidies would fall into FPL between 133-400%.

The Kaiser Family Foundation reports that “the most that families buying coverage in an insurance Exchange would pay towards a health insurance premium would range from 3.0% of income at 133% of poverty to 9.5% of income at 400% of poverty, with amounts at specific income levels specified in a table in the law. Subsidies are tied to a benchmark level of coverage based on actuarial value. And, subsidies would only be available through organized purchasing pools called Exchanges.”

Medicaid Expansion

*Effective: 2014*

Eligibility of Medicaid will be expanded by 2014, but states can choose to expand sooner. States set their own eligibility requirements within federal guidelines. By 2014, the law requires that eligibility will be expanded to individuals who are below 133% of the Federal Poverty Line ($14,856 for an individual or $30,657 for a family of four).

The recent Supreme Court decision, however, ruled that the federal government can’t take away states’ existing Medicaid funding if they refuse to participate in the expansion. If they choose to participate, they are eligible for additional federal funding to support expansion. The federal government can still deny expansion funding to states that choose not to expand.

LEARN MORE

- Use the [Health Reform Subsidy Calculator](#) from Kaiser Family Foundation
- Read about the [government tax credit for purchasing insurance](#) from Community Catalyst
- Read about the [Supreme Court decision relating to Medicaid expansion](#) and state participation
- Read a [fact sheet on Medicaid expansion](#) from American Cancer Society
- View a [timeline of Affordable Care Act provisions](#) from Department of Health and Human Services
Guaranteed Issue and Renewal
Effective: 2014

Guaranteed issue means that health plans must accept eligible applicants regardless of their health status. Currently, this requirement applies to small group markets (employers with under 50 workers).

By 2014, all new policies in the individual and group health insurance markets will have to guarantee issue to eligible applicants. The Affordable Care Act allows carriers to limit this to specific enrollment periods in a given year, known as open enrollment or special enrollment, rather than annual enrollment. Coverage renewal requests also cannot be denied.

State High-Risk Pools and the Pre-Existing Condition Insurance Plan (PCIP)
Effective: Until 2014

For those with pre-existing health conditions that place them in a “high-risk” category, and who have been denied insurance coverage or have been without coverage for over 6 months, the Affordable Care Act has created the “Pre-Existing Condition Insurance Plan” (PCIP), which provides funding to existing state high-risk pools.

The plan is administered by either U.S. Health and Human Services or similar state level department. PCIP is available until 2014, when guaranteed issue will be in effect and the PCIPs will no longer needed.

LEARN MORE

→ Read about [guaranteed issue](#) from the American Cancer Society

→ Read about [Pre-Existing Condition Insurance Plan](#) (PCIP) from Department of Health and Human Services

→ View a [timeline of Affordable Care Act provisions](#) from Department of Health and Human Services
Coverage of Pre-Existing Conditions for Children

*Effective: Currently*

Insurance companies can no longer deny coverage to children under the age of 19 with pre-existing conditions.

Beginning in 2014, this provision will be extended to all citizens (see page 9). Insurers are prohibited from excluding a pre-existing condition from coverage unless the plan as a whole does not offer that type of coverage to any of its enrollees.

Keeping Young Adults on Their Parents’ Plans

*Effective: Currently*

Young adults can now remain insured on their parents’ plans until age 26.

**LEARN MORE**

⇒ Learn more about [coverage provisions for children with pre-existing conditions](#) from Department of Health and Human Services

⇒ Read about the [young adult coverage extension](#) from Department of Health and Human Services

⇒ View a [timeline of Affordable Care Act provisions](#) from Department of Health and Human Services
No Lifetime or Annual Limits on Coverage
*Effective: Currently and through 2014*

Lifetime dollar limit restrictions on most benefits are currently prohibited under the Affordable Care Act.

Between 2010 and 2014, there has been and will be a gradual elimination of annual limits as well. By 2014, insurers will not be able to place any annual limits on coverage. These provisions apply to “essential benefits” only (see page 14).

Access to Emergency Room Services
*Effective: Currently*

Individuals will no longer need to obtain prior authorization from their insurers for emergency care, and insurers will no longer be able to charge high co-pays or co-insurance for out-of-network emergency room care. This does not apply to grandfathered plans.

End of Rescission of Coverage
*Effective: Currently*

“Rescission” refers to the practice of insurance companies cancelling policies of individuals who became sick or otherwise are found to be in violation of their policy agreement. Starting in 2010, insurers can no longer drop coverage due to finding a mistake honestly made on the insured’s application.

Insurers can still rescind coverage due to failure to pay premiums, or if it is determined that a policyholder intentionally submitted false or incomplete information on the application.

---

**LEARN MORE**

- Read about [ending lifetime and annual limits](#) from Families USA
- Read the [Patients’ Bill of Rights](#) including information on emergency room provisions.
- Read about [emergency room access](#) from Department of Health and Human Services
- View a [timeline of Affordable Care Act provisions](#) from Department of Health and Human Services
**Individual Requirement to Purchase Health Insurance**

*Effective: 2013*

Beginning in 2013, all U.S. citizens and legal residents will be required to purchase health insurance through individually purchased coverage, employer-sponsored coverage, or a federal insurance program. The penalty for not maintaining health insurance would be an excise tax of $695 per adult in the household.

The per-adult penalty would be phased in as follows:

- 2013: $0
- 2014: $95
- 2015: $325
- 2016: $695

The tax in 2014 is $95, or 1 percent of income, whichever is greater. The amount rises until 2016, when it becomes $695 for an individual (up to $2,085 for a family), or 2.5 percent of income, whichever is greater.

The tax would be indexed after 2016 and could increase based on inflation. No criminal penalties can be imposed on the failure to pay the excise tax. Exemptions to this provision provide for financial hardships, religious reasons, and Native Americans. Financial hardship may be designated if the cheapest health insurance plan costs more than 8% of an individual’s household income, or if an individual’s income is below the minimum threshold for filing taxes [$9,500 for an individual under 65 in 2011], according to the Kaiser Family Foundation.

**LEARN MORE**

- View the [flowchart explaining individual penalties](#) from Kaiser Family Foundation
- Read [Q&As on the individual requirement](#) to buy health insurance from Aetna
- View a [timeline of Affordable Care Act provisions](#) from Department of Health and Human Services
Health Benefit Exchanges (HBEs)
Effective: 2014

HBEs are online markets where individuals and small businesses can buy lower-cost health insurance as a part of a purchasing pool. The Affordable Care Act mandates that HBEs be established and run by state government agencies or a nonprofit organization.

Once HBEs become operational, individuals with incomes between 133 percent and 400 percent of the Federal Poverty Level (FPL) will be eligible to receive cost-sharing subsidies for purchasing health insurance in HBEs.

Each state’s HBE must establish a website designed to help individuals and small businesses shop for QHPs, which are health plans that meet minimum federal and certification standards established by each separate state Exchange. Colorado’s Health Benefit Exchange will be open for business at the end of 2013 at http://www.getcoveredco.org/.

If states do not create an HBE by the end of 2013, the federal government will set one up for them.

LEARN MORE

› Visit Colorado’s Health Benefit Exchange, opening for business in 2013

› View a timeline of Affordable Care Act provisions from Department of Health and Human Services
The ‘Essential Health Benefits Package’

*Effective: 2014*

Essential Health Benefits (EHB) are a set of defined health care service categories that, starting in 2014, must be covered by certain markets such as individual and small group plans. The Department of Health and Human Services gives states flexibility to choose a benchmark plan that covers EHB. All plans must include services within the following 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,
- pediatric services, including oral and vision care

In order to be certified and offered in Health Benefit Exchanges, insurance policies must cover these categories. By 2014, all Medicare state plans will include these services in coverage.

Qualified Health Plans (QHPs) are plans that meet these minimum federal standards, as well as the certification standards established by each separate state Exchange. Insurers are required to provide benefits at various actuarial levels of value – bronze (60%), silver (70%), gold (80%) and platinum (90%). QHPs are also required to offer a catastrophic coverage plan to those aged 30 or under, or those that qualify for exemption from the individual mandate. Actuarial levels are defined by the American Academy of Actuaries as the “average share of medical spending paid by the plan, rather than paid out of pocket by the consumer.”

---

**LEARN MORE**

- Read about [essential health benefits](#) from Colorado’s Health Benefit Exchange
- View a [timeline of Affordable Care Act provisions](#) from Department of Health and Human Services
Insurance Companies Reporting “Medical Loss Ratio” (MLR) and Rebates

*Effective: Currently*

Medical Loss Ratio existed before the Affordable Care Act, but the law sets a firm standard on insurers. Beginning in 2011, insurers are required to report their MLR to consumers (MLR, also known as the “80/20 Rule”, is a financial rule put in place by the Affordable Care Act to ensure that insurance carriers are providing maximum value to enrollees).

It represents how much of an enrollee’s premium dollar is spent on medical care and benefits, rather than the insurer’s overhead costs.

- In the individual and small group markets, MLR must be at least 80% of an enrollee’s premium dollar.
- In the large group market, MLR must be at least 85% of an enrollee’s premium dollar.

If insurers don’t meet the minimum standards set by the Affordable Care Act (which varies by market as well state law), they are required to give consumers a rebate for the money not spent on their medical care.

---

**80%**

*Premium dollar spent on medical care*

Failure to meet the “80/20” requirement will trigger consumer rebates.

---

**LEARN MORE**

- Find out your insurance company’s [Medical Loss Ratio and Rate Reviews](#) from the Department of Health and Human Services
- View a [timeline of Affordable Care Act provisions](#) from Department of Health and Human Services

---
NONPROFITS AS SERVICE PROVIDERS

Changes to Medicare: Decreasing Payments to Medicare Advantage by Cutting Incentives for Private Insurers

Effective: Currently

Medicare Advantage (Part C) is the government’s private health plan coverage option. Medicare Advantage plans cost the federal government about 13% more per person than the traditional Medicare (Parts A&B) programs. This extra spending comes in the form of incentives and subsidies paid out to private insurers to encourage them to offer plans to eligible Medicare enrollees.

The Affordable Care Act does not cut any benefits from any Medicare programs; it slows the growth of Medicare by reducing reimbursements to private insurers (and hospitals), and by connecting the new payment calculations to quality of care and patient satisfaction.

Among the changes in the treatment of Medicare Advantage spending under the Affordable Care Act are:

- freezing benchmarks to 2010 levels
- bringing benchmarks closer to the costs in traditional Medicare plans in 2012-13
- reducing risk scores which guide insurer compensation rates, and which are based on enrollee health status
- providing bonus payments for high-quality plans

The Congressional Budget Office estimates that the Affordable Care Act’s Medicare Advantage payment reform provisions and changes will save $135.6 billion from fiscal years 2010 to 2019.

LEARN MORE

➤ Read an issue brief on Medicare Advantage from Kaiser Family Foundation

➤ Read about changes to Medicare Advantage from AARP

➤ View a timeline of Affordable Care Act provisions from Department of Health and Human Services
NONPROFITS AS SERVICE PROVIDERS

Changes to Medicare: Cuts in Payments to Hospitals and Increased Savings to Beneficiaries

Effective: Currently

Along with the cuts in subsidies to private insurers mentioned in the previous section, the Affordable Care Act also slows Medicare’s reimbursement rates paid out to hospitals over time. Medicare payments to hospitals and other providers (like home health care services) have traditionally been adjusted each year to match the rise of inflation, but the Affordable Care Act’s new payment calculations, instituted in 2010, gradually slow the rise of these payments rates as hospitals and healthcare providers see an increase in the number of patients carrying health insurance.

These cuts (together with other cuts to Medicare such as reimbursements to hospitals that treat large numbers of uninsured patients) add up to $716 billion, a much-politicized number during the 2012 presidential election. While the Affordable Care Act cuts Medicare spending and growth, it does not make any cuts to Medicare benefits. In fact, the Department of Health and Human Services has reported that individual Medicare beneficiaries will see a savings of up to $5,000 through 2022 due to provisions set forth in the Act.

These projected savings are reflected in the closing of the prescription drug "donut hole", a current gap in coverage in Medicare Part D. Other savings will be achieved through enhanced access to no-cost preventive services, as well as a slowing of the increase in premiums for physician care and other services.

LEARN MORE

- Read an [issue brief on Medicare Savings](#) from Department of Health and Human Services
- View a [timeline of Affordable Care Act provisions](#) from Department of Health and Human Services
About Us

*Colorado Nonprofit Association leads, serves and strengthens Colorado nonprofit organizations.* We are a statewide nonprofit membership coalition connecting nonprofits of all sizes, missions and geographic locations.

We **lead** the nonprofit sector in influencing public policy and public opinion.

We **serve** our members by providing tools for communication, networking and administration.

We **strengthen** the nonprofit community through trainings, issue discussions, and public advocacy about the importance of the nonprofit sector.