The Affordable Care Act

Legislative History –

The Affordable Care Act was passed on March 23, 2010 as Public Law 111-148. There was a companion law known as the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). The combined bills comprise over 2700 pages and have been known at various times as the Patient Protection and Affordable Care Act (PPACA), the Affordable Care Act (ACA), and ObamaCare. A complete copy of the law can be found at http://www.healthcare.gov/law/full/.

Purpose of the Act—

The most widely accepted reason for passage of the act is to provide affordable coverage for most Americans. It is generally accepted that nearly 50 million Americans are without some form of insurance. There are a number of elements to the law intended to achieve the goal of coverage for most Americans that go into effect on January 1, 2014:

1. An ***Individual Mandate*** that requires nearly every American to have some form of either private or public insurance or pay a penalty.
2. ***Guaranteed Issue*** or the requirement that insurance companies must accept individuals without regard to pre-existing conditions or health conditions.
3. Use of ***Community Rating*** by insurance companies when establishing rates so that unhealthy individuals pay no more than healthy individuals for insurance.
4. Expansion of the methods in which individuals can acquire insurance in the market place to include:
    a. Expansion of Medicaid[1] to Individuals and Families whose household income is equal to or less than 138%[2] of the Federal Poverty Level (FPL)
    b. Creation of American Health Benefit Exchanges (**Exchanges**) known as Marketplaces for individuals and small businesses (with less than 50 employees)

[1] PPACA originally mandated that states expand Medicaid. The United States Supreme Court Decision on June 28, 2012 made state expansion of Medicaid voluntary and as of this date, Ohio has not made a decision regarding Medicaid expansion

[2] The legislation originally defined Medicaid eligibility as 133% of the FPL but mandated that the first 5% of income be ignored making the net effect of increasing the threshold to 138% of the FPL.

c. Requirement that all employers with 50 or more full-time and full-time equivalent employees provide coverage to its employees or pay a penalty (**Pay or Play Mandate**).

Benefit Mandates

The ACA imposes new **Benefit Mandates** on group health plans and health insurance issuers. Health plans that maintain "grandfather status" escape some but not all of the requirements of the ACA. Grandfather status will be discussed more fully below. Benefit mandates began to be implemented on Sept 23, 2010, six months after the passage of ACA and have continued to be implemented at time intervals dictated by regulation. Below is a summary of those benefit mandates that apply to **all** health plans:

Coverage of Children to Age 26 was effective for plan years beginning on or after September 23, 2010. Group Health Plans and Health Insurance Issuers must make coverage available to dependent children up to age 26, whether the child is married or unmarried. Such coverage must not be contingent on financial dependency, residency, student status or employment. In addition, coverage must be extended in the same form and fashion as any other dependent child on the plan. There is one temporary exemption for **grandfathered health** plans that allow those plans to exclude coverage to Adult Dependents if there is other coverage available to a dependent. This temporary exemption expires for plan years beginning on or after January 1, 2014.

No Pre-existing Condition Exclusions for Individuals under Age 19 was effective for plan years beginning on or after September 23, 2010. This mandate requires that group health plans and health insurance issuers are prohibited from excluding individuals under age 19 from coverage because of a pre-existing condition.[3]

Essential Health Benefits are loosely defined in ACA as falling into the ten categories listed below and ACA applies certain restrictions to group health plans and health insurance issuers regarding essential health benefits:

1. Ambulatory Patient Services
2. Emergency Services
3. Hospitalization
4. Maternity and Newborn Care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices

[3] Pre-existing conditions are prohibited for all individuals effective with plan renewals on or after January 1, 2014.

8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care.

No Lifetime or Annual Dollar Limits on Essential Health Benefits are permitted for plan years beginning on or after September 23, 2010 for group health plans and health insurance issuers. With the removal of lifetime limits, group health plans and health insurance issuers are permitted to include a combined annual limit on Essential Health Benefits until the 1st plan renewal on or after January 1, 2014. The schedule for these annual limits is as follows:

1. Effective for Plan renewals on or after September 23, 2010, **Annual limits** on group health plans must be at least $750,000[4].
2. Effective for Plan renewals on or after September 23, 2011, **Annual limits** on group health plans must be at least $1,250,000.
3. Effective for Plan renewals on or after September 23, 2012, **Annual limits** on group health plans must be at least $2,000,000.
4. Effective for Plan renewals on or after January 1, 2014, **Annual limits** on group health plans must be removed.

Temporary Waivers to the **Annual limit** for group health plans were granted to plans that made application to HHS and provided justification for such waiver. Plans were required to submit applications before September 23rd, 2011 and the waiver expires on January 1, 2014.

Rescissions of Coverage are not permitted effective for plan years beginning on or after September 23rd, 2010. Rescission means a cancellation or discontinuance of coverage after a policy has been issued. A cancellation is not a rescission if it:

1. Is prospective in nature or;
2. Is the result of non-payment of premium in accordance with the terms of the policy.

Rescissions are permitted in the case of fraud or intentional misrepresentation of material facts by the applicant(s). However, plans must provide 30 days advance notice before coverage may be rescinded.

Over-the-Counter medication expenses incurred on or after January 1, 2011 and purchased without a prescription are not eligible to be reimbursed in an FSA, HRA, or HSA. IRS notice 2010-59 defines a prescription as a written or electronic order for a medicine that meets the legal requirements of a prescription in the state in which it is dispensed.

[4] If a grandfathered health plan has a higher lifetime maximum than minimum statutory annual amount, the plan must keep their annual maximum at least as high as the plan's lifetime maximum or risk losing grandfather status.

Grandfathered Health Plans[5] are plans that do not significantly change benefits that were in place on March 23, 2010. In order to maintain status as a grandfathered health plan, a plan must:

1. Include a statement in any plan materials that the plan is a grandfathered health plan within the meaning of section 1251 of PPACA and;
2. Maintain records necessary to substantiate the terms of the plan in effect on March 23, 2010.

A group health plan can maintain its status indefinitely as long as it does not do any of the following changes that would cause it to lose its grandfather status:

1. Elimination of all or substantially all benefits to diagnose or treat a condition;
2. Any increase in a percentage cost-sharing (e.g. co-insurance) measured from the cost-sharing requirement in effect on March 23, 2010;
3. Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points measured from the amounts in effect on March 23, 2010;
4. Increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, $5 plus medical inflation);
5. A decrease of more than 5%, in the employer's **contribution rate** toward the cost of coverage for any tier of coverage for similarly situated individuals. This decrease is measured from the **contribution rate** in effect on March 23, 2010; or
6. Imposition of dollar limit on all benefits below specified amounts.

[5] Grandfathered Health Plans are defined in ACA §1251(e), 10103(d), HCERA §2301.

Benefit Mandates for Non-Grandfathered Health Plans

Mandatory Coverage of Certain Preventive Services beginning with plan renewals on or after September 23, 2010, requires plans and issuers to cover certain preventive services without any cost-sharing for the enrollee when delivered by in-network providers. Preventive services under the following government bodies are required to be covered:

1. Recommendations of the United States Preventive Services Task Force (USPSTF) with a grade of A or B.
2. Recommendations of the Advisory Committee on Immunization Practices (ACIP) Immunization Schedules.
3. Recommended Immunization Schedule for Persons Aged 0 Through 6 Years.
4. Recommended Immunization Schedule for Persons Aged 7 Through 18 Years.
5. Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind.
6. Recommended Adult Immunization Schedule.

Recommendations also include Bright Futures Recommendations for Pediatric Preventive Health Care and recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. Updates to lists are effective for the first plan year that begins a year after the change is effective but they can be implemented sooner.

Designation of Primary Care Provider effective with plan renewals on or after September 23, 2010 must include any such provider that is included in the network. This requirement must appear in notice form in the summary plan description or other similar description of benefits.

No pre-authorization for Obstetrical and Gynecological Care beginning with plan renewals on or after September 23, 2010. This requirement must appear in notice form in the summary plan description or other similar description of benefits.

Coverage for Emergency Room Services effective with plan renewals on or after September 23, 2010 must include cost-sharing requirements that are equal for both network and non-network emergency services and without prior authorization.

As of February 5, 2012

Appeal Rights and Claim Dispute Resolution are expanded effective with plan renewals on or after September 23, 2010. The following are the changes to the appeal process:

1. Rescissions are now considered an adverse benefit determination and may be appealed.
2. Plans or issuers must provide the claimant (free of charge) any new or additional. evidence used in connection with a claim and if a final adverse benefit determination is based on a new or additional rationale, must provide the claimant with that information as soon as possible and sufficiently in advance of the deadline for providing the final decision to give the claimant a reasonable opportunity to respond.
3. The plan or issuer must ensure that all claims and appeals are reviewed in a manner designed to ensure the independence and impartiality of the person(s) making the decision.
4. All notices of adverse benefit determinations must include information identifying the claim, including the reason for the denial, how to initiate any appeal or external review and contact information for any available office of health insurance, consumer assistance, or ombudsman.
5. If the plan or issuer fails to strictly adhere to the required claims and appeals rules, the internal claims and appeals process will be deemed exhausted and the claimant may initiate an external review and pursue any remedies in civil court that are available under ERISA section 502(a) or state law as applicable.
6. The group health plan or issuer must also provide an external review process available to the claimant at no charge. External reviews are only available for adverse benefit determinations that involve medical judgment (e.g. medical necessity, appropriateness, or whether a treatment is experimental or investigation) or a rescission of coverage. The external review must be independent and is binding on both parties.
7. A plan or issuer must meet the culturally and linguistically appropriate standard in delivering adverse benefit determination in those counties that meet the thresholds established by law for non-English language participants.

Discrimination in favor of highly compensated individuals in fully insured plans, originally effective for plan years beginning on or after September 23, 2010 has been delayed. The non-enforcement period will continue until final regulations are issued and become effective.

Medical Loss Ratio Rules effective January 1, 2011, require an insurer to spend a certain percentage of premium dollars on reimbursement for medical services and health care quality improvement activities. The following rules are in effect:

1. For Small Group (under 50 employees) and Individual policies, Insurers must spend $.80 of every premium dollar collected on medical services and health care quality improvement activities. The requirement applies to the aggregate premium collected by each insurer in the individual and small group markets and does not apply to each policy sold separately.
2. For Large Groups (50 or more employee), Insurers must spend $.85 of every premium dollar collected on medical services and health care quality improvement activities. The requirement applies to the aggregate premium collected by each insurer in the large group market and does not apply to each policy sold separately.

If these medical loss ratios are not met, insurers are required to issue rebates to policyholders so that, when the rebate is included, the medical loss ratio requirement is met.

W-2 reporting is effective for tax years beginning January 1, 2012 and requires employers to report the aggregate cost of employer-sponsored health coverage on employees Form W-2[6]. Employers that produced 250 W-2s in 2011 are required to comply with the rule in 2012 and beyond. In its original form the rule extended to employers under 250 but that compliance has been suspended until further guidance is issued.

Summary of Benefits and Coverage (SBC) is effective for plan year renewals or open enrollment (whichever comes first) on or after September 23rd, 2012. As the name implies, SBCs are intended to provide plan sponsors, as well as eligible and covered individuals, a summary of plan benefits in an easy to read format. Distribution of the SBC must comply with various timeframes depending on the circumstances in which the distribution takes place. Generally, SBCs must be distributed:

1. During Open Enrollment if the employer has an open enrollment period;
2. 30 days prior renewal if the employer plan has an automatic renewal;
3. Upon request, enrollees must receive a copy of the SBC within 7 days;
4. Mid-year benefit changes require that the SBC be distributed 60 days in advance of any such changes;
5. Special enrollments require distribution of the SBC with 90 days of enrollment.

[6] The cost of coverage is defined as the fully-insured premium or in the case of a self-insured plan, the applicable COBRA premium.

Failure to comply with the SBC requirements carries a fine of $1,000.00 per instance and $100.00 per day until the infraction is remedied. The penalty will not be enforced during the first year the rule is in effect as long as insurers and plan sponsors are making good faith efforts to comply with the law.

Glossary of Health Coverage and Medical Terms is a companion document to the SBC and provides easy to understand definitions of commonly used insurance terms. The distribution of the glossary to enrollees is not mandatory but there is a link to the glossary contained in the SBC.

Patient Centered Outcomes Research Institute (PCORI) or also known as the Comparative Effectiveness Research Fee is a tax on fully-insured, self-insured, and retiree plans[7]. The tax is effective for plan years ending on or after October 1, 2012. The first year the tax is in effect, plans are levied a tax of $1.00 per participant per year. The second year (and subsequent years) the fee is $2.00 per participant. The tax expires on September 30, 2019. Plans remit the tax on IRS Form 720 and the filing is due by July 31st of the year AFTER the plan ends. So for example, a plan that ends on December 31st must file and remit the tax no later than July 31st of the following year.

Medicare Tax Increase for Certain Filers goes into effect starting in 2013. The 0.9 percent Additional Medicare Tax applies to an individual's wages, Railroad Retirement Tax Act compensation, and self-employment income that exceeds a threshold amount based on the individual's filing status. The threshold amounts are $250,000 for married taxpayers who file jointly, $125,000 for married taxpayers who file separately, and $200,000 for all other taxpayers. An employer is responsible for withholding the Additional Medicare Tax from wages or compensation it pays to an employee in excess of $200,000 in a calendar year.

Health Flexible Spending Account Limitations starting in 2013 limit the amount an employee can deduct for their Health Flexible Spending Account to $2,500.00. There are transition rules that allow non-calendar year plans to change their plan limit on the anniversary date of the plan.

[7] Self-insured plans are responsible for payment of the PCORI fee. Insurers are responsible for payment when a plan is insured

MANDATES EFFECTIVE IN 2014[8]

Automatic Enrollment requires health plans with 200 or more employees to automatically enroll individuals in the plan. This provision has been delayed until further guidance is issued.

Coverage of Children to Age 26 for Grandfathered Health Plans cannot be denied even if there is employer-based coverage for adult dependents.

90 Day Limit on Waiting Periods begins in 2014.

Reinsurance Tax is assessed for all fully-insured and self-insured plans. The amount collected is $63.00 per participant. This tax is temporary and expires in 2016.

No Pre-existing for Adults effective for Plan years on or after January 1, 2014.

Pay or Play Mandate IRS code section 4980H requires large employers with 50 or more Full-time and full-time equivalent employees to offer coverage to employees working 30 or more hours. Failure to offer coverage will result in a penalty of $2,000 per employee if any employees receive a premium subsidy. The penalty is assessed monthly. In addition, if an employer provides coverage but that coverage is deemed either unaffordable[9] or does not meet the minimum value[10] the employer is assessed a penalty of $3,000 for each employee that receives a premium subsidy from the Exchange.

Reporting Requirements for Large Employers begins in 2014. The IRS has not announced the form or the due date for such reporting but the purpose is to provide data to IRS for management of the "Pay or Play" mandate as well as monitoring individual eligibility for exchanges. A list of data elements follows:

- Include the name and Employer Identification Number (EIN) of the applicable large employer;
- Include the date the return is filed;

[8] Generally mandates are effective on the plan anniversary in 2014.
[9] Coverage is deemed unaffordable if the cost of self-only coverage exceeds 9.5% of the employee's W-2 wages.
[10] Minimum Value is defined as providing (on average) at least 60% of the cost of medical services.

- Certify whether the applicable large employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in § 5000A(f)(2)) and, if so, certify
- (1) The duration of any waiting period (as defined in § 6056(b)(2)(C)) with respect to such coverage;
- (2) The months during the calendar year when coverage under the plan was available;
- (3) The monthly premium for the lowest cost option in each enrollment category under the plan; and
- (4) The employer's share of the total allowed costs of benefits provided under the plan.
- Report the number of full-time employees for each month of the calendar year;
- Report, for each full-time employee, the name, address, and taxpayer identification number (TIN) of the employee and the months (if any) during which the full-time employee (or any dependents) were covered under the eligible employer-sponsored plan; and
- Include such other information as required by the Secretary of the Treasury.

Wellness Program Rewards (NGF Only) effective January 1, 2014, increases the limit to up to 30% of the cost of coverage for participating in a wellness program; the limit is increased to 50% for smoking cessation. The legislation stipulates that employers must offer an alternative standard for an individual for whom it is unreasonably difficult or inadvisable to participate in the wellness program.

Cost-Sharing Limitations are imposed on small group plans that originally limited the deductible to $2,000 single and $4,000 family. However, because of the interplay of actuarial value and deductibles, HHS has granted leeway to plans and allows deductibles to increase as long as actuarial value standards are maintained in the small group market.

Essential Health Benefits for Individual and Small Group requires that non-grandfathered health insurance coverage offered in the individual and small group markets, both inside and outside of the health insurance exchanges, offer a standard package of coverage known as "essential health benefits." Subject to clarification by the regulations, essential health benefits are to include at least the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse services;

prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).

Health Insurance Exchanges are new transparent and competitive insurance marketplaces where individuals and small businesses can buy qualified health benefit plans beginning January 1, 2014. Insurance Exchanges, also known as Marketplaces, will offer a choice of health plans that meet certain benefit and cost standards. The Individual exchange will offer coverage in 4 categories: Bronze; Silver; Gold; and Platinum. The "metal" designations are not an indicator of the quality of the plans but an indicator of how much of the cost of medical services are paid for (on average) by plans offered in each metal tier. Below are the actuarial values[11] of the 4 metal plans offered in the Public Exchange:

Bronze – 60% Actuarial Value

Silver – 70% Actuarial Value

Gold – 80% Actuarial Value

Platinum – 90% Actuarial Value

SHOP Exchanges are **S**mall **B**usiness **H**ealth **O**ptions **P**rogram exchanges designed to give small business the opportunity to buy small group coverage in the competitive environment of an exchange. Plans offered on the SHOP exchange will mirror those offered on the individual exchange and be classified as Bronze, Silver, Gold, and Platinum with the corresponding actuarial value:

Bronze – 60% Actuarial Value

Silver – 70% Actuarial Value

Gold – 80% Actuarial Value

Platinum – 90% Actuarial Value

[11] Actuarial Value is defined as the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you could expect to be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

As of February 5, 2012