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THE AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (PPACA) was signed into law by President Obama on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name Affordable Care Act (ACA) is used to refer to the final, amended version of the law. It is sometimes also referred to as Obamacare. The act includes numerous provisions which are designed to expand coverage, control health care costs, provide free wellness care, and promote wellness.

Benefits for Women

Providing insurance options, covering preventive services, and lowering costs.

Young Adult Coverage

Coverage available to children up to age 26.

Strengthening Medicare

Yearly wellness visit and many free preventive services for some seniors with Medicare.

Holding Insurance Companies Accountable

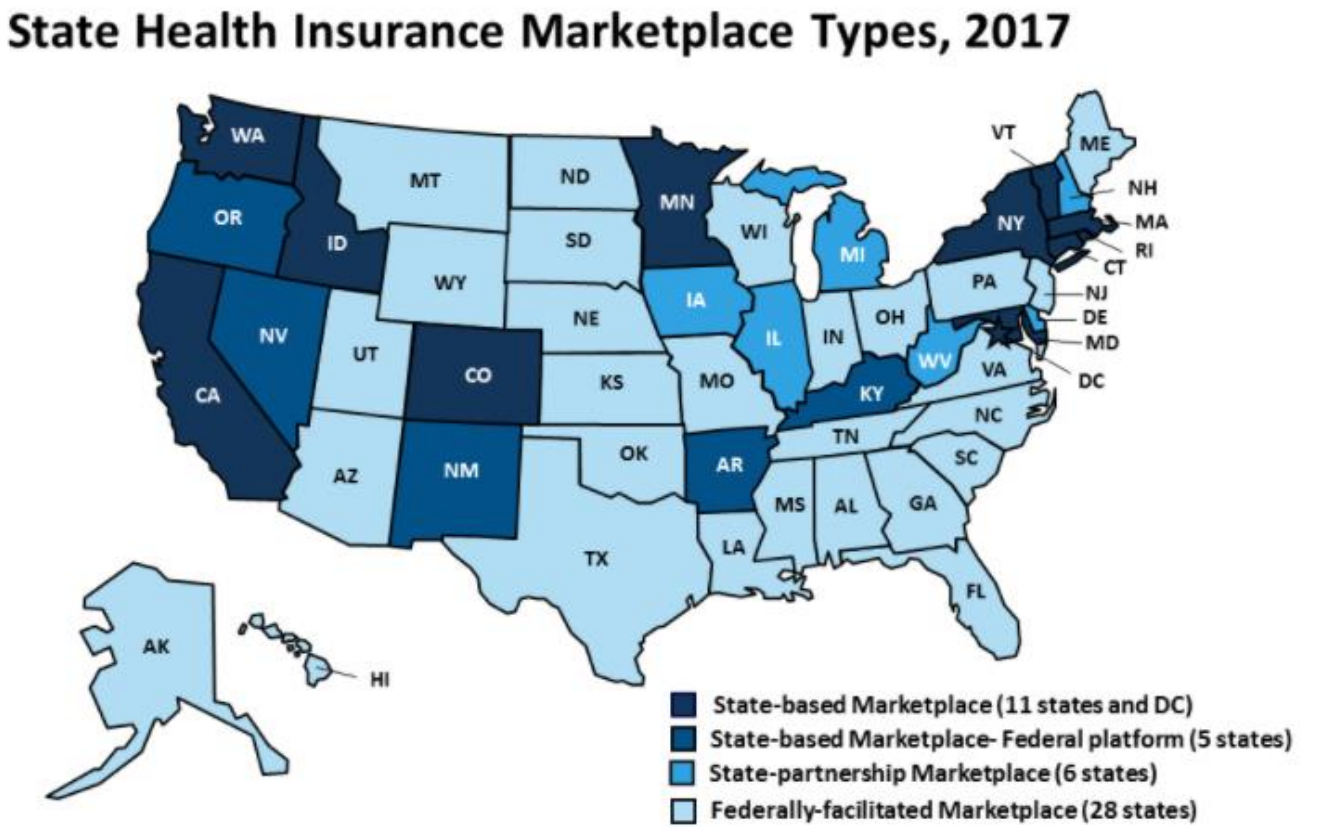
Insurers must justify any premium increase of 10% or more before the rate takes effect.

Some of the key provisions of the law and how they affect your clients will be outlined in the following pages.

To view the ACA Timeline, click the following link to our Flex website:
http://www.flexiblebenefit.com/healthcare-reform/timeline

Health Insurance Marketplace (Exchange)

Exchanges (also called "marketplaces") are online markets where consumers and small businesses can go to shop for health insurance. On their websites, they can compare the available plans and then purchase online. Some states opted to create and operate their own exchanges. If a state decided not to create its own exchange, the federal government administers or partners with the exchange in that state.



NOTES: This map displays the marketplace type for the individual market. For most states, the marketplace type is the same for the small business, or SHOP, marketplace; however, AR, MS, NM, and UT operate State-based SHOP Marketplaces.
SOURCE: *State Health Insurance Marketplace Types, 2017,* KFF State Health Facts: http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/.

There are two types of marketplaces within each state. One is the Individual Marketplace, where i ndividuals can shop for insurance. The other is for small business employers, called the Small Business Health Options Program, or SHOP. The SHOP Marketplace provides a place for eligible employers to explore health insurance plans and choose which level of coverage to offer their employees. More information regarding the SHOP Marketplace and which employers will qualify will be discussed later in this presentation.

Metallic Levels

The health plans offered through the Marketplace must meet standard requirements for affordability, cover Essential Health Benefits, and provide consumer protections. The plans are separated into four health plan categories, also known as metallic levels. These categories are based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. The categories are called Bronze, Silver, Gold, or Platinum.

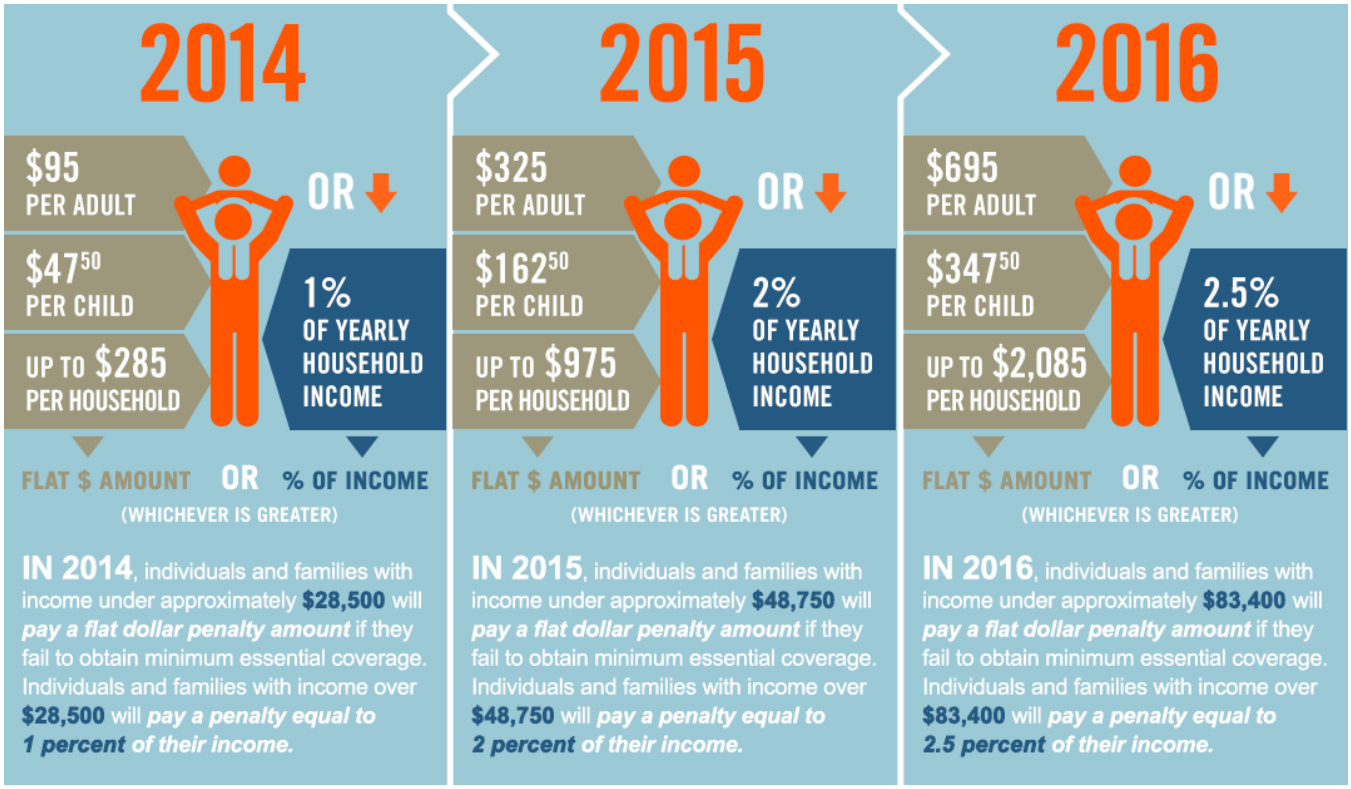
	Platinum	Gold	Silver	Bronze
Monthly Cost	$$$$	$$$	$$	$
Cost When You Get Care	$	$$	$$$	$$$$
Good Option If You...	plan to use a lot of health care services	want to save on monthly premiums while keeping your out-of-pocket costs low	need to balance your monthly premium with your out-of-pocket costs	don't plan to need a lot of health care services

Catastrophic Plans

People under the age of 30 and/or with hardship exemptions are able to buy a "catastrophic" health plan. This type of plan mainly protects the member from very high medical costs and is used for worst case scenario claims. Catastrophic plans have a lower premium than other health plans, but have higher deductibles.

Individual Mandate

The ACA includes a mandate which requires most individuals to have minimum essential health coverage or potentially pay a tax penalty if they go uninsured. This provision applies to U.S. citizens of all ages, including children.



There is a family cap on the flat dollar amount (but not percentage) of 300%, and the overall penalty is capped at the national average premium of a bronze level plan purchased through an exchange.

If a person is uninsured for just part of the year, only 1/12th of the yearly penalty applies to each month he/she was uninsured. If they are uninsured for less than 3 months, there will be no penalty.

There are exceptions to the mandate for financial hardship, religious objections, Native Americans and individuals below the tax filing threshold. For additional information visit the IRS website at http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

Subsidies

Some individuals may be eligible to receive federal subsidy assistance to help them pay for the cost of health insurance if they buy their coverage through the Health Insurance Marketplace in their state. Individuals are not

eligible for federal subsidy assistance if they're eligible for Medicaid, or if their employer provides coverage which is affordable and meets minimum value.

Quick Check Chart: Do I qualify to save on health insurance coverage?

		Number of people in your household					
		1	2	3	4	5	6
Private Marketplace health plans	You may qualify for **lower premiums on a Marketplace insurance plan** if your yearly income is between... *See next row if your income is at the lower end of this range.*	$11,490 - $45,960	$15,510 - $62,040	$19,530 - $78,120	$23,550 - $94,200	$27,570 - $110,280	$31,590 - $126,360
	You may qualify for **lower premiums AND lower out-of-pocket costs for Marketplace insurance** if your yearly income is between...	$11,490 - $28,725	$15,510 - $38,775	$19,530 - $48,825	$23,550 - $58,875	$27,570 - $68,925	$31,590 – $78,975
Medicaid coverage	If your state **is** expanding Medicaid in 2014: You may qualify for **Medicaid coverage** if your yearly income is below...	$16,105	$21,707	$27,310	$32,913	$38,516	$44,119
	If your state **isn't** expanding Medicaid: **You may not qualify for any Marketplace savings programs** if your yearly income is below...	$11,490	$15,510	$19,530	$23,550	$27,570	$31,590

The Kaiser Family Foundation website contains a calculator to determine subsidy eligibility
http://kff.org/interactive/subsidy-calculator/

Open Enrollment Period

The open enrollment period is a duration of time in which individuals who are eligible to enroll in a Qualified Health Plan can sign up for coverage in the Marketplace. **The 2018 Open Enrollment period begins November 1, 2017 and ends December 15, 2017.** Members must enroll by the 15th of the month to receive a 1st of the month effective date.

Special Enrollment Period

After the Open Enrollment Period ends, individuals cannot make changes to their plan or apply for coverage unless they experience a "Qualifying Event" which triggers a Special Enrollment Period. They have **60 days from the qualifying event date** to apply for or make changes to a policy. Qualifying events include:

INVOLUTARY LOSS OF COVERAGE – Coverage effective 1st of the month following qualifying event	
Job loss	COBRA ends
Reduction in hours	Loss of HMO due to relocation
Divorce of legal separation	Employer ceases contributions
Loss of dependent status	Incur claims that meet or exceed lifetime benefits
Death	Reasons other than non-payment or recession

GAINING DEPENDENTS – Coverage effective as of the date of event (except marriage)	
Birth	Adoption
Foster Care	Marriage (effective 1st of the month following)

PLEASE NOTE – the termination of a Short-Term policy (whether voluntarily or involuntarily) is not a qualifying event to apply for a permanent policy. Short-Term policies are also not "qualified health plans", so a client may be subject to penalties.

For additional details regarding qualifying events visit https://www.healthcare.gov/sep-list/

Model Exchange Notices

Employers must provide each employee at the time of hiring a written notice:

1. Informing the employee of the existence of the Marketplace including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance
2. If the employer's plan share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, then the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code (the Code) if the employee purchases a qualified health plan through the Marketplace
3. If the employee purchases a qualified health plan through the Marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and then all or a portion of such contribution may be excluded from income for Federal income tax purposes.

   Employers must provide a notice of coverage options to each new employee, regardless of plan enrollment status or of part-time or full-time status. Employers are not required to provide a separate notice to dependents. **The notice is to be provided within 14 days of the employee's start date.**

The Department of Labor has created two model notices that can be used:

Model notice if you currently offer health insurance

Model notice if you currently don't offer health insurance

Essential Health Benefits

The ACA requires that non-grandfathered health insurance plans in the individual and small group markets, both on and off of the health insurance exchanges, offer a standard package of coverage known as "essential health benefits." The categories of essential health benefits are:

- 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 *****

The following plans are not required to add Essential Health Benefits:

- Large Group (50+) fully insured
- Self-funded (ASO) plans
- Grandfathered plans

Employer Waiting Periods Limited to 90 Days

Beginning with the first plan year on or after Jan. 1, 2014, all group health plans – including grandfathered and non-grandfathered, fully insured and self-funded – must have a waiting period for new hires that does not exceed 90 calendar days.

PLEASE NOTE - For employees who are already in a waiting period when the proposed rule goes into effect on the employer's plan renewal date, the days served prior to the renewal date will count toward the 90-day waiting period.

Example: An employee who has elected coverage is hired Sept. 15, 2014 and is in a 90-day waiting period. If the individual's waiting period has exceeded 90 days upon plan renewal on Jan. 1, 2015, coverage must be made available as of that day.

Adjusted Community Rating

For ACA compliant group health plans, adjusted (or modified) community rating laws prohibit carriers from using actual or expected health status, claims experience, or gender in setting rates for premiums. Other factors such as age, geographic area, and tobacco use may be used to vary premiums, within certain limits. The ACA also contains provisions that require insurance companies to guarantee issue and renewal for individual and group plans. Click **here** to view a helpful overview from UnitedHealthcare about Adjusted Community Rating.

Pre-Existing Condition Limitations

A pre-existing condition is a physical or mental health condition, disability, or illness that is diagnosed prior to enrollment in a health plan. The ACA pre-existing condition exclusion provision prohibits health insurers from denying coverage to individuals because of a pre-existing condition. Beginning in September 2010, group health plans could not exclude enrollees (employees, spouses or dependents) under age 19 based on pre-existing conditions.

For plan years beginning on or after January 1, 2014, pre-existing condition exclusions will no longer be applied to members covered under health insurance policies and group health plans, both non-grandfathered and grandfathered. However, a special rule applies to individual health insurance coverage. The pre-existing condition exclusion prohibition only applies to non-grandfathered individual health insurance policies. The rules do not apply to grandfathered individual policies.

Coverage for Dependents to Age 26

Under ACA, young adult dependent children can remain on their parent's group or individual policy, **regardless** of the dependent's **residency, student or marital status, or if they are filed as a dependent on their parent's tax return,** until they turn age 26.

The state of Illinois passed the Young Adult Dependent Coverage Law on June 1, 2009, that also extends coverage to military veterans up to age 30.

To be eligible, a veteran must:

- Be an Illinois resident
- Have served in the active or reserve components of the U.S. Armed Forces, including the National Guard.
- Have received a release or discharge other than a dishonorable discharge
- Submit proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty."
    - This form is issued by the federal government to all veterans. For more information on how to obtain a copy of a DD2-14, the veteran can call the Illinois Department of Veterans' Affairs at 1-800-437-9824 or the U.S. Department of Veterans' Affairs at 1-800-827-1000.

Illinois Insurance Facts – Young Adult Dependent Coverage Fact Sheet

The state of Texas passed V.T.C.A. Insurance Code § 846.260 and V.T.C.A. Insurance Code § 1201.059 which makes dependent status available for an unmarried child up to age 25 for insurance purposes.

Employer Shared Responsibility

The Employer Shared Responsibility provision of the ACA, often referred to as the Employer Mandate, requires large employers (50 or more full-time employees, including full-time equivalents) to offer affordable health insurance that meets minimum value requirements. **Small employers (less than 50 full-time) are not required to offer health coverage to their employees.**

For purposes of the Employer Mandate, the ACA defines a full-time employee as someone that performs 30 or more hours of service per week. Coverage does not need to be offered to:

- Part-time employees (performing less than 30 hours of service per week)
- Seasonal employees (working 6 months or less during the year)
- Temporary or Leased employees that are common law employees of the leasing company or temporary agency
- Employees working abroad
- 1099 contractors

Starting in 2015, employers with 100 or more full-time employees and full-time equivalents will need to offer health insurance to at least 70% of full-time employees or face financial penalties. In 2016, this rule is extended to employers with 50 or more full-time employees and full-time equivalents and the percentage of full-time employees that must be offered coverage is increased to 95% to avoid penalties.*

If the employer does not offer Minimum Essential Coverage (MEC), they may be subject to a $2,000* per full-time employee per year penalty if even just one full-time employee applies through the public exchange and is found eligible for an applicable premium tax credit or cost-sharing reduction.

If the employer's coverage meets MEC but the coverage is deemed unaffordable and does not provide minimum value for some full-time employees, those employees may also obtain health insurance through a public insurance exchange and qualify for an applicable premium tax credit or cost-sharing reduction. In such case, the penalty would be $3,000* per full-time employee who qualified for the applicable premium tax credit or cost-sharing reduction. Penalties will be calculated on a monthly basis.

*It is important to note that although the penalty enforcement was delayed until 2015 and in some cases 2016, the penalty amount is based on a 2014 enforcement date. Therefore, the penalty amounts listed ($2,000 and $3,000) will be adjusted annually, starting in 2015, and these numbers only reflect an estimate, not the true cost of the penalty.

U.S. Treasury Department Fact Sheet: Employer Shared Responsibility

Full-time Equivalent (FTE) Employee Calculator https://www.healthcare.gov/fte-calculator/