# The Affordable Care Act

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**This presentation is not intended to provide or constitute legal advice.**

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# The Affordable Care Act

## (aka "the ACA" and "Obamacare")

- **The ACA was passed by Congress on March 23, 2010. The vote was 60-39 in the Senate, and 219-210 in the House. No Republicans voted in favor of the law.**
- **As of January 2015, 30 of the 60 Senators who voted for the ACA were no longer in the Senate (19 had retired or resigned, eight had lost their re-election bids, and three had died while in office).**
- **On June 28, 2012, the U.S. Supreme Court issued a 5-4 decision that held the requirement to purchase health insurance under the ACA is constitutional pursuant to Congress' power to tax the citizenry. The Court determined the shared responsibility payment is a "tax" for the purpose of Congress' power to tax its citizenry, but it's a "penalty" (*i.e.*, not a tax) for the purpose of the federal Anti-Injunction Act which prohibits the bringing of a lawsuit to challenge a tax before the tax is paid.**

# The Seven Major Parts of the ACA:

1. **The Individual Mandate**
2. **The Employer Mandate**
3. **Expansion of Medicaid and Other Public Programs**
4. **Market-Based Insurance Exchanges**
5. **Premium and Cost-Sharing Subsidies**
6. **Insurance Market Reform**
7. **Health System Reforms**

**Note: The ACA doesn't contain health care cost reform for private insurance, so there is nothing to bend the medical cost curve downward or to control skyrocketing health care costs. (*Recommended reading:* America's Bitter Pill by Steven Brill, Time Magazine journalist and author).**

# The Individual Mandate:

- **One of the most controversial and contentious parts of the ACA is the requirement that nearly every American must carry "minimum essential health insurance coverage" or pay a penalty. In June 2012, the US Supreme Court determined the penalty is a "tax" and is constitutional under federal law.**
- **The term "minimum essential coverage" is defined very broadly and vaguely, but we know it includes the following types of coverage:**
  - **An individual insurance policy**
  - **An employer-sponsored plan**
  - **A government-sponsored plan (*e.g.*, Medicare, Medicaid, CHIP, TRICARE)**
  - **A grandfathered health insurance policy or plan**
  - **Coverage through a self-insured employer plan**

  **Note: The term "minimum essential coverage" is not to be confused with the term "minimum value," which is only relevant for purposes of determining employer penalties.**
- **The individual mandate penalty for failing to carry minimum essential health insurance coverage is referred to as the "shared responsibility payment" (26 USC §5000A).**

# The Individual Mandate (cont.):

- **The penalty is assessed against every individual (and any dependent(s)) for each month the individual fails to carry minimum essential coverage. According to the proposed IRS regulation, this penalty is assessable against a taxpayer with respect to any individual for which the taxpayer may claim a personal exemption deduction for the individual for the taxable year, regardless of whether the taxpayer actually claims the individual as a dependent for the taxable year (IRS Reg-148500-12).**
- **The tax for an individual failing to carry qualifying health insurance is equal to the greater of a flat dollar amount or a percentage of household income amount (after subtracting the taxpayer's exemption(s) and standard deductions). That tax is $95 or 1% in 2014; $325 or 2% in 2015; and $695 or 2.5% in 2016 and thereafter. The dollar amount for individuals age 18 or younger is half of the dollar amount otherwise applicable (*e.g.,* $47.50 in 2014).**
- **The flat dollar shared responsibility payment for any taxpayer's family is capped at three times the annual flat dollar amount per year, regardless of the number of individuals in the taxpayer's household who actually lack minimum essential coverage during the year. It is also capped at the national average of the annual cost of a bronze level health insurance plan, for the applicable family size offered through the Exchanges.**

**In March 2014, the Obama administration delayed until 2017 the individual mandate for anyone whose plan was cancelled by their insurer. The Obama administration also created an exemption for anyone who experienced a "hardship" in obtaining health insurance (Hardship No. 14 on Form. OMB No. 0938-1190 HARDSHIP). The term "hardship" is undefined, and it is unclear what documentation (if any) is required for this exemption. It is also unclear for how long this blanket hardship exemption will be available.**

# Exemptions from the Individual Mandate Penalty:

**Certain individuals are exempt from the individual mandate penalty:**

- **Individuals who don't have access to "affordable" coverage because it costs more than 8% of their household income.**
  - **If the individual has access to employer-sponsored coverage, the 8% is based on the employee's share of self-only premiums;**
  - **For a spouse or a child who has access to employer-sponsored coverage, the 8% is based on the cost of family coverage; and**
  - **For an individual who doesn't qualify for coverage under an employer-sponsored plan, the 8% is based on the annual premium for the lowest-cost bronze plan in the state of residence (less any premium tax credit). The lowest-cost bronze plan is approximately $3,000 for single coverage, and $8,000 for family coverage. This means an individual would need to earn more than about $37,500, and a family would need to earn more than about $100,000 for the penalty to apply.**

  **Note: For the purpose of this exemption, the federal government defines "affordability" differently than it is defined in the employer mandate and the subsidy eligibility provisions. In those cases, affordability is defined as 9.5% of household income. Also, because this test for "affordability" considers the cost of family coverage (as opposed to the employer mandate test which only looks at the cost of self-only coverage), family members may be exempt from this penalty, but not qualify for premium tax credits.**
- **Individuals whose household income does not exceed the federal income tax return filing threshold (approximately $10,000 for an individual and $24,000 for a family of five);**
- **Members of certain Native American tribes;**
- **Individuals who have a gap of coverage of less than three months (only one per year);**
- **Religious conscience objectors;**
- **Members of a health care-sharing ministry;**
- **Individuals who are not citizens, nationals, or aliens lawfully present in the U.S.;**
- **Individuals who are incarcerated; and**
- **Individuals who are extended a hardship exemption by the Secretary of Health and Human Services ("HHS");**

# The Individual Mandate – Penalty for Failing to Carry Coverage (Example):

**According to IRS Bulletin 2013-39, here's how the Shared Responsibility Penalty will work in 2016 for a couple with three children, none of whom have minimum essential coverage for any month of the year:**

- **Harry and Wilma are married and file a joint return. They have three children: Allie (age 21), Beth (age 15), and Charlie (age 12). Harry and Wilma's household income is $250,000, and their applicable tax return filing threshold is $24,000. The annual national average bronze plan premium for a family of five (3 adults, 2 children under age 18) is $15,000.**
- **For each month in 2016, the applicable dollar amount of the penalty would be one-twelfth of ($695 x 3 adults) + (($695/2) x 2 children) = $2,780/month. However, because the annual flat dollar penalty is capped at three times the per person fee ($695 x 3 = $2,085), the monthly flat dollar fee is $2,085/12 = $173.75. Under the percentage of household income penalty, the excess income amount is $250,000 - $24,000 x 0.025 = $5,650. Therefore, because the 2.5% penalty is greater than the flat dollar amount, the monthly penalty amount is $5,650/12 = $470.83 (which is greater than $2,085/12 = $173.75).**
- **Since the sum of the monthly penalty amounts is $5,650 ($470.83 x 12), and the sum of the monthly national average bronze plan premiums is $15,000 ($15,000/12 x 12), the shared responsibility payment imposed on Harry and Wilma for 2016 is $5,650 (the lesser of $5,650 or $15,000)!**

# The Shared Responsibility Mandate for Employers ("Play or Pay"):

**FULL IMPLEMENTATION DELAYED UNTIL 2016**

*** In July 2013, the Obama administration unilaterally delayed the employer "play or pay" mandate across the board for one year for all affected employers. In February 2014, the Obama administration further delayed the mandate for employers with 50-99 employees until 2016, and reduced the "substantially all" percentage requirement from 95% to 70% for employers with 100 or more employees. For the time being, employers can plan on having to fully comply with the "play or pay" mandate in 2016. ***

- **The employer mandate requires employers with 50 or more full-time and full-time equivalent employees ("FTEs") to provide "affordable" health insurance with "minimum value" to "substantially all" of their employees and their children (but not spouses) or face financial penalties. These penalties are commonly referred to as "play or pay" penalties, but they are also called "shared responsibility payment" or "assessable payment" penalties. "Small employers" with less than 50 employees are completely exempt from this requirement.**
- **Full-time employees are defined as those working at least 30 hours per week or 130 hours per month.**
- **Full-time equivalent employees ("FTEs") are calculated by converting part-time employees and seasonal employees on "business days" during the *preceding* calendar year into FTEs.**

# The "Play or Pay" Mandate: What must an employer offer in order to avoid a penalty?

- **In order to avoid a penalty for failing to provide appropriate health insurance, an applicable large employer must offer coverage that: (1) is deemed "affordable;" (2) provides "minimum value;" and (3) is offered to "substantially all" full-time employees.**

  - **REQUIREMENT #1: The "affordable" health insurance test means the *employee's share* of premium for *self-only* coverage must be less than 9.5% of the employee's *household* income. Note: For the purpose of the affordability test (and subsidy eligibility), "affordability" is defined as 9.5% of the employee's household income. However, for the purpose of the individual mandate penalty exemption, "affordability" is defined as 8% of the taxpayer's household income. This creates an affordability gap between 8% and 9.5%!**

  - **REQUIREMENT #2: Basically, an employer-sponsored plan provides "minimum value" if the plan pays at least 60% of the total allowed cost.**

  - **REQUIREMENT #3: Coverage is offered to "substantially all" employees if it is offered to at least 95% of all eligible full-time employees (70% until 2016). Coverage must also be offered to dependent children under age 26, but not spouses or domestic partners.**

# The Employer Mandate – How to Count Employees:

- **What constitutes a "large employer?" An employer is an applicable large employer that is subject to the employer mandate if the employer employed at least 50 full-time employees (including full-time equivalent employees) on "business days" during the *preceding* calendar year.**
- **Full-time employees are defined as those working at least 30 hours per week or 130 hours per month. The common law standard is used, so truly leased employees (as defined in IRC §414(n)(2)) are generally not considered employees for the purpose of calculating the number of FTEs.**
- **The term "business days" is not explained, but the IRS has provided a formula to determine whether an employer is an applicable large employer while avoiding the confusion of the meaning of the term. This formula looks at the number of full-time employees (including seasonal workers) over the course of an entire month, adds the number of full-time equivalent workers in each month to the monthly totals, sums the monthly totals, and divides the sum by 12. If the total is less than 50, the employer is not an applicable large employer. If the total is 50 or more, the employer is a large employer (unless the employer is otherwise eligible to apply a special rule for seasonal workers because the employer's workforce exceeded the 50-employee threshold on 120 or fewer days during the calendar year, and seasonal workers were the only reason the threshold was exceeded).**

# The Employer Mandate – How to Count Employees (cont.):

- **Full-time equivalent employees are calculated by converting part-time employees and seasonal employees on "business days" during the *preceding* calendar year into FTEs (even though those employees don't trigger the "play or pay" penalty). Employees who work outside the U.S. are excluded.**
  - **To calculate the number of FTEs in a given month, all part-time employees who worked less than 30 hours per week (including seasonal workers) are used. This process has two steps: (1) calculate the aggregate hours of service in the month for any part-time employee (up to a maximum of 120 hours for any employee); and (2) divide the total number of hours by 120.36.**
- **Part-time and "seasonal workers" are relevant for counting employees to determine whether an employer is subject to the "play or pay" mandate, but they are excluded for penalty purposes. Additionally, the ACA distinguishes "seasonal workers" who generally work less than 120 days out of the year (*e.g.*, seasonal farm workers, holiday employees) from "seasonal employees" who generally work six months or less (*e.g.*, ski instructors). Seasonal workers aren't entitled to health insurance, but depending on the specific circumstances, seasonal employees may qualify as full-time employees.**

# The Employer Mandate – How to Count Employees (cont.):

- **For the purpose of determining an applicable large employer, the IRS's control group test is used, and all employees of all employers within a control group (as defined in §414 of the Internal Revenue Code) are combined. In other words, carving up a commonly-controlled business into separate businesses with fewer than 50 employees won't circumvent the ACA's "play-or-pay" provisions.**
- **Whereas the test to determine whether an employer qualifies as an applicable large employer is a retroactive test based on the preceding calendar year, the test to determine whether an employee is a full-time employee is on a monthly and ongoing basis during the current year.**
- **Rule for New Employers - If an employer was not in existence throughout the preceding calendar year, whether the employer is considered a large or small employer for purposes of the employer mandate is based on the average number of full-time employees the employer is reasonably expected to employ on business days during the current calendar year.**

# The Employer Mandate – Penalties:

- **The "play or pay" penalties only apply for full-time employees. Part-time employees are excluded. Although the language of the ACA would seem to require an employer to calculate an employee's full-time status on a month-to-month basis, the governing IRS regulation provides two different methods to determine a employee's full-time status for penalty purposes:**

  **(1) The monthly measurement method: The employer counts an employee's hours of service on a month-to-month basis; or**

  **(2) The "look-back measurement" method: The employer counts an employee's hours of service in a "measurement period," to determine the employee's full-time status for a subsequent period (*i.e.*, the stability period) (*see*, Treas. Reg. § 54.4980H-3(d)).**

- **In order for an employer to be assessed any type of a "play or pay" penalty, it is necessary that at least one full-time employee must enroll in a qualified health plan on an Exchange and receive a premium tax credit or a cost-sharing subsidy. Note: If one employee opens the penalty door, the penalty assessment for not offering coverage is triggered, and the employer's penalty is based on the total number of employees!**

- **There are some limited and temporary exceptions to the "play or pay" penalty (*e.g.*, newly categorized large employer, or newly categorized full-time employee(s)).**

# How much is the penalty?

- **Penalty for failing to offer coverage at all: If a large employer doesn't offer "minimum essential coverage" to "substantially all full-time employees," the employer will be assessed a penalty tax of $2,000 per full-time employee (less a 30 employee exemption (80 employees in 2015)). The term "minimum essential coverage" is very broad. It includes any coverage under an eligible employer-sponsored plan. Note: It is not the same as "minimum value" coverage.**

  **Part-time equivalent employees are relevant for counting employees for eligibility purposes, but not penalty purposes. Only employees who work 30+ hours/week are taken into account for the calculation of the penalty.**

- **Penalty for failing to offer "minimum value" or "affordable" coverage: If a large employer offers coverage, but that coverage isn't deemed to be of "minimum value" or "affordable," the employer will be assessed a penalty of $3,000 for each full-time employee who obtains insurance and who receives a subsidy through an Exchange (capped at the amount that would have been assessed if the employer had failed to offer coverage).**

**In both instances, the penalty tax is calculated and assessed monthly … and it is not tax deductible.**

# How are Employers Responding?

- **The 49ers = Some employers are capping payrolls at 49 full-time equivalent employees.**
- **The 29ers = Some employers are limiting the amount of employee hours to a maximum of 29 hours per week in order to disqualify them from entitlement to health insurance under the ACA. (Note: The Save American Workers Act H.R. 30 (2015) is an effort by Congress to restore the definition of a full-time employee to one who works 40 hours per week or more. It faces a Presidential veto.)**
- **20/20s = Some employees are forced to job share amongst two completely different employers so they can work 40 hours per week without qualifying for benefits at either job. This is particularly appealing to employers in the franchise food industry (*e.g.*, 20 hours at McDonald's and 20 hours at Wendy's).**
- **Some employers are offering bare bones (*i.e.*, non-minimum value) coverage. This offer of *minimum essential coverage* protects the employer from the more expensive $2,000 penalty that applies to all but 30 employees (all but 80 employees in the 2015 plan year), but subjects them to the more limited $3,000 penalty for failing to provide *minimum value* (but which only applies to the employees who obtain subsidized coverage through an Exchange).**
- **Some employers are carving out spouses from their plan to save premium costs, taxes and fees (*e.g.*, UPS dropped 15,000 spouses who have access to coverage through their own jobs). According to a Towers Watson survey, 12% of employers plan to exclude spouses in 2014. Obamacare requires that employers offer coverage to employees and children, but not spouses.**

# Expansion of Medicaid:

- **Medicaid Expansion: When the ACA was passed, it contained a provision that required states to expand Medicaid to people with incomes of up to 133% of the federal poverty level ("FPL") (approximately $32,500 for a family of four), or risk losing all current Medicaid funding. Note: Because of the way the 133% is calculated, it is effectively 138% of the FPL. This mandate would have extended Medicaid to 17 million more Americans, but the Supreme Court invalidated this provision because it was found to be unduly coercive due to the fact that it threatened to withdraw existing Medicaid funds. The Court allowed the Medicaid expansion provision to stand, but stripped out the punitive provision.**
- **MEDICAID EXPANSION UPDATE – According to The Advisory Board Group (1/27/15), a total of 28 states and the District of Columbia have expanded Medicaid (AZ, AR, CA, CO, CT, DC, DE, HI, IL, IN, IA, KY, MD, MA, MI, MN, NV, NH, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA and WV). Three states are considering expansion (TN, UT and WY).**

# Consumer Operated and Oriented Plans ("Co-Ops"):

- **Consumer Operated and Oriented Plans ("Co-Ops"): The ACA provided for the creation of loans to non-profit organizations to establish consumer-governed, member-run health insurance companies to offer individual and small group health insurance plans. It was the intent of the program to establish a Co-Op in every state, but the program drained its $2+ billion budget after making loans to Co-Ops in only 24 states.**

  **Arizona – Compass Cooperative Mutual Health Network**
  **Idaho – Mountain Health Co-Op**
  **New Mexico – New Mexico Health Connections**
  **Nevada – Nevada Health Co-Op**
  **Montana – Montana Health Co-Op**
  **Utah – Arches Health Plan**

- **According to *Investors Business Daily* (2/11/15), there are 500,000 individuals enrolled in ACA Co-Ops.**
- **The Iowa Co-Op (CoOportunity Health) was established in 2011 with $146 million in federal ACA grants and loans. It covered nearly 120,000 people in Iowa and Nebraska until December 2014, when it became insolvent and was seized by the Iowa Insurance Commissioner. One month later, it was determined that rehabilitation was not possible and liquidation proceedings were begun.**
- **According to a *Bloomberg News* report (February 10, 2015), Obamacare's Co-Ops are "flirting with financial distress." Citing a *Standard & Poor's* report, *Bloomberg News* reported that all but one of the 23 non-profit Co-Ops had negative income; all but five had negative cash flow from operations in the first three quarters of 2014; and nine reported loss ratios (*i.e.*, medical claims / medical premium) of greater than 100%!**

# Marketplace Exchanges:

**Individual and Small Business Health Options Program Marketplace Exchanges**

- **Marketplace Exchanges: The ACA provided for the creation of government-run health insurance marketplaces called "Exchanges." The Department of Health and Human Services ("HHS") has stated the Exchanges are venues for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. HHS believes the Exchanges will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing clout as large businesses. 77 Fed. Reg. 18309 (Mar. 27, 2012).**
- **Exchanges are run by the state, the federal government, or both. Individuals and employees of employers with 100 or fewer employees can shop for and obtain qualified health insurance coverage. Exchanges don't provide coverage, rather they serve as a link between consumers and health insurance companies. Only "lawful residents" may obtain coverage through an Exchange.**
- **Coverage Options: Health insurance sold through the Exchanges is available at four levels: bronze, silver, gold, and platinum. These four "metal plans" have actuarial values of 60%, 70%, 80% and 90% respectively, and they must cover at least the ten "essential health benefits" as defined by the federal government (including dental and vision care for kids up to age 19).**
- **"Navigators" assist individuals who wish to enroll through the Exchange.**

# Marketplace Exchanges (cont.):

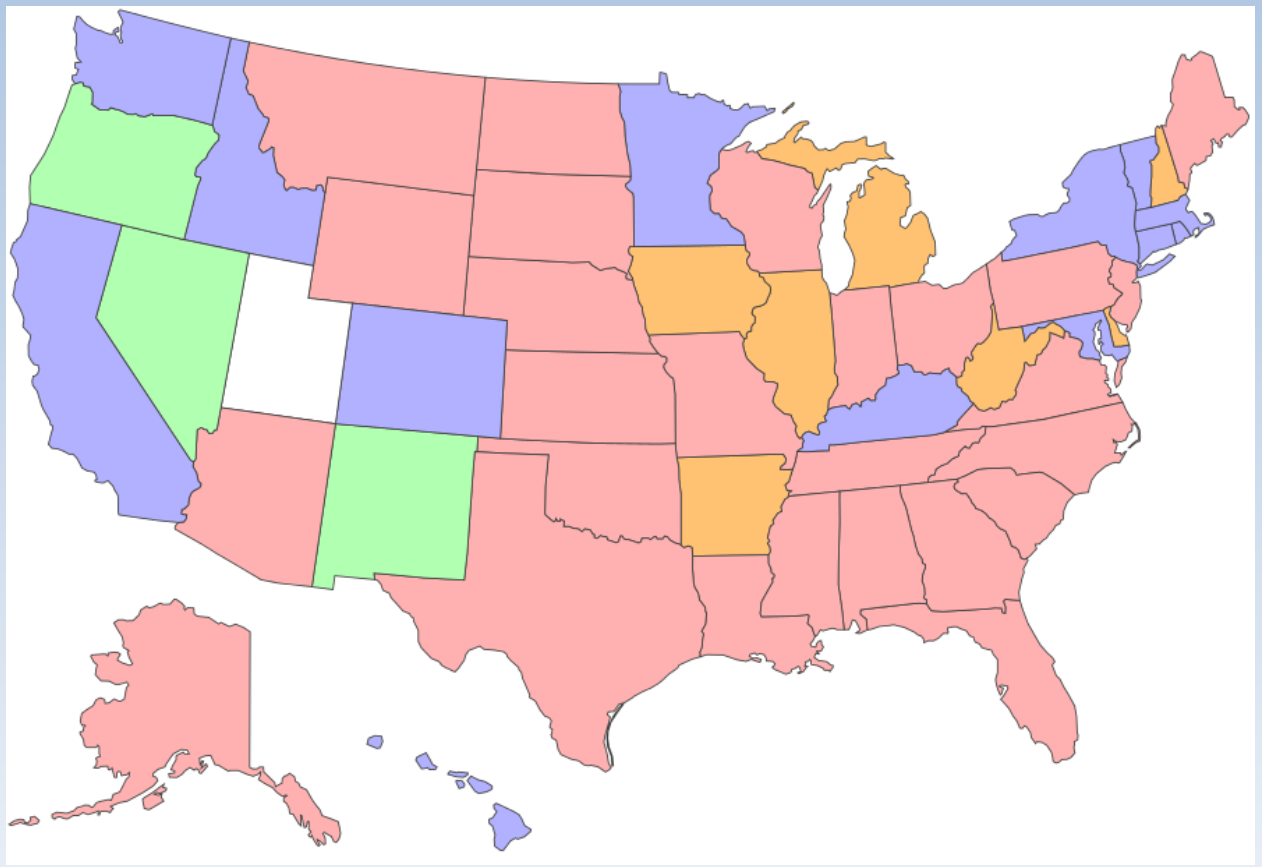
- **Individual Exchanges:**
  - **Individuals must purchase insurance through an individual Exchange in order to qualify for, and receive, a refundable premium tax credit or a cost-sharing subsidy.**
  - **Any lawful resident who resides in a state and is not incarcerated may purchase insurance through the individual Exchange (even if they aren't eligible for a subsidy).**
- **Small Business Health Options Program ("SHOP") Exchanges:**
  - **Small employer = ≤ 100 employees (Eligible)**
  - **Large employer = 101+ (Not Eligible until 2017)**
  - **Only "qualified employers" are eligible to participate in a SHOP Exchange.**
  - **Participation in a SHOP is voluntary; however, purchasing employer-provided health coverage for employees through a SHOP is the only way qualified employers can receive the small business health care tax credit.**

# Marketplace Exchanges (cont.):

- **According to HHS Secretary Sylvia Burwell, 9.9 million Americans had signed up for coverage on the Obamacare Exchanges as of February 4, 2015. This figure is significantly lower than the 13 million that was originally projected, but higher than the revised target of 9.1 million.**
- **According to the Centers for Medicare and Medicaid ("CMS"), the Assistant Secretary for Planning and Evaluation ("ASPE") Marketplace Enrollment Report shows that 87% of more than four million consumers who selected 2015 health insurance plans through Healthcare.gov in the first month of open enrollment are receiving financial assistance, as compared to 80% of enrollees over a similar period last year.**
- **According to HHS Secretary Sylvia Burwell, the ACA tax subsidies through HealthCare.gov are worth an average of $268 per person per month, which represents an average of 72% of the full cost of the insurance!**
- **According to Foxnews.com, a report from the Hawaii Commerce and Consumer Affairs Department indicates Hawaii's Obamacare exchange, Hawaii Health Connector, the most costly in the nation, shows the Connector won't be fiscally sustainable until 2022!**

# Federal Exchanges vs. State Exchanges

**(as of February 1, 2015)**



- **Red – Federally-Facilitated Marketplace (26 states)**
- **White – State-Based SHOP Marketplace and a Federally-Facilitated Individual Marketplace (1 state)**
- **Blue – State-Based Marketplace (13 states)**
- **Orange – Partnership Marketplace (7 states)**
- **Green – Federally-Supported State-Based Marketplace (3 states)**
- **Washington D.C. – State-Based Marketplace**

# Marketplace Exchanges (cont.):

## Critical Legal Issue – The King v. Burwell Case:

**In November 2014, the U.S. Supreme Court agreed to hear the case of *King v. Burwell*. That case, which originated in Virginia and was appealed out of the Fourth Circuit Court of Appeals, examines the question of whether the IRS can promulgate regulations that allow the federal government to pay subsidies to individuals who purchase health insurance through federal marketplace Exchanges through Healthcare.gov, or whether those subsidies are only available to individuals who purchase health insurance through marketplaces that are "established by the states." The Fourth Circuit ruled the federal government can offer ACA subsidies to individuals who purchase health insurance on the federal marketplace Exchange. However, on the very same day, a three-judge panel in the District of Columbia Circuit Court of Appeals reached the opposite conclusion (*see, Halbig v. Burwell*). The Supreme Court has agreed to resolve the circuit split. Oral argument is scheduled for March 4, 2015, and a decision is expected in the summer.**

- **Section 36(B)(b)(2) of the Internal Revenue Code, which was amended by 1401 of the ACA, states in pertinent part, "The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of – (A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange *established by the State* under 1311 of the Patient Protection and Affordable Care Act (*emphasis added*)."**
- **Section 1311(d) of the ACA states in pertinent part, "REQUIREMENTS – (1) IN GENERAL. – An Exchange shall be a governmental agency or nonprofit entity that is *established by a State* (*emphasis added*)."**
- **Section 1321 states, "If states fail to establish or take other steps, HHS "shall … establish and operate such Exchange within the State."**

# King v. Burwell … the case that could throw a huge monkey wrench into Obamacare

- **If the Supreme Court determines that subsidies are not available to Healthcare.gov insureds, somewhere in the neighborhood of 4-6 million Americans will lose their ACA subsidies. Since ACA subsidies would not be available in those states, the taxes and penalties on employers who fail to provide health insurance (or health insurance that is affordable), could not be triggered. This would effectively gut the ACA in the 34 states that have not established state-based marketplace Exchanges. Moreover, since federal support is no longer available to states that wish to establish their own marketplace Exchange, it is unclear whether states would be in a position to establish state-based marketplaces in time to salvage the ACA.**
- **If the Supreme Court eliminates subsidies on federal Exchanges, it may have an impact on the number of individuals who are otherwise subject to the individual mandate penalty, since the elimination of subsidies would make their health insurance more expensive (in some cases, more than 8% of their household income), and the only time the individual mandate penalty is triggered is when an individual has access to "affordable" insurance coverage (*i.e.*, coverage that costs less than 8% of household income).**
- **If the Supreme Court eliminates subsidies on federal Exchanges, it will undoubtedly result in adverse selection and a catastrophic death spiral in those states with federal Exchanges, since the sick will most assuredly retain coverage and will remain in the Exchange marketplace (even without subsidies), while the healthy will drop coverage since it's no longer as affordable. This will result in higher premium costs which will exacerbate the adverse selection and death spiral. The end game will be cataclysmic.**
- **Some states might try to quickly establish a state Exchange in order to ensure continuity of subsidies to the citizens who would otherwise lose them, but the affordability and feasibility of that effort would be problematic.**
- **Seven state legislatures have passed restrictions on further compliance with the ACA without explicit approval by the legislature. Those states are Georgia, Missouri, Montana, New Hampshire, North Carolina, Utah and Wyoming. Therefore, if the Supreme Court rules that tax credits aren't available in states with a federal Exchange, those state legislatures would have to take formal legislative action or their citizens would lose their tax credits.**

# Tax Credits and Cost-Sharing Subsidies for Individuals:

**Financial Assistance: There are three types of financial assistance available to *individuals* who purchase their health insurance through an Exchange:**

**(1) Tax credits to help pay premium;**

**(2) Cost-sharing subsidies (*e.g.*, deductibles, co-payments and co-insurance); and**

**(3) Out-of-pocket spending subsidies.**

- **The amount of the credit/subsidy depends on the individual's income in relation to the federal poverty level guidelines.**
- **Premium Assistance: In an effort to assist individuals and families who can't afford insurance or who don't have minimum essential coverage, the ACA provides for refundable and advanceable premium tax credits for low-income individuals (provided coverage is purchased through an eligible government Exchange). Beware of the true-up when taxes are filed! Generally, these "low-income individuals" are defined as taxpayers with federal adjusted gross income ("AGI") between 100% - 400% of the federal poverty line ("FPL"). Under the 2015 FPL guidelines, an individual with income of $47,080, and a family of four with household income of $97,000 would qualify for a premium tax credit.**

# Tax Credits for Individuals (cont.):

- **The IRS and HHS have issued regulations relating to premium tax credit eligibility standards. In order for an individual to receive a tax credit, the following conditions must be satisfied:**
  - **The taxpayer must have, or be expected to have, a modified adjusted gross *household* income of 100% - 400% of the Federal Poverty Level ("FPL");**
  - **The applicant must be eligible to purchase coverage on the individual Exchange; and**
  - **The applicant must not be eligible for non-individual coverage that meets the affordability and minimum value standards (*e.g.*, employer-sponsored coverage, Medicare, Medicaid). Note: Coverage under an eligible employer-sponsored plan is deemed affordable for this tax credit eligibility purpose if the employee's required contribution for self-only coverage (whether by salary reduction or otherwise) does not exceed 9.5% of the employee's household income. For the purpose of the *employer* "play or pay" mandate, affordability is also defined as 9.5% of the employee's household income. For the purpose of the *individual* mandate penalty exemption, "affordability" is defined as 8% of the taxpayer's household income.**
  - **The "family glitch" – If the employer's plan costs the employee less than 9.5% of his or her income, and if the plan *offers* coverage for the spouse and children, none of the family members can get subsidized coverage on the Exchange!**

# Federal Poverty Guidelines (2015)

**2015 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA**

| Persons in Family / Household | Poverty Level Guideline | | | | | | |
|---|---|---|---|---|---|---|---|
| | **100%** | **150%** | **200%** | **250%** | **300%** | **350%** | **400%** |
| **1** | $11,770 | $17,655 | $23,540 | $29,425 | $35,310 | $41,195 | $47,080 |
| **2** | 15,930 | $23,895 | $31,860 | $39,825 | $47,790 | $55,755 | $63,720 |
| **3** | 20,090 | $30,135 | $40,180 | $50,225 | $60,270 | $70,315 | $80,360 |
| **4** | 24,250 | $36,375 | $48,500 | $60,625 | $72,750 | $84,875 | $97,000 |
| **5** | 28,410 | $42,615 | $56,820 | $71,025 | $85,230 | $99,435 | $113,640 |
| **6** | 32,570 | $48,855 | $65,140 | $81,425 | $97,710 | $113,995 | $130,280 |
| **7** | 36,730 | $55,095 | $73,460 | $91,825 | $110,190 | $128,555 | $146,920 |
| **8** | 40,890 | $61,335 | $81,780 | $102,225 | $122,670 | $143,115 | $163,560 |

For families/households with more than 8 persons, add $4,160 for each additional person.

# Tax Credits for Individuals (cont.):

- **Tax credits are touted as making health insurance more affordable. In actuality, they do nothing to reduce the cost of the policy. They merely subsidize the cost with government funds, thus making it "more affordable" to the policy purchaser. According to a press release issued by HHS in January 2015, a whopping 87% of people who selected 2015 plans through HealthCare.gov in the first month of open enrollment are getting financial assistance to lower monthly premiums! These subsidies cover an average of 72% of the premium cost.**
- **Tax credit subsidies are calculated based on the second-lowest cost silver plan.**
- **Tax credits can be taken every month, partially every month (to minimize the likelihood of an overpayment), or not until the following year (to ensure there is not an overpayment).**

| In the case of household income (expressed as a percent of poverty line) within the following income tier: | The minimum premium percentage payable by the insured is — | The maximum premium percentage (based on a sliding linear scale) is — |
|---|---|---|
| Up to 133% | 2.00% | 2.00% |
| 133% up to 150% | 3.00% | 4.00% |
| 150% up to 200% | 4.00% | 6.30% |
| 200% up to 250% | 6.30% | 8.05% |
| 250% up to 300% | 8.05% | 9.50% |
| 300% up to 400% | 9.50% | 9.50% |

26 USC §36B (Refundable Credit for Coverage Under a Qualified Health Plan)

# Tax Credits for Individuals (cont.):

- **According to *USA Today* (2/10/15), premium tax credits reduced consumers' monthly premiums by an average of $269 (from $374 per month to $105 per month after credits). In other words, tax credits reduce an individual's annual premium from $4,488 to $1,260.**
- **The tax credits are determined monthly and are based off an estimated household income for the coming year, and must be paid back if the taxpayer's income is underestimated. Lower Income = Higher Subsidies. Problem: If an individual's income increases or if family status changes during the year and household income increases, subsidies will have to be paid back (*see*, IRS Form 8962 (Premium Tax Credit ("PTC"))).**
- **It appears any individual who is merely offered access to employer-based coverage (not just the employee) is disqualified from receiving Exchange tax credits. Therefore, an individual who was legitimately receiving subsidies (and the dependents of that individual) may be disqualified from future subsidies if:**
  - **The person changes jobs mid-year to a new job that offers minimum value coverage that is affordable;**
  - **The person marries a spouse who has qualifying coverage with his/her employer; or**
  - **An existing employer decides mid-year to offer a qualifying health insurance plan for the first time.**

# Cost-Sharing Subsidies and Out-of-Pocket Assistance (for individuals):

- **What are cost-sharing subsidies and out-of-pocket assistance subsidies *for individuals*?**
  - **Federal subsidies that operate to reduce deductibles, co-payments and out-of-pocket amounts to the insured. In essence, the qualifying individual gets a plan "buy-up" to a higher value metal plan.**
- **How much are they?**
  - **The value of these subsidies vary based on income, but at the lowest income level, the policy's out-of-pocket ("OOP") cap could be lowered by as much as $4,000.**
- **Who Is Eligible?**
  - **People who earn less than 250% of the FPL ($29,425 for an individual and $60,625 for a family of four), and who buy a silver metal plan (only) on an individual marketplace Exchange (only).**
- **How does cost-sharing assistance work?**
  - **The insured purchases a silver plan with a 70% actuarial value. Depending on the person's income level, their deductibles, co-payments, and out-of-pocket liability will be lowered through subsidies.**
  - **These subsidies will effectively increase the actuarial value of the plan.**
    - **People with incomes below 150% of the FPL ($36,375 for a family of four) will be responsible for paying 6% of covered expenses rather than the 30% that silver plans normally require. They will also have a maximum OOP of $2,250 (individual) or $4,500 (family). In essence, they will have a plan with an actuarial value of 94%, which is better than a platinum plan.**
    - **People with incomes from 150% - 200% of the FPL ($36,375 - $48,500 for a family of four) will be responsible for paying 13% of expenses. They will also have a maximum OOP of $2,250 (individual) or $4,500 (family). At 200% of the FPL, the plan will have an actuarial value of 87%.**
    - **People with incomes from 200% - 250% of the FPL ($48,500 - $60,625 for a family of four) will be responsible for paying 27% of expenses and will have a maximum OOP of $5,200 (individual) or $10,400 (family). At 250% of the FPL, the plan will have an actuarial value of 73%.**

# Cost-Sharing Subsidies and Out-of-Pocket Assistance:

## Covered California's 2014 Sliding Scale Plans – Family of 4

| Annual Income | $23,550 - $35,325 | $35,325 - $47,100 | $47,100 - $58,875 | $58,875 - $94,200 |
|---|---|---|---|---|
| **Monthly Consumer Cost** (Balance paid by Federal subsidy) | $39 - $118 | $118 - $247 | $247 - $395 | $395 - $746 |
| COPAYS IN THE GREEN SECTIONS ARE NOT SUBJECT TO ANY DEDUCTIBLE AND COUNT TOWARD THE ANNUAL OUT-OF-POCKET MAXIMUM | | | BENEFITS IN BLUE ARE SUBJECT TO EITHER A MEDICAL DEDUCTIBLE, DRUG DEDUCTIBLE OR BOTH | |
| Deductible (if Any) | No Deductible | No Deductible | $1500 Medical Deductible | $2000 Medical Deductible |
| Preventive Care Copay | No Cost – 1 Annual Visit | No Cost – 1 Annual Visit | No Cost – 1 Annual Visit | No Cost – 1 Annual Visit |
| Primary Care Visit Copay | $3 | $15 | $40 | $45 |
| Specialty Care Visit Copay | $5 | $20 | $50 | $65 |
| Urgent Care Visit Copay | $6 | $30 | $80 | $90 |
| Lab Testing Copay | $3 | $15 | $40 | $45 |
| X-Ray Copay | $5 | $20 | $60 | $65 |
| Generic Medication | $3 | $5 | $20 | $25 |
| Emergency Room Copay | $25 | $75 | $250 | $250 |
| High cost and infrequent services like Hospital Care, Outpatient Surgery, and Imaging (MRI, CT, Pet Scans) | HMO<br>Outpatient Surgery -- $250; Hospital -- $250 per day up to 5 days<br>PPO<br>10% | HMO<br>Outpatient Surgery -- $600; Hospital -- $600 per day up to 5 days<br>PPO<br>20% | 20% or Your Plan's Negotiated Rate | 20% or Your Plan's Negotiated Rate |
| Brand Medications May be subject to Annual Drug Deductible before the Copay | No Deductible on Brand Drugs | $50 Brand Drug Deductible then you pay the Copay Amount | $250 Brand Drug Deductible then you pay the Copay Amount | $250 Brand Drug Deductible then you pay the Copay Amount |
| Preferred Brand Copay After Drug Deductible | $5 | $18 | $30 | $50 |
| MAXIMUM OUT-OF-POCKET FOR ONE | $2,250 | $2,250 | $5,200 | $6,400 |
| MAXIMUM OUT-OF-POCKET FOR FAMILY | $4,500 | $4,500 | $10,400 | $12,800 |

http://www.cahba.com/assets_c/2013/02/SLIDING%20SCALE%20BENEFITS-403.htm (Accessed February 2, 2015)

# Insurance Reform:

**"IF YOU LIKE YOUR HEALTH INSURANCE PLAN, YOU CAN KEEP YOUR HEALTH INSURANCE PLAN" … OR MAYBE YOU CAN'T.**

**The ACA has caused many changes in the health insurance market and has imposed many burdens on health insurance companies. Despite President Obama's repeated promise that the ACA wouldn't affect existing coverage, that promise simply wasn't true. Virtually every plan has been, and will continue to be, changed by the ACA. It's just a matter of degree.**

- **Insurers have been forced to increase preventive care benefits, allow dependents to remain on the plan until age 26, and accept all applicants with no limitations for pre-existing conditions ("PEC"). In *theory*, the PEC prohibition is an altruistic and honorable undertaking. In *reality*, it's a disaster. Unless there is a requirement that everyone must carry health insurance (and that requirement is coupled with a meaningful penalty for failing to do so), this reform provision will inevitably result in adverse selection which will be followed by the rate death spiral. According to the National Center for Policy Analysis ("NCPA"), here is a sampling of the effects of how no-PEC regulations have affected health insurance markets in the past:**
  - **Kentucky – 40 insurers left the market and only two remained until the law was repealed.**
  - **New Hampshire – Virtually all individual health insurers fled the market. The law was repealed in 2002.**
  - **New Jersey – Premiums rose by as much as 350%.**
  - **New York – 21% of non-elderly New Yorkers became uninsured. Moreover, premiums rose to as high as $25,000 per year for a family of four; and in 2010, only 26,000 individual policies were sold statewide.**
  - **Washington – Non-managed care options disappeared from the state's individual market.**
- **Under the ACA, health insurers must pay rebates to individuals and employers if the insurance companies fail to satisfy certain minimum medical loss ratios ("MLRs") (80% for individuals and small employers, and 85% for employers with 51+ employees). This sounds great, but it jeopardizes the solvency of insurers.**

# Small Business Health Care Tax Credits:

- **The ACA provided for small business health care tax credits for eligible small employers that offer health insurance to their employees. For the purposes of this program, the test for an "eligible small employer" is unlike anything else in the ACA:**
  - **The employer cannot have more than 25 full-time equivalent employees ("FTEs") for the tax year (excluding self-employed individuals, sole proprietors, partners, independent contractors, and certain other individuals);**
  - **The employer's FTEs must have average annual wages that do not exceed an indexed dollar amount ($50,800 in 2014); and**
  - **The employer must have a contribution arrangement in effect that meets the requirements of Internal Revenue Code §45R(d)(4) (*i.e.*, non-elective contribution of at least 50% of the premium amount on behalf of each employee who enrolls in a Qualified Health Plan ("QHP") through a SHOP Exchange).**
- **The maximum credit amount increased to 50% in 2014 (35% for tax-exempt eligible small employers).**
- **The credit is phased out once an employer hits 10 FTEs or the average wages exceed $25,400. It is eliminated if the average wages exceed $58,000.**
- **In order to qualify for the tax credit, the employer must offer coverage through a Small Business Health Options Program ("SHOP Exchange").**
- **The credit can be claimed only for one two-consecutive-year credit period.**

# Changes in the Health Insurance Market:

- **An employer's waiting period can be no more than 90 (absolute) calendar days (subject to a reasonable and *bona fide* employment-based orientation period of no more than one month).**
- **No annual or lifetime limits can be applied against any insured or plan participant for essential health benefits. Applies to fully-insured and self-funded plans regardless of grandfather status.**
- **Government-prescribed health plans (*i.e.*, metal plans) must be issued for new fully-insured businesses and on renewal to small employer plans (except for grandfathered plans). These plans must include ten government-specified essential health benefits: (1) Ambulatory patient services; (2) Emergency services; (3) Hospitalization; (4) Maternity and newborn care; (5) Mental health and substance abuse; (6) Prescription drugs; (7) Rehabilitative and habilitative services; (8) Laboratory services; (9) Preventive and wellness services; and (10) Pediatric services (*e.g.,* pediatric dental care and vision services). Clinical trials must also be covered. Note: State Insurance Departments have been given authority to delay this requirement until October 2016 under the "transitional relief" guidelines published by the federal government. (*See*, CMS Bulletin: Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1, 2016 (Mar. 5, 2014), available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf (as visited Mar. 7, 2014)).**

# Changes in the health insurance market (cont.):

- **Cost-Sharing Limits:**
  - **In 2015, annual deductibles cannot exceed $2,050 for an individual and $4,100 for two-party or family coverage (*see*, 45 CFR §156). According to HHS, the DOL, and the IRS, this requirement only applies to non-grandfathered small employer plans. (An exception has been made for bronze plans so they can satisfy the required actuarial valuation target. Bronze plans are allowed to increase deductibles to the level necessary to satisfy the actuarial valuation requirements (*i.e.*, 60% (+/-2%)), but no more than the allowable out-of-pocket maximum.)**
  - **Out-of-pocket maximums cannot exceed $6,600 for individuals and $13,200 for two-party or family coverage in 2015 (grandfathered plans are exempt).**
  - **Cost-sharing limitations also apply to self-insured plans, but grandfathered (and possibly non-grandfathered large group health plans) are exempt**

  **Note: Cost sharing does not include premiums, balance billed amounts for non-network providers, or amounts paid for non-covered items and services.**
- **Modified community rating applies to small employers (2-50 employees) - All insured groups (except grandfathered plans) must be charged the same rate (with a few limited exceptions for age, tobacco use, family structure and geographic area). Medical underwriting is prohibited, and group specific underwriting is only permitted in certain limited circumstances: (1) coverage category (*e.g.*, individual versus family coverage); (2) geographical differences; (3) age (with a limited range of three times the lowest rate); and (4) tobacco use (limited to 1.5 to one). Expect the rates of healthy groups to jump significantly, while the rates for the unhealthy groups will be lowered slightly as the allowable rate band variance gets squished together.**

# Changes in the health insurance market (cont.):

- **Mechanisms to Allocate Risk – "The Three Rs": The ACA created several reforms to allocate risk in the health insurance both inside and outside the Marketplace Exchanges. These mechanisms include pooling, reinsurance, risk corridors, and risk adjustment.**

  **(1) Transitional Reinsurance Program: A temporary reinsurance program (2014–2016) to which all health insurance companies and self-funded plans are required to contribute in order to subsidize the non-grandfathered individual market (inside and outside the Exchange) as high-risk individuals move out of state-run uninsurable pools and into the open health insurance market. The fee for this program in 2014 was $63 per covered life. It was lowered to $44 in 2015, and is expected to be reduced further in the final year.**

  **(2) Risk Adjustments: A permanent reinsurance program that adjusts payments to and from insurers in the individual and small group markets to take into account the risk that each plan is bearing based on its enrolled population. Grandfathered plans are exempt from this program.**

  **(3) Risk Corridors: A temporary reinsurance program (2014–2016) that is intended to protect against inaccurate rate setting of QHPs in the Exchanges by limiting the extent of insurer losses and gains. A plan's payment is increased or decreased based on whether the plan's expenses exceed a certain percentage above or below the target. Note: The Consolidated and Further Continuing Appropriations Act of 2015 purports to make this program budget neutral by eliminating HHS's ability to pay more money out in risk corridor payments than are brought in.**

# Grandfathered, Grandmothered and Non-Grandfathered Plans:

- **A "grandfathered" health plan is a plan that was in existence on March 23, 2010 (the day the ACA was enacted), and that has not been changed (other than certain minor changes that are specifically allowed by the federal government). Grandfathered plans receive special consideration (and in many instances, great advantages) under the ACA.**
- **"Transitional" or "grandmothered" plans are plans that are technically non-grandfathered plans, but have been granted a special exemption by the Obama administration and the applicable state insurance commissioner to operate as grandfathered plans through October 2016. For the most part, grandmothered plans are treated the same as grandfathered plans (with a few additional benefits and other minor exceptions).**
- **Changes that will cause a plan to lose grandfather status:**
  - **Increasing employee premium contributions by more than 5% (but an employer can eliminate coverage for an entire class of workers without losing grandfather status)**
  - **Eliminating plan benefits**
  - **Adding or lowering plan limits**
  - **Increasing co-insurance amounts**
  - **Increasing deductible and out-of-pocket amounts by more than 15% (cumulative)**
  - **Increasing co-payment amounts by more than the greater of $5 or 15% above inflation**
- **Why is grandfather status relevant or important?**
  - **Obamacare doesn't apply equally to grandfathered and non-grandfathered health plans, and grandfathered plans are exempt from many of the ACA's most onerous requirements (*e.g.*, community rating, essential health benefits, and age rating by year).**

# Provisions that apply to both grandfathered and non-grandfathered plans:

- **Some provisions of the ACA apply to <u>both</u> grandfathered and non-grandfathered plans:**
  - **Coverage of dependent children up to age 26**
  - **Medical Loss Ratio ("MLR") rebate requirements**
  - **No Pre-Existing Condition ("PEC") exclusions for anyone (no longer just children)**
  - **No waiting periods of more than 90 absolute days**
  - **No annual or lifetime limits on any essential health benefits that are currently covered**
  - **The employer "play or pay" mandate**
  - **Automatic enrollment of new full-time employees into the employer's health care plan if the employer has 200+ employees (unclear effective date)**
  - **The "Cadillac" plan excise tax**
  - **Previously existing laws (*e.g.*, ERISA, COBRA, HIPAA, and the Mental Health Parity Act)**

# Provisions that only apply to non-grandfathered plans:

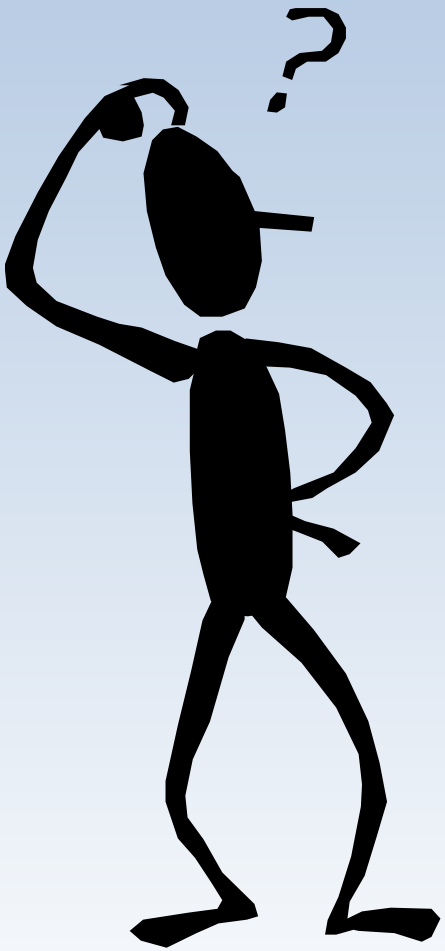
**Some provisions of the ACA only apply to non-grandfathered plans while grandfathered (and for the most part, grandmothered) plans are exempt.**

- **§2701 Fair health insurance premiums (*i.e.*, rating limitations) - All non-grandfathered individuals and small employer insured groups must be charged the same rate with a few limited exceptions for age, tobacco use, family structure, and geographic area.**
- **§2702 Guaranteed availability rules extended to large group market – Minimum participation and contribution requirements can't be enforced for guaranteed availability purposes, but they can be enforced for guaranteed renewability purposes. Large employers can purchase insurance at any point during the year; however, small employers who don't meet required participation levels can be limited to an open enrollment period (11/15 - 12/15).**
- **§2703 Guaranteed renewability – These rules already applied to both small and large employers, but the guaranteed availability rules now create a conflict. Carriers can refuse to renew a policy for failure to meet participation, but they can't refuse to issue it for the same reason. Since minimum participation and contribution requirements can still be applied to small employers on renewal, this inconsistency could cause small employers to seek a new carrier every year.**
- **§2705 Nondiscrimination based on health status - No longer can individuals who purchase their insurance in the individual health market be charged different premiums based on healthiness. Wellness and adherence discounts are still allowed.**

# Provisions that only apply to non-grandfathered plans (cont.):

- **§2706 Nondiscrimination against health care providers - Health plans can't discriminate against any health care provider acting within the scope of the provider's license. However, providers of different licensure or qualifications aren't entitled to equal reimbursement.**
- **§2707 Comprehensive health insurance coverage - Metal Plan / Essential Health Benefits Requirements.**
- **§2709 Coverage for clinical trials – An "approved clinical trial" is a phase I, phase II, phase III or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition.**
- **§2713 Coverage of preventive health services – Plans must cover first dollar coverage of preventive health services at PPO providers at 100%. Applies to self-insured and fully-insured plans (including grandmothered, but not grandfathered plans).**
  - **Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force ("USPSTF") (*e.g.*, mammograms, colonoscopies, blood pressure screenings, diabetes screenings, cholesterol screenings)**
  - **Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention**
  - **Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents**
  - **Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women**

# Provisions that only apply to non-grandfathered plans (cont.):



- §2715A Transparency in coverage - Transparency in coverage requires Qualified Health Plan ("QHP") insurers to disclose certain information .
- §2716 Nondiscrimination for insured plans – Internal Revenue Code §105(h) prevents employment-based health plans from discriminating in favor of highly compensated employees. This law already applies to self-funded plans, but the ACA extended its application to non-grandfathered fully-insured plans (although this extension of the law has been indefinitely postponed by the federal government as to fully-insured plans).
- §2717 Quality of Care Reporting - Insurers are required to report quality of care information to HHS (this provision of the law has been delayed indefinitely).
- §2719 Appeals – The ACA mandates enhanced internal claims and appeals requirements and external review procedures for self-funded health plans and health insurers.
- §2719A Patient Protections - Choice of health care professionals and coverage of non-PPO emergency services at PPO percentages.

# Health Systems Reforms:

- **Medicaid Expansion – The ACA sought to make Medicaid available to people with income up to 133% of the federal poverty level (currently about $15,650 for an individual and $32,250 for a family of four). Medicaid requires states to cover certain limited categories of people (*e.g.*, impoverished families, pregnant women, children, the blind, the elderly, and the disabled). Initially, Obamacare intended to extend Medicaid coverage to 17 million more Americans; however, because the Supreme Court reined in this mandate, states are now free to decide for themselves whether they want to expand their Medicaid programs to adults with incomes of up to 133% of the FPL. The federal government has promised to pay 100% of the cost of the "newly eligible" Medicaid enrollees through 2016, and 90% thereafter, but many state legislators are skeptical.**
- **Medicare Reform – Covered individuals no longer have to pay for annual checkups and many preventive screenings *(e.g.*, cancer, diabetes, cholesterol); the prescription drug "donut hole" is gradually being closed; the amount Medicare pays HMOs and doctors for Medicare Advantage plans is being reduced; changes designed to improve the quality of care and the exchange of information amongst providers are being implemented; and premiums for wealthier individuals with incomes of $85,000/year (single) or $170,000/year (married) are being increased.**
- **Dual Eligibles - The Affordable Care Act creates a new office within the Centers for Medicare & Medicaid Services, the Medicare-Medicaid Coordination Office, to coordinate care for individuals who are eligible for both Medicaid and Medicare.**

# Health Systems Reforms (cont.):

- **Medical Malpractice - Whether medical malpractice claims will rise or fall is uncertain. Some believe more newly insured people will result in more medical malpractice claims. Others believe more upfront free preventive care will lower the incidence of medical malpractice claims.**
- **Primary Care Provider Requirements – If a group health plan requires the use of a primary care provider, the plan must allow participants to designate any available participating primary care provider. The plan can't require preauthorization for emergency room services or obstetrical or gynecological care.**
- **Comparative Effectiveness Research ("CER") - An effort to produce more informed health care decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options. Obamacare has created a quasi-governmental entity, the Patient-Centered Outcomes Research Institute ("PCORI"), to advance the use of CER by doctors, patients, and administrators.**
- **National Quality Strategy – HHS must establish a National Strategy for Quality Improvement in Health Care. The strategy is intended to promote quality health care. It will incorporate the evidence-based results of the latest research and scientific advances in clinical medicine, public health, and health care delivery. Its goal is to provide better care, improve the health of people and communities, and reduce the cost of care.**
- **Financial Disclosure – Nonprofit hospitals must disclose more information about their finances in an effort to bring about greater transparency and accountability.**
- **Disparities - The ACA contains provisions that are aimed at reducing health care disparities (*i.e.*, differences in the quality of health and health care for specific populations based on race, geography, and disabilities). These provisions are intended to improve the quality of care, reduce costs, and increase access to care.**

# Prevention & Wellness:

- **Coverage of Preventive Care – Non-grandfathered plans (including self-funded plans) must provide first-dollar coverage for certain preventive services rendered by preferred providers (*i.e.*, without imposing any cost-sharing such as deductibles, co-payments or coinsurance).**

- **Wellness Programs – These are programs that are offered to encourage good health and healthy lifestyles. Under the ACA, they are divided into stand-alone wellness programs and health-contingent wellness programs that relate to group health plans. These rules apply to fully-insured and self-funded plans, regardless of grandfather status.**

  **(a) Stand-alone wellness programs are exempt from Obamacare**

  - **Gym memberships**
  - **Walking programs (if unrelated to health results)**
  - **Weight loss clubs**
  - **Programs where the award is unrelated to the health plan (*e.g.*, bonuses or vacation days for employees who don't smoke or who have acceptable cholesterol levels)**
  - **Stand-alone health-risk questionnaire programs that are not attached to any medical benefit**

  **(b) Health-contingent wellness programs that relate to a group health plan are subject to Obamacare. These types of programs must: (1) be reasonably designed to promote health or prevent disease; (2) offer eligible individuals the opportunity to qualify for the reward at least once a year; (3) offer any non-qualifying individual a reasonable alternative; and (4) not be overly burdensome. These types of wellness programs may be "activity-only" or "outcome-based."**

  - **Wellness programs that provide health insurance premium discounts (up to a maximum of 30% of the cost of individual coverage)**
  - **Smoking Cessation programs that provide premium discounts (up to a maximum of 50% of the cost of individual coverage)**
  - **Walking, diet, and weight loss programs that are related to a health result**

- **Nutritional Information – Restaurant chains with more than 20 locations must provide caloric and other nutritional information on standard menu items.**

# Important provisions of Obamacare that have been postponed, repealed, ignored or outright discarded:

- **"Play or Pay" Mandate – For employers with 50-99 employees, this requirement was delayed until 2016. For employers with 100+ employees, the mandate doesn't apply in 2014, will be relaxed during 2015, and will apply in 2016.**
- **The Class Act long-term care insurance plan was discarded because it wasn't financially viable.**
- **The federal high-risk pool was prematurely closed because the program ran out of money.**
- **IRC §105(h) – This provision of the Internal Revenue Code, which was supposed to go into effect in 2010, prevents employment-based health plans from discriminating in favor of highly compensated employees (*e.g.*, management-only insurance plans). It has been indefinitely postponed as to fully-insured plans (except for grandfathered plans which are exempt), but still applies to self-funded plans.**
- **The multi-employer Taft-Hartley plans run by labor unions were given an exemption from the Obamacare reinsurance fee. The revenue shortfall was shifted to fully-insured and self-funded plans.**
- **W-2 Reporting – This "informational" disclosure provision was delayed indefinitely for employers with less than 250 W-2s.**
- **The Free Choice Vouchers provision that required employers to provide insurance vouchers to certain employees so they can purchase coverage through an Exchange with the money the employer would have otherwise paid to cover the employee on the employer's plan was repealed.**
- **Automatic Enrollment – The ACA requires certain employers with 200 full-time employees to automatically enroll new full-time employees in one of the employer's health benefit plans (subject to waiting period). No clear effective date, but expected to be delayed until at least 2015.**

# Taxes and Fees under Obamacare:

- **Patient-Centered Outcomes Research Institute ("PCORI") Fee – Used to provide evidence-based research so people can make informed health care decisions. The fee started at $1 per covered life in 2013, was increased to $2 per covered life in 2014, and was bumped to $2.08 in 2015. It will be phased out after 2019.**
- **Transitional Reinsurance Program and Fee (2014 – 2016) – This temporary program provides insurance for insurers. In 2015, the fee is $44 per covered life. It is payable by all insurers and self-funded plans (except for Taft-Hartley plans sponsored by labor unions), but it only benefits insurers who offer coverage in the non-grandfathered individual market.**
- **Annual Fee on Health Insurers (aka "the HIT tax") – This permanent program is designed to generate income to fund certain components of the ACA. For 2014, health insurers must pay a fee that will generate a combined $8 billion. (Small health insurers and self-insured plans are exempt, but grandfathered plans are not.)**
- **Risk Adjustment Program and Fee – This permanent program applies to non-grandfathered individual and small employer plans (inside and outside the Exchange marketplace). The purpose of this program is to stabilize premiums in the individual and small employer markets. It will shift profit from insurers with less risk and better claims experience to insurers with more risk and worse claims experience.**
- **Risk Corridors (2014 – 2016) – This temporary program caps profits and losses for qualified health plans ("QHPs").**
- **Exchange Marketplace User Fees – To fund Exchanges, participating insurers will pay a monthly user fee of 3.5% of premium.**
- **Cadillac Excise Tax – This provision of Obamacare imposes a 40% excise tax on high cost employer-sponsored coverage. The thresholds for these high-cost plans are $10,200 for single coverage and $27,500 for family coverage. The implementation date of this tax is 2018.**

# ACA DEVELOPMENTS UNDER THE NEW REPUBLICAN CONGRESS

**HOUSE**

- **On 1/6/15, the House passed H.R. 22 (the Hire More Heroes Act of 2015) by a vote of 412 to 0. This bill encourages employers to hire veterans who already have health insurance under certain government programs by exempting those employees from the employer mandate count.**
- **On 1/8/15, the House passed H.R. 30 (the Save American Workers Act of 2015) by a vote of 252 to 172. This bill redefines a full-time employee for purposes of the law's employer responsibility requirements as someone who is employed on average at least 40 hours per week (rather than 30 hours, as under current law). This bill could face a Presidential veto.**
- **On 1/12/15, the House passed H.R. 33 (the Protecting Volunteer Firefighters and Emergency Responders Act) by a vote of 401 to 0. This bill provides that for purposes of the law's employer responsibility requirements, services rendered by a *bona fide* emergency services volunteer shall not be taken into account as services provided by an employee.**
- **On 1/22/15, the House passed H.R. 7 (the No Taxpayer Funding for Abortion Act) by a vote of 242 to 179. This bill would prohibit premium assistance, cost-sharing subsidies, and tax credits for any QHPs that provide coverage for abortion. It is likely the President would veto the bill.**

**SENATE**

- **On 1/16/15, in an effort to fully repeal the ACA health insurance tax ("the HIT tax"), 21 Republican senators introduced S. 183 (the Jobs and Premium Protection Act). This five-line bill would fully repeal the HIT tax, which is levied annually on certain health insurance companies based on each carrier's net premium. This tax was assessed at $8 billion in 2014, and it is scheduled to increase every year.**

# Glossary:

- **Advanced Premium Tax Credit - A tax credit that helps individuals afford health coverage purchased through the Marketplace Exchange. Advance payments of the tax credit can be used immediately to lower monthly premium costs, or can be claimed on the following year's income taxes. If the amount of advance credit payments is less than the tax credit due, the difference will be paid as a refundable credit when federal income taxes are filed. If the advance payments for the year are more than the amount of the credit, the taxpayer must repay the excess advance payments when the tax return is filed.**
- **Affordable Coverage - Employer coverage is considered affordable, as it relates to the "play or pay" mandate and the Advanced Premium Tax Credit, if the employee's share of the annual premium for self-only coverage is no greater than 9.5% of annual household income. Individuals offered employer-sponsored coverage that is "affordable" and provides "minimum value" aren't eligible for premium tax credits (and neither are their dependents). For the purpose of the individual mandate, coverage is considered affordable if it doesn't cost more than 8% of household income. If such coverage costs more than 8% of household income, the individual is exempt from the individual mandate. If coverage is available to a spouse or child(ren), and it costs more than 8% of household income, they are also exempt.**
- **Employer Shared Responsibility Payment – The ACA requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to their full-time employees (and their dependent children) that meets certain minimum standards set by the ACA or to make a tax payment called the Employer Shared Responsibility Payment.**

# Glossary (cont.):

- **Essential Health Benefits - A set of health care service categories that must be covered by certain plans. The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 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; and pediatric services (including oral and vision care). Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace. States expanding their Medicaid programs must provide these benefits to people newly eligible for Medicaid.**
- **Exchange – A resource where individuals, families, and small businesses can compare health insurance plans based on costs and benefits, and can select a plan and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program ("CHIP"). In some states, the Marketplace is run by the state. In other states, it is run by the federal government, or through a federal/state partnership. Exchanges are also called the Health Insurance Marketplace.**

# Glossary (cont.):

- **Grandfathered Health Plan - A group health plan that was created, or an individual health insurance policy that was purchased, on or before March 23, 2010, and has only been slightly modified as permitted by the ACA. Grandfathered plans are exempt from many requirements of the ACA. Plans or policies may lose their "grandfathered" status if they make certain changes that reduce benefits or increase costs to insured consumers.**
- **Grandmothered Health Plan – *See*, Transitional Plan.**
- **Large Group Health Plan - In general, a group health plan that covers employees of an employer that has 101 or more employees. Until 2016, states are allowed to set the threshold for large groups (for MLR reporting and rebate requirements) at 51 or more.**
- **Medical Loss Ratio ("MLR") - A basic financial measurement used in the ACA that requires health plans to use 80 cents out of every premium dollar (*i.e.*, 80%) to pay customers' medical claims and for activities that improve the quality of care. For large employer groups, the MLR threshold is 85%. A medical loss ratio of 80% allows the insurer to use the remaining 20 cents of each premium dollar to pay overhead expenses (*e.g.*, marketing, salaries, administrative costs, and independent agent commissions), and for profits. If an insurer fails to satisfy the required MLR, it must pay the difference in the form of a premium rebate to all affected insureds and/or employer groups.**

# Glossary (cont.):

- **Metal Plans – Health insurance plans that are available to small employers on or after January 1, 2014, and that comply with the terms and the conditions of the ACA. These plans are sold inside and outside the Marketplace Exchanges, and are primarily separated into four health plan categories: Bronze, Silver, Gold and Platinum. These categories are referred to as "metal plans," and they are based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum).**
- **Minimum Essential Coverage - The type of coverage an individual needs to have in order to meet the individual responsibility requirement under the ACA. This includes job-based coverage, individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.**
- **Minimum Value – An employer-sponsored plan provides "minimum value" if the plan's share of the total cost of benefits provided to the employee is at least 60%. Individuals offered employer-sponsored coverage aren't eligible for a premium tax credit unless that employer-sponsored coverage doesn't provide minimum value or it is deemed unaffordable.**
- **Qualified Health Plan – An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (*e.g.*, deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.**
- **Small Business Health Options Program ("SHOP") Exchange – A program that each Marketplace Exchange must create to assist eligible small employers in enrolling their employees in Qualified Health Plans offered in the Small Group Market. This is the only way an employer can qualify for the Small Business Health Care Tax Credit.**
- **Transitional Health Plan (aka Grandmothered Plans)– Health insurance policies that were in existence as of October 1, 2013, but had lost grandfather status. Due to executive action by the Obama administration, these plans were allowed to retain most of the characteristics of a grandfathered plan through October 2016 (or earlier in some states). Transitional health plans are only permitted in states where the state insurance commissioner has taken affirmative action to allow them.**