

AFFORDABLE CARE ACT: INSURANCE-RELATED PROVISIONS

This is a brief description of certain insurance-related provisions of the Affordable Care Act (ACA). For more details and a complete copy of the ACA, click on the following link <http://www.healthcare.gov/law/provisions/index.html>

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ANNUAL LIMITS

There are restrictions on a health plan's annual limits on the dollar value of Essential Health Benefits. Annual limits may not be less than the following amounts.

For the following plan years, your health plan may establish the following limits:

- \$750,000 on or after September 23, 2010;
- \$1,250,000 on or after September 23, 2011; and
- \$2,000,000 on or after September 23, 2012 to January 1, 2014.

These restricted annual limits apply to each covered individual on all health plans except for grandfathered individual health plans.

For plan years beginning on or after January 1, 2014, your health plan may not establish any annual dollar limits on Essential Health Benefits.

APPEALS

Your health plan must have an effective process for appeals of coverage determinations and claims. You must be given notice of available appeals processes, both internal and external, and the opportunity to review your file and present evidence as part of the appeals process.

DEPENDENT (ADULT CHILD) COVERAGE

Health plans that provide coverage for dependents are required to extend the coverage of dependents (adult children) to age 26, regardless of their eligibility for other insurance coverage. Your health plan must provide coverage to all eligible dependents, including those who are not enrolled in school, not dependents on your tax returns, and those who are married.

Grandfathered group health plans are not required to cover your adult children to the age of 26 if your child is eligible to enroll in another employer-sponsored health plan. On or after January 1, 2014, all health plans must cover your child who is under age 26 regardless of employment status.

EMPLOYER REQUIREMENTS

Employers must provide employees at the time of hiring with written notice informing them of the existence of the exchange and the availability of subsidies through the Exchange if the health plan covers less than 60% of the cost of covered benefits.

If an employer fails to offer minimum essential coverage and one of its employees receives a subsidy through the Exchange, the employer will be subject to a penalty of \$2,000 per employee.

Employers offering coverage whose employees receive a subsidy through the Exchange will be subject to a penalty of \$3,000 per employee receiving a subsidy. The penalty shall not exceed \$2,000 times the number of full-time employees.

(Employers of 50 or fewer employees are exempt from these requirements, and the first 30 employees in any size group are disregarded in calculating the penalty.)

Employers with more than 200 employees offering a health plan must automatically enroll all new employees in one of the plans and automatically continue the enrollments of current employees, unless the employee opts out.

ESSENTIAL HEALTH BENEFITS

The ACA defines certain general categories of benefits as “Essential Health Benefits”, which must be included in a qualified health plan effective January 1, 2014:

- 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.

FSA/HSA/HRA CHANGES

Beginning January 1, 2011, over-the-counter (OTC) medications are no longer eligible for reimbursement from a Flexible Spending Account (FSA), Health Savings Account (HSA), or Health Reimbursement Account (HRA) unless obtained with a prescription.

Also in 2011, the excise tax for non-qualified HSA withdrawals doubles to 20%. Beginning January 1, 2013, employee contributions to health FSAs will be limited to \$2,500 per year, with future increases to allow for inflation.

GRANDFATHERED HEALTH PLANS

A grandfathered plan is a health plan that was in existence on the March 23, 2010, ACA effective date. A grandfathered health plan is exempt from complying with some parts of the ACA, such as certain lifetime and annual benefit limits on Essential Health Benefits, Rescissions, pre-existing condition exclusions for children under 19, excessive waiting periods, and the requirement to extend dependent (adult child) coverage to age 26. As long as the health plan does not make certain changes (such as eliminating or reducing benefits, increasing cost-sharing, or reducing the employer contribution toward the premium), it maintains its grandfathered status. Once a health plan makes such a change, it becomes subject to other health reform provisions (e.g., appeals and cost sharing restrictions on preventive services). New employees may be added to group health plans that are grandfathered, and new family members may be added to all grandfathered health plans.

HEALTH BENEFIT EXCHANGES

The ACA requires each state to establish an American Health Benefit Exchange (Exchange) and a Small Business Health Options Program (SHOP) by January 1, 2014.

In 2014-2016, only individuals and small group employers are eligible to participate in the Exchange; beginning in 2017, states may permit employers in the large group market to participate. States may also form regional Exchanges.

The Exchange is a competitive marketplace for consumers shopping for health plans. Individuals and small employers can choose from a variety of health plans that are administered by issuers, which may include HMO or PPO type plans. No individual or employer is required to purchase health plans through the Exchange.

The health plans offered in an Exchange must be qualified health plans and must meet the requirements of a qualified health plan. The ACA defines four coverage levels plus a catastrophic plan:

- **Bronze Plan:** covers 60% of the actuarial value of the covered benefits. For 2011 the out of pocket limit is \$5,950 for single coverage and \$11,900 for family coverage. For 2012 the out of pocket limit is \$6,050 for single coverage and \$12,100 for family coverage.
- **Silver Plan:** covers 70% of the actuarial value of the covered benefits, with the same HSA out of pocket limits as the Bronze Plan.
- **Gold Plan:** covers 80% of the actuarial value of the covered benefits, with the same HSA out of pocket limits as the Bronze Plan.
- **Platinum Plan:** covers 90% of the actuarial value of the covered benefits, with the same HSA out of pocket limits as the Bronze Plan.
- **Catastrophic Plan:** individuals under 30 years of age or those exempt from the individual mandate because no affordable health plan is available to them or because of hardship, may purchase a catastrophic plan with the coverage level set at the HSA current law levels except that prevention benefits and 3 primary care visits would be exempt from the deductible. This plan is available only in the individual market.

The out of pocket limits for 2012 will be reduced for those with incomes up to 400% of the FPL to the following levels:

- 100-200% FPL: one-third of the HSA limits (\$2,000/individual and \$3,993/family);
- 200-300% FPL: one-half of the HSA limits (\$3,025/individual and \$6,050/family);
- 300-400% FPL: two-thirds of the HSA limits (\$5,050/individual and \$8,107/family).

These out of pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.

These Exchanges must include:

- Adjusted community rating rules with rates only varying by age, tobacco use, geography, and family status;

- Essential benefit requirements;
- Limits on individual cost sharing;
- Subsidies up to 400% of the poverty level.

In addition, the Exchanges must provide specific support services including:

- Certification of Exchange qualified health plans;
- Calculation of premium subsidies;
- Health plan rating system and rate review;
- Standardized format and definitions for plan options and coverage;
- Enrollment facilitation; and
- Website and toll-free hotline.

Exchange Premium Subsidies/Tax Credits

Premium subsidies will be available through the Exchange for individual taxpayers whose household income falls between 100% and 400% of the Federal Poverty Level (FPL). These subsidies work as follows:

- 400% of FPL for a family of four is approximately \$89,000 for calendar year 2011. As a result, a large number of Alabamians will be eligible for some level of federal subsidy.
- This subsidy will equal the difference between a percentage of household income and the second lowest cost Silver plan available through the Exchange.
- These subsidies will be paid by the Federal Government directly to the issuer and will only be available through the Exchange.

In 2014, unless exempt, all individuals must maintain minimum essential coverage or pay a tax penalty that starts out at the greater of \$95 or 1% of household income per year for each covered family member (up to 3 family household members) and eventually increases to the greater of \$695 or 2 ½% of household income per year for each covered family member (up to 3 family household members) for years 2016 and subsequent.

HEALTH INSURANCE ISSUER

Health insurance issuer (issuer) means an insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in Alabama and which is subject to Alabama law. Issuers may also be referred to as carriers, insurance companies, or insurers.

LIFETIME LIMITS

A group health plan may not establish any lifetime dollar limits on the value of Essential Health Benefits for any individual.

Your group health plan may impose lifetime limits on the dollar value of specific covered benefits that are not “Essential Health Benefits” to the extent that those limits are not otherwise prohibited under federal or state law.

MEDICAL LOSS RATIO

Health Plan Reporting Requirement

The ACA requires issuers to report health plan costs for the purpose of calculating the insurers’ medical loss ratio (MLR) (the percentage of insurance premium dollars spent on reimbursement for clinical services and activities to improve health care quality).

Large group insurers must spend at least 85% of premium dollars on claims and activities to improve health care quality. Individual and small group insurers must spend at least 80% of premium dollars on claims and activities to improve health care quality.

The calculations will be based on the aggregate experience of the issuer for each state in which the issuer is licensed. Medical cost activities that are grounded in evidenced-based medicine and improve health care quality will be included in the calculations. Activities designed primarily to control or contain costs will be considered administrative and are not included in the MLR calculation.

Adjustments will be made for:

- Prevention of market destabilization;
- Issuers with low volume in a state;
- New health plans with over 50% of premium in-state in the new health plan; and
- Mini-med and expatriate plans.

Rebate Requirement

Beginning August 2012, health plans must provide rebates to enrollees if their MLR does not meet the minimum standards for a given plan year.

MEDICARE PART D DRUG COVERAGE

Prior to 2011, most Medicare Part D enrollees were required to pay 100% of prescription drug costs once expenses exceeded \$2,830 and until they reached

\$4,550 (catastrophic coverage). This gap in coverage is often referred to as the “donut hole.”

- Beginning in 2011, Part D enrollees who reach the donut hole gap will receive a 50% manufacturer discount on the total cost of their brand-name medications.
- Beginning in 2013, in addition to the 50% discount, a portion of the cost of brand-name medications will be covered, reaching 75% in 2020.
- Beginning in 2011 through 2020, Part D will also cover a portion of the cost of generic medications in the gap, reaching 75% by 2020.
- The actual out-of-pocket amount paid to become eligible for catastrophic coverage will be reduced by the amount of current manufacturers’ discounts.

PATIENT PROTECTIONS

You can select any participating available primary care provider (PCP) as your PCP, and you can choose any participating pediatrician as you child’s PCP. You have direct access to participating obstetrics or gynecology (OB-GYN) providers.

There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are provided by an out-of-network provider. Payment for the emergency services will follow the health plan rules for network emergency coverage.

This provision applies to all non-grandfathered health plans.

PRE-EXISTING CONDITIONS

Group health plans and non-grandfathered individual health plans cannot impose pre-existing condition exclusions on enrollees or their spouses or dependents under age 19. No pre-existing condition exclusions are allowed in any health plan beginning in 2014.

A temporary pre-existing condition insurance plan is available for those eligible individuals who have been uninsured for at least 6 months and who have a pre-existing condition. For details, see <https://www.pcip.gov>.

PREVENTIVE CARE SERVICES

All non-grandfathered group and individual health plans must provide coverage for preventive care without any cost-sharing requirements.

For a list of covered preventive health services, see <http://www.healthcare.gov/law/about/provisions/services/lists.html> .

RESCISSIONS

Rescission is the retroactive cancellation or discontinuance of your coverage due to fraud or intentional misrepresentation of material fact. Rescission is permitted only for an act, practice, or omission by you that constitutes fraud, or an intentional misrepresentation of a material fact. Rescission is not permitted in the case of inadvertent misstatements of fact.

You must be given at least thirty calendar days advance written notice when coverage is to be rescinded, and the notice must include your appeal rights as required by law and as provided in your health plan benefit documents. The purpose for the advance notice is to allow you to explore other coverage options.

SMALL BUSINESS HEALTH CARE TAX CREDIT

Certain small businesses that offer health plans are now eligible for health care tax credits. These vary depending on the tax-exempt status of the organization and employer contribution toward health plans.

The Small Business Health Care Tax Credit is designed to encourage small businesses and small tax-exempt organizations to offer health plans for their employees. The credit is targeted specifically to help businesses and organizations that employ moderate-and low-income workers.

For further information, see

<http://www.irs.gov/newsroom/article/0,,id=223666,00.html>

UNIFORM COVERAGE DOCUMENTS AND DEFINITIONS

The ACA requires health insurance issuers offering group or individual health plans and plan sponsors or administrators of self-insured group health plans to use Health and Human Services (HHS) standards in benefit summaries and coverage explanations.

The benefit summaries and coverage explanations must comply with the following:

- Is presented in a uniform format.
- Is presented in a manner determined to be understandable by the average health plan enrollee.
- Includes uniform definitions of standard insurance terms as well as a description of the coverage.
- Includes the exceptions, reductions and limitations on coverage; cost-sharing provisions; renewability and continuation of coverage provisions; examples of common benefit scenarios; statement whether the plan provides minimum essential benefits; statement that the outline is a summary only.

- Includes a contact number for you to call and a web link where you may obtain a copy of the actual policy or certificate of coverage to review.

No later than March 23, 2012, plan sponsors or administrators, and health insurance issuers must provide summaries of benefits and coverage explanations that comply with the new standards to all applicants at the time of application, enrollees prior to enrollment, and policyholders at the time of policy issuance or delivery. Failure to do so may result in a fine up to \$1,000 per enrollee for each failure.

In addition, when a group health plan or health insurance issuer materially modifies the terms of the plan or coverage, notice of a material modification must be provided to enrollees at least 60 days before the modification is effective.

These documents may be delivered in either electronic or paper form.

W-2 REPORTING

Employers will be responsible for calculating and reporting to employees the total cost of their group health plan coverage on their W-2 forms under the ACA. This reporting requirement provides employees with information on the cost of their health plans. This requirement is informational only and does **not** mean that employer sponsored health plan coverage will become taxable. The issuer or the plan administrator will pay any tax due on a high cost employer sponsored plan.

Employers are not required to report the cost of health plan coverage on any W-2 forms furnished to employees prior to January 2013.

WEB PORTAL

An HHS website through which individuals and small businesses may identify affordable health insurance coverage and other ACA related information. See <http://www.healthcare.gov> .