Table of Contents

Health Insurance and the PPACA

0315

Chapter 1

Introduction

The Patient Protection and Affordable Care Act, referred to as the Accordable Care Act (ACA), was signed into law by President Barack Obama on March 23, 2010 and changed the landscape of the health care system in the United States. The original goals of the administration with respect to the ACA included health care reform benefitting Americans by providing stronger consumer rights and protections, making health insurance more affordable, providing better access to health care, and strengthening the Medicare system.

Immediately upon enactment of the ACA, the state of Florida filed a lawsuit in federal court that challenged the constitutionality of two of its major provisions: the individual mandate and the expansion of Medicaid. Twenty-five (25) other states joined Florida in the lawsuit; the National Federation of Independent Businesses (NFIB) and several other parties jointly filed a similar lawsuit—also in the state of Florida. The Supreme Court considered both cases at the same time.

The Supreme Court ruled the individual mandate was constitutional because it is an implementation of Congress' power to tax. Although the individual mandate requires Americans to purchase health insurance or pay a penalty, which is called a "shared responsibility payment," the Court confirmed that the failure to purchase health insurance is not and will not be considered an unlawful act. The Court also emphasized that the Internal Revenue Service is prohibited by the ACA from using criminal prosecution as a means to collect the penalty.

The Court also ruled that the Medicaid expansion provision of the ACA was unconstitutional and cited two specific reasons.

1. The states were not given enough time to voluntarily consent to the provision
2. The Secretary of Health and Human Services had the power to withhold existing Medicaid funds if a state chose not to adopt the Medicaid expansion

The Supreme Court ruling allows all provisions of the PPACA's individual mandate to be carried out and effectively allows the provisions of the Medicaid expansion to be optional for the states. Federal funding for Medicaid expansion benefits may be withheld in the future; however, the Secretary of Health and Human Services may not withhold any of a state's other Medicaid funding should it opt out of future Medicaid expansion.

The Supreme Court ruling allows all provisions of the ACA's individual mandate to be carried out and effectively allows the provisions of the Medicaid expansion to be optional for the states. Federal funding for Medicaid expansion benefits may be withheld in the future; however, the Secretary of Health and Human Services may not withhold any of a state's other Medicaid funding should it opt out of future Medicaid expansion. At the current time, 29 states including the District of Columbia have adopted the Medicaid expansion; 7 states are discussing whether to adopt it, and 15 states have decided not to expand their programs at this time.[1]

[1] http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/

Federal Legislation Affecting Health Care

The ACA is not the first legislation enacted by the federal government to regulate the health and medical well-being of Americans. That honor is held by the Act for the Relief of Sick and Disabled Seamen, which was enacted by President John Adams in July of 1798. The Act established the Public Health Service, which authorized marine hospitals to care for American merchant seamen. Over the years, subsequent legislation has amended the Act and the range of the Public Health Service's activities, most notably the Public Health Service Act (1944).

The Public Health Services Act has also been amended several dozen times by more recent legislation, including:

- Vaccination Assistance Act of 1962
- Communicable Disease Control Amendments of 1970
- National Cancer Act of 1971
- Omnibus Budget Reconciliation Act of 1981 (OBRA)
- Indian Health Care Amendments of 1988
- Breast and Cervical Cancer Mortality Prevention Act of 1990
- Terry Beirn Community Based AIDS Research Initiative Act of 1991
- Alzheimer's Disease Research, Training, and Education Amendments of 1992
- Mammography Quality Standards Act of 1992
- Veterans Health Care Act of 1992
- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- National Bone Marrow Registry Reauthorization Act of 1998
- Mammography Quality Standards Reauthorization Act of 1998
- Children's Health Act of 2000
- Patient Protection and Affordable Care Act of 2010
- Health Care and Education Reconciliation Act of 2010

In addition to federal legislation that amended the Public Health Service Act, other legislation has also been enacted by the federal government with respect to health care. The Health Maintenance Organization Act of 1973 organized and promoted HMOs. The Employee Retirement Income Security Act (ERISA) was enacted in 1974 and; in addition to stipulating minimum standards for private pension plans, it initiated tax laws pertaining to employee benefit plans.

The Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) require health plans with more than 50 employees to provide annual and lifetime dollar limits for mental health benefits at the same level for benefits that are provided for medical and surgical benefits. The MHPAEA extended those requirements to include substance use disorder benefits and established new requirements for group health plans and insurance coverage.

The Women's Health and Cancer Rights Act (WHCRA) was enacted in 1998 to provide protections for individuals who elect breast reconstruction in connection with a mastectomy. Under the WHCRA, if group health plans and health insurers provide coverage for mastectomies, they must also cover certain post-mastectomy benefits.

The Genetic Information Nondiscrimination Act of 2008 (GINA) is an anti- discrimination statute prohibiting employment discrimination based on genetic information. Such genetic information includes information about a disease or disorder in family members (also called family history), an individual's genetic tests or those of an individual's family member, any request for or receipt of genetic services, and participation in genetic testing or counseling by any individual or family member.

The ACA's laws are found in Internal Revenue Code, ERISA, and the Public Health Service Act.

State Legislation Affecting Health Care

It is important to remember that in addition to federal laws affecting health insurance and health care, each state has enacted specific laws that apply not only to residents of its jurisdiction but also to insurers and employers doing business within the state. The McCarran-Ferguson Act is federal legislation passed by Congress in 1945. Although it neither regulates insurance nor *requires* the individual states to regulate insurance, McCarran-Ferguson permits Congress to pass future laws that have the effect of regulating the insurance business.

Essentially, McCarran-Ferguson allows the states to regulate most aspects of the insurance industry and permits Congress to enact insurance legislation as needed--so long as it does not interfere with the states' authority. McCarran-Ferguson stipulates that the federal government will not preempt state law regulating insurance; however, cases concerning boycotting, coercion, and intimidation are still regulated by federal anti-trust laws (i.e., Sherman Act, Clayton Act, and Federal Trade Commission Act).

Although many components of health insurance are universal, others are not. For example, maternity coverage is treated differently by the states. The Pregnancy Discrimination Act of 1978 is federal legislation that applies to health insurance provided by employers with 15 or more employees. It requires maternity coverage to be provided on the same basis as coverage for other medical conditions. However, it does not address employer-sponsored health insurance for firms with fewer than 15 employees nor does it address individual health insurance. As a result, some states do not require small group or individual health plans to provide maternity coverage. The ACA mandates maternity and newborn care to be included among the essential health benefits that must be provided by all health plans.

History of Health Insurance in the United States

Although many Americans take health insurance for granted, the first health insurance policies covering illness were issued just after the turn of the century. Before the early 1900s, health insurance only provided coverage for accidents; specifically, for accidents that occurred while traveling by railroad or steamboat. The Franklin Health Assurance Company of Massachusetts was founded in 1850 and sold the first accident insurance policy in the United States.

At that time, the medical insurance available for illnesses did not actually pay for the cost of medical care; instead, it paid for the insured's inability to work and compensated for lost wages. Because Americans held hospitals and doctors in low esteem because of the poor quality of care they provided, people often preferred to stay home rather than risk further injury or illness when treated by doctors and hospitals.

Between 1900 and 1935, a number of medical advances took place:[2]

- The first successful blood transfusion was performed
- The electrocardiograph was invented
- Numerous discoveries concerning blood were made—including the ABO blood typing technique
- The endotracheal tube was invented
- Penicillin was first observed by a British bacteriologist
- The first cardiac catheterization was developed and performed (by a doctor and performed on himself!)

- The first heart-lung machine concept was conceived
- Phenobarbitone was first used for anesthesia
- The DeBakey pump was invented (an essential component of the heart-lung machine)

Regulation of the medical profession began in 1904, when the American Medical Association, through its Council on Medical Education, developed the first standards for medical licensing. Because of licensing requirements, the number of medical professionals dwindled but the quality of care was greatly enhanced. This phenomenon generated an increased demand for medical services, which, in turn, drove the costs for medical services up ... and health insurance was born.

In the late 1920s, an administrator at Baylor University Hospital in Dallas created a plan that allowed schoolteachers to obtain medical services for up to 21 days in any one year in exchange for the payment of a monthly charge. He developed the Baylor Plan as a method of resolving the hospital's concern about the frequent non-payment of medical bills by certain patients.

During the depression, other hospitals followed the example set by the Baylor Plan and pre-paid health insurance became better known. To avoid pricing competition, the American Hospital Association established Blue Cross to appoint approved health care plans, which served to be a crucial step in establishing the health insurance market.

The emergence of labor unions also helped expand the market because a great number of Americans did not have health insurance. Private health insurance companies came into being and the major life insurance companies, not wanting to bypass an opportunity, also began selling health insurance. The government then began establishing programs to assist those who were unemployed or otherwise ineligible for insurance.

In the 1940s and 1950s, employee benefit plans became popular and more comprehensive. In 1954, disability benefits became part of Social Security and President Lyndon Johnson signed the Social Security Act into law in 1965, which created Medicare and Medicaid. Advances in medical technology occurred in the 1970s and 1980s, along with issues within the health care system, greatly increasing the cost of health care. As a result, managed care plans and health maintenance organizations were developed to limit rising health care costs.

COBRA was enacted in 1986. Under many circumstances, it allows employees and their families to continue their health benefits after employment termination, death, divorce, and other events. Although President Clinton proposed an overhaul to the delivery system of U.S. health care, Congress did not approve it. During that same decade, however, mental health parity was addressed by federal legislation and the Health Insurance Portability and Accountability Act (HIPAA) was passed by Congress.

The majority of the ACA's provisions have already taken place; the remainder will continue to take place throughout 2018. Implementation of the Affordable Care Act will be discussed in the next chapter.

Health Insurance Terminology

Creditable Coverage

Before enactment of the ACA, when enrolling in a new health plan, HIPAA allowed individuals to use the existence of prior health coverage as a method to reduce the length of any pre-existing conditions exclusion period. So long as an individual did not spend more than 63 days without health insurance coverage in place, the prior health insurance was considered "creditable coverage."

For example, if the pre-existing conditions exclusion on a health plan was 12 months, and the enrolling individual was continuously insured for 10 years, the pre-existing conditions exclusion could not apply. However, if the individual was uninsured for four of the 12 months preceding enrollment, only eight of

those months were "creditable coverage"—meaning the pre-existing conditions exclusion would apply for four months. HIPAA guidelines required the plan to provide a certificate of creditable coverage when an individual's health insurance terminated.

The ACA eliminated the exclusion or limitation of coverage for pre-existing conditions. As a result, the issue of creditable coverage and the requirement for the issuance of a certificate of creditable coverage no longer applies. However, the ACA's requirement for Americans to obtain and maintain *minimum essential coverage* is based on the fundamentals of creditable coverage—which is the reason for this discussion.

It is important to keep in mind that not all types of insurance were considered creditable coverage. Insurance that was NOT creditable included:

- Accident-only coverage
- Disability income insurance
- Workers' compensation insurance
- Dental and vision benefits, if offered separately from health insurance
- Disease-specific policies

Cost-Sharing

All health insurance plans include cost-containment measures that require the insured person to share with the insurer in losses. Deductibles, co-payments, and coinsurance are forms of cost sharing.

The ACA's provisions impose restrictions pertaining to cost-sharing elements of health plans, including:

- The cost-sharing features of a plan will determine its actuarial value
- Although the ACA originally included annual deductible limits for small group health plans, the Protecting Access to Medicare Act of 2014 repealed those limits[2]
- Cost-sharing limits may not exceed limits established for health savings accounts (HSAs) and high deductible health plans (HDHPs); in 2015, those limits are:[3]
    - For HSAs and HDHPs, the annual contribution limit is $3,350 for individuals and $6,650 for families
    - For HDHPs, the annual deductible can be no less than $1,300 for individuals and $2,600 for families
    - For HDHPs, the annual out-of-pocket limits cannot exceed $6,450 for individuals and $12,900 for families—these limits include deductibles, copayments, and other amounts for essential health benefits

Deductible

Health insurance deductibles work in the same fashion as other insurance policy deductibles work: the higher the deductible, the lower the policy premium. Two types of deductibles apply to health plans: individual and family. If a plan has a deductible, it usually applies to all losses unless the contract states otherwise.

An individual deductible is the dollar amount paid by the consumer on an annual basis for each individual before the health plan pays for covered medical expenses. If the plan covers a husband, wife, and child, each of the three individuals has a separate individual deductible.

[2] http://www.ncsl.org/research/health/protecting-access-to-medicare-act-of-2014.aspx

[3] http://www.irs.gov/pub/irs-drop/rp-14-30.pdf

Example

If the plan's individual deductible is $2,000, the insured must pay the first $2,000 of covered medical expenses for each of the three individuals.

A family deductible is the dollar amount paid by the consumer on an annual basis for the sum of all insured family members before the health plan pays for covered medical expenses.

Previous example continued…

If a plan's individual deductible is $2,000 it is likely the family deductible will be $4,000. The family deductible is a type of aggregate—once the consumer pays a total of $4,000 toward the individual deductibles of all insured family members, the family deductible is deemed to have been met.

Even if one or more of the separate individual deductibles have not been met, the insured's obligation to meet deductibles has been satisfied once the family deductible has been met. At this time, the health plan will begin making payment for covered medical expenses.

The following chart illustrates how a family deductible works when the consumer's health plan contains a $2,000 individual deductible and a $4,000 family deductible:

	Husband's Covered Expenses Incurred	Wife's Covered Expenses Incurred	Child's Covered Expenses Incurred
January	$500		
February	$1,000		
March		$500	
April			$500
May	$1,000	$500	

By the time the wife has incurred her $500 of expenses in May, the family has incurred and paid for $4,000 of covered medical expenses. Although the individual deductibles for the wife and child have not been met, the family deductible *has* been met. At this point, the insurance company begins paying for covered medical expenses according to the terms of the health plan.

Coinsurance

Coinsurance is another form of cost containment. After the consumer's deductible has been met, the insurance company begins making payment for covered medical expenses. The rate of payment by the insurer is a certain percentage of covered medical expenses until a specific dollar limit has been met. When the threshold is met, the insurer begins making payment for 100 % of covered medical expenses.

The most common coinsurance percentages are 80/20, 70/30, 60/40, and 50/50. For example, if the health plan uses 80/20 coinsurance, the insurer pays 80% of covered expenses after the policyholder's deductible has been met, and the policyholder pays 20% of covered expenses until the coinsurance threshold has been met. If the coinsurance threshold is $3,000 per individual, the insurer will begin making payment for 100% of covered medical expenses once a total of $15,000 of medical expenses has been generated.

	Insurer Pays 80%	Policyholder Pays 20%
$15,000 expenses	$12,000	$3,000

As with the plan's deductible, the coinsurance percentage has a direct impact on policy premiums. The higher the coinsurance amount paid by the policyholder, the lower the policy premium.

Out-of-Pocket Limit

Of all the cost containment measures in a health plan, the out-of-pocket limit generates the most confusion. Many consumers mistakenly believe the out-of-pocket limit is the most they will pay, per

individual or per family, for all medical expenses covered by their health plans. It is especially important for agents to explain precisely how the deductible and out-of-pocket limit are both out-of-pocket expenses for the policyholder AND how the ACA changed requirements for how out-of-pocket limits are calculated for different types of health plans (i.e., grandfathered versus qualified health plans).

With enactment of the ACA, the out-of-pocket limit must include copayments, deductibles, coinsurance, and any other amount paid for a qualified medical expense for essential health benefits. Items that are not included in the out-of-pocket limit are:[4]

- Health insurance premiums
- Balance-billed amounts invoiced by non-network providers (including cost-sharing for non-network providers)
- Costs for medical expenses that are not among the ten essential health benefits

Example

If the insured has 80/20 coinsurance, an individual deductible of $2,000, and an individual out-of-pocket limit of $3,000, the policyholder is responsible for paying $5,000 of the first $17,000 of covered medical expenses:

$30,000 claim	Policyholder Pays	Insurer Pays
Deductible	$2,000	$0
Coinsurance	$3,000	$12,000
Balance	$0	$13,500
Total Paid	$5,500	$25,000

Pre-Existing Conditions

The term pre-existing condition does not have a single, specific definition because each insurer, and each state, defined the term. The universally accepted definition, in broad terms, is a medical condition for which an applicant for health insurance was either diagnosed or treated before being insured by a new health insurance plan.

The ACA does not recognize pre-existing conditions in health insurance—meaning health insurers cannot take any of the following actions pertaining to an application's pre-existing condition:

- Refuse to issue new coverage or
- Non-renew, restrict, or charge a higher premium for existing coverage

It should be noted that pre-existing condition exclusions and limitations still apply in disability and long-term care insurance.

Delivery of Health Insurance

Health insurance benefits are delivered to consumers in a variety of methods, each of which generates its own requirements, conditions, and cost. Originally, health insurance worked like other types of insurance: it calculated the risk of loss due to certain perils of the units in the exposure group (i.e., medical conditions of enrollees) and charged an appropriate premium to each unit (enrollee).

These premiums were calculated based on an insurer's prediction of losses and the costs associated with those losses. Premiums charged in future years were based on actual loss experience. For example, if actual losses for the previous year were overestimated, the following year's premiums would be reduced. On the other hand, if actual losses for the previous year were underestimated, the following year's premiums would

[4] https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

increase.

Because insurance companies realized that different segments of the population experienced fewer losses than other segments did, they began using risk rating—which charged premiums per individual based on health risk, rather than community rating—which charged the same rate for all enrollees. Risk rating became especially popular in the group health insurance market because people who were employed tended to have fewer health conditions than people who did not work.

As a result, group health insurance premiums were much less costly than premiums in the individual market, which was the primary health insurance market for those who did not, or could not, work. The same phenomenon became evident with the elderly. The establishment of Medicare was prompted because so many people over age 65 could not afford the extremely high premiums charged for health insurance and, as a result, were uninsured.

Today, a variety of health care insurance plans are available. Our brief discussion focuses on the most popular of these types of plans.

Traditional Health Insurance

Traditional health insurance, also called fee-for-service health insurance, offers the consumer the broadest level of choice with respect to treatment and care. Enrollees may choose their own doctors, hospitals, and medical providers anywhere within the coverage territory (typically the U.S.). They do not need to obtain referrals to consult with specialists, provider pre-certifications, or utilization reviews. Of course, the premium for a traditional health plan is more expensive than it is for other types of plans and enrollees must meet underwriting requirements.

Managed Care

Managed care programs of health insurance contract with health care providers and facilities to offer medical services and treatment at lower costs. The goal of managed care is twofold; it seeks to improve the quality of care while also controlling costs. Managed care plans were designed to accomplish five major objectives:

1. Manage and monitor covered services, the utilization of services, medical necessity standards, and requirements of service authorization and discharge
2. Establish networks of providers based on criteria for licensing, credentialing, and medical practices
3. Collect data and then analyze and report outcomes
4. Monitor fraud and abuse, set premium rates, and establish claims procedures
5. Provide customers with service and provide processes for appeal and grievance

The providers and facilities that contract with an insurer in a managed care plan form networks; each network establishes its own set of rules. Obviously, networks that require more restrictive rules provide services and treatment at lower costs than those with less stringent rules.

Three basic types of managed care organizations (MCOs) exist:

- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Point of Service (POS) Plan

Preferred Provider Organization (PPO) Plan

A PPO is an organization of medical providers (including physicians, hospitals, and other medical facilities) that delivers medical treatment and services to enrollees based on a fee schedule and guidelines for managed medical care. Medical providers sign contracts with the insurer and agree to provide services according to the fee schedule, which offers care at reduced rates because of the high volume of patients it will receive through the network.

PPOs allow enrollees to seek services and treatment outside the network; however, the PPO will only pay reduced benefits for treatment from out-of-network providers and/or it will apply higher deductibles and coinsurance percentages to the services and treatment of out-of-network providers. PPOs do not limit benefits for emergency treatment outside the network.

Health Maintenance Organization (HMO) Plan

An HMO is an organization of medical providers (including physicians, hospitals, and other medical facilities) employed or contracted by the insurer to provide health care to its members. Each provider is paid a specific fee per member and the fee is not based on the number or types of visits made by members. The fee is called a capitation fee and its purpose is to help control costs by making physicians financially responsible for the care and services they provide.

HMOs require an enrollee (called a member) to choose a primary care physician within its network of providers; that primary care physician (PCP) manages all medical care for the member. If a member requires treatment by a specialist or other provider, coverage is only provided if the PCP refers the patient to that provider—who is almost always employed or contracted by the HMO's network.

When members obtain medical treatment or services outside the HMO, or from providers who are not employed or contracted by the HMO, the plan does not make payment unless the care is for emergency services. Several different types of HMOs exist, including staff-model (providers are employees of the HMO), group-model (providers are multi-specialty physician groups), and network-model (more than one provider group or practice).

Point of Service (POS) Plan

A POS plan is a combination PPO/HMO. Like an HMO, the POS plan requires enrollees to choose a primary care physician to manage their health care. PCPs are the "point of service." POS plans, unlike HMOs, allow enrollees to use out-of-network treatment when specialists are needed. When seeking out-of-network treatment, enrollees must handle certain administrative duties (i.e., paperwork) themselves and, if the PCP does not issue a referral to the out-of-network specialist, benefits are provided at reduced rates or higher deductibles and coinsurance payments apply.

Differences between Fee-for-Service and Managed Care Plans

Traditional (fee-for-service) health insurance plans differ from managed care plans because they actively promote the use of health care services. Managed care plans, on the other hand, only promote the use of health care services when absolutely necessary—and only under certain conditions.

The use of traditional insurance allows medical providers to profit when people are sick and seek services and treatment. Providers do not bear the costs of treatment; enrollees do … when their premiums increase. Because the providers in a managed care plan receive a set rate of funding, they must conserve those funds by only offering the care and services needed by enrollees. Both systems of health care delivery offer the opportunity for providers and consumers to abuse them.

In *Managed Care: Handbook for the Aging Network*, the authors say:

"Some economists see availability of health insurance as a major contributor to the rapid escalation in health care costs. Financial barriers to obtaining care were removed, and the idea that someone else was paying the bill encouraged both providers and consumers to take full advantage of the growing array of technological advances becoming available. With insurance companies acting as intermediaries in the financing of health care, accountability for cost of care was removed from either doctor or patient. This shift gradually led to a climate within the health care system which encouraged, indeed actually provided incentives for, doctors and other health care providers to serve as many people as possible with as many procedures as possible. By providing services to large numbers of people and ordering tests and procedures at high rates, doctors received more fees-for-services rendered and collected sizable salaries."

Health Insurance Marketplaces (Exchanges)

One of the goals of the ACA is to offer Americans expanded access to affordable health care. The ACA created the American Health Insurance Exchanges, which are now referred to as marketplaces. These marketplaces are online forums in which individuals and small businesses may view qualified health plans and determine their eligibility for premium tax credits and public programs. The federal government operates the federally facilitated marketplace in 27 states (*http://HealthCare.gov*), a state/federal partnership marketplace operates in seven states, three states have federally-supported marketplaces, and 14 states run their own marketplaces.

Federal Marketplace		Federally-supported State-based Marketplace suppMarketplace	State-based Marketplace	Federal/State Partnership Marketplace

Consumer Driven Health Plans (CDHPs)

According to the Bureau of Labor Statistics,[5] the average cost American employers paid to provide health insurance to employees doubled between 1989 and 2009. Over time, the cost of health insurance for individuals has risen dramatically, as well. Many employers stopped providing health insurance to their employees during this time of economic hardship; others reduced the benefits provided by their plans and/or significantly increased their plans' deductibles and the level of coinsurance assumed by employees. Individuals and families who do not have access to group health insurance, or who could not afford it, often opted to be uninsured.

Consumer-driven health care allows individuals to use a three-tiered approach to funding the costs of medical services and treatment. Each of the three tiers is designed to handle a specific portion of the individual's (or family's) costs of health care. CDHPs require the individual to select and manage the plan's components.

- **Tier 1:** Pretax account, such as a health savings account (HSA), Archer medical savings account (MSA), health reimbursement account (HRA), flexible spending account, (FSA)
- **Tier 2:** The amount the individual chooses to pay, out-of-pocket, after the funds in the pretax account have been exhausted and before the health insurance plan's deductible is met
- **Tier 3:** A high deductible health plan (HDHP), which is a health insurance plan that has been designed to coordinate with pretax accounts to help consumers manage their spending for health care and insurance

[5] http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/

The first component (Tier 1) is a pretax account established according to IRS and insurer guidelines. Pretax dollars are deposited into this account for the explicit purpose of using funds to pay for eligible medical expenses. Depending upon the type of account, contributions into the account may be made by the individual and/or an employer. In some circumstances, payments made from this account may be used to satisfy the HDHP's deductible.

High deductible health plans are very similar to other health insurance plans; however, they contain restrictions pertaining to the individual and family deductibles and annual out-of-pocket limits. For example, in 2015, the minimum annual deductibles for HDHPs are $1,300 for an individual and $2,600 for a family. The maximum out-of-pocket limits in 2015 are $6,450 for an individual and $12,900 for a family.[6]

High deductible health plans also limit the contributions an individual may make to an HSA, MSA, HRA, or FSA. For example, in 2015, the contribution limits for both HSAs and HDHPs are $3,350 for an individual and $6,650 for a family. The following chart displays the relationship between these various accounts and a HDHP:[7]

Account Type	May Employee Contribute Pretax?	May Employer Contribute?	Must Account be Linked to HDHP?
HSA	Yes	Yes	Yes
MSA	Yes, if employer does not contribute	Yes	Yes
HRA	No	Yes	No
FSA	Yes	Yes	No

It is important to keep in mind that an individual cannot open a health savings account or medical savings account if he or she does not have a high deductible health plan. These pretax health care funding accounts were created expressly for the purpose of coordination with a HDHP.

If an individual does not have an HDHP, health reimbursement accounts and flexible spending accounts may be used to fund the costs of health care with pretax dollars. A brief outline of the four pretax accounts follows:

- **HSA:** Health savings accounts allow consumers and their employers to deposit pretax dollars up to limits established by the IRS. If funds remain in the account at the end of the calendar year, they may be rolled over for use in the following year without penalty. Guidelines apply with respect to the types of medical expenses for which funds can be used. If funds are used to pay for expenses other than eligible medical expenses, penalties and taxation apply. Rules apply with respect to use of the funds for retirement income and investing.
- **MSA:** Archer medical savings accounts are similar to HSAs; however, they have different contribution limits, minimum annual deductibles, and maximum out-of-pocket limits. If funds remain in the account at the end of the calendar year, they may be rolled over for use in the following year without penalty. MSAs were designed specifically for small businesses and those who are self-employed because self-employed individuals may not establish HRAs and FSAs. The funds in MSAs may only be used for eligible medical expenses.
- **HRA:** Health reimbursement accounts (or arrangements) do not allow employees to contribute; they must be funded by employers. If funds remain in the account at the end of the calendar year, they may be rolled over for use in the following year without penalty. One advantage to an HRA is that it does not require coordination with a high deductible health plan.

6 http://www.irs.gov/pub/irs-drop/rp-14-30.pdf

7 http://www.irs.gov/uac/About-Publication-969

- **FSA:** Flexible spending accounts (or arrangements) are funded through voluntary salary reduction programs established by employers. Both the employee and the employer must contribute to the account and the employee's contributions are made pretax. One big difference between an FSA and the three other types of pretax accounts is that funds do not roll over at the end of the year—if funds are not used to pay for eligible medical expenses, they are forfeited. An advantage to an FSA, like the HRA, is that it may be opened without a HDHP. In fact, the employee is not required to have any health plan in place in order to open a FSA.

Consumer driven health plans are popular because they allow consumers to make their own choices about the type of health insurance they carry and the amount of money they will spend each year for their health care and health insurance. Because consumers pay a significant portion of their health care costs when electing CDHPs, they tend to be more selective about seeking medical treatment and are less likely to abuse the health care system.

Eligible and Ineligible Medical Expenses

When consumers choose to open HSAs, MSAs, HRAs, or FSAs, they may use pretax dollars to pay for eligible medical expenses. The IRS defines "medical expenses" in its Publication 502 as:[8]

> *The costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes. Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation. Medical expenses include the premiums you pay for insurance that covers the expenses of medical care, and the amounts you pay for transportation to get medical care. Medical expenses also include amounts paid for qualified long-term care services and limited amounts paid for any qualified long-term care insurance contract.*

Examples of medical expenses that may be included in a consumer's medical expense tax deduction include, but are not limited to abortion, acupuncture, alcoholism, ambulance, birth control pills, breast reconstruction surgery, chiropractor, contact lenses, dental treatment, diagnostic services, drug addition, drugs, eye exams, guide dog or service animal, hearing aids, hospital services, insurance premiums (only for specific medical, dental, certain vision, and long-term care insurance), laboratory fees, long-term care, nursing services, optometrist, prosthesis, psychiatric care, psychoanalysis, stop-smoking programs, surgery, transplants, transportation, vasectomy, weight-loss program (if prescribed to treat a specific disease diagnosed by a physician), and x-ray.

Examples of expenses that **may not** be included in a consumer's medical expense tax deduction include, but are not limited to babysitting for a healthy baby, controlled substances (even if legalized by state law, such as medical marijuana), cosmetic surgery, diaper service, funeral expenses, hair transplant, health club dues, household help, **nonprescription or over-the-counter drugs and medicines (other than insulin and those actually prescribed by a physician)**, nutritional supplements (i.e., vitamins and herbal supplements), teeth whitening, veterinary fees (other than those permitted for guide dogs or service animals), weight-loss program (other than those that are includable). Also considered ineligible are those expenses paid under other pretax accounts. For example, a person may not collect from both an HSA and an FSA for the same expenses.

[8] http://www.irs.gov/pub/irs-pdf/p502.pdf

Chapter 1 Review Questions

1. Immediately after its enactment, a number of states sued the federal government over the constitutionality of the ACA. Which of the following portions of the ACA were subjects of the litigation?
   a. Individual mandate and employer mandate
   b. Individual mandate and Medicaid expansion
   c. Medicaid expansion and health exchanges
   d. Health exchanges and pre-existing conditions

2. What federal legislation created Medicare and Medicaid?
   a. Health Insurance Portability and Accountability Act
   b. Consolidated Omnibus Budget Reconciliation Act
   c. Social Security Act
   d. Pregnancy Discrimination Act

3. What is a cost-containment measure that requires an insured person to share a portion of the cost of ALL losses, or claims?
   a. Deductible
   b. Copayment
   c. Coinsurance
   d. Out-of-pocket limit

4. What is a medical condition for which an applicant for health insurance was either diagnosed or treated before being insured by a new health insurance plan?
   a. Illness
   b. Disease
   c. Accident
   d. Pre-existing condition

5. Which of the following is NOT a type of Managed Care Plan?
   a. Point of Service
   b. Health Maintenance Organization
   c. Preferred Provider Organization
   d. Major Medical

6. The ACA contains requirements for the establishment of state insurance marketplaces in which individuals and small businesses may view competitive private health insurance plans. What are these markets called?
   a. Insurance companies
   b. Assigned risk pools
   c. Health exchanges
   d. Federal exchanges

7. When insurance companies realized that different segments of the population experienced fewer losses than other segments, what did they begin doing with respect to the rating of health insurance?
   a. Nothing
   b. They stopped writing health insurance
   c. They stopped underwriting
   d. They began rating based on an individual person's health

8. What type of heath plan delivers treatment and services to enrollees based on a fee schedule and guidelines for managed medical care?
   a. Preferred Provider Organization (PPO)
   b. Disability plan
   c. Viatical Plan
   d. Traditional Health Plan

9. What type of health plan delivers health care solely to its members by providers who are employed or contracted by the insurer?
   a. Viatical Plan
   b. Health Maintenance Organization (HMO)
   c. Traditional Health Plan
   d. Disability Plan

10. What type of health plan is a combination PPO/HMO?
    a. Traditional
    b. Viatical
    c. Disability
    d. Point of Service

Chapter 2

Because the ACA requires most individuals to be covered by health insurance (the individual mandate), and for large employers to offer health insurance to their full-time employees (the employer mandate), it is crucial for producers to understand how these requirements of federal law work. The ACA not only overhauled the underwriting and rating of health insurance, it also made significant changes about how coverage is delivered and how benefits must be provided.

In this chapter, we will define new health insurance vocabulary introduced by the ACA and discuss the timeline for implementation of the Act's major provisions. The following resources are provided so producers can conduct further research about the ACA and how it affects them and their clients:

- Federal Healthcare Marketplace[1]
- Internal Revenue Service's ACA Tax Provisions[2]
- Centers for Medicare & Medicaid Services' (CMS) ACA[3]
- Department of Labor's ACA[4]
- Department of Health and Human Services' ACA[5]
- Kaiser Family Foundation's Health Reform[6]
- National Conference of State Legislatures' Health Reform[7]

ACA Goals

Each of the ten sections, or titles, contained in the ACA addresses a separate topic.

Title I: Quality, Affordable Health Care for All Americans

Title I allows individuals, families, and small businesses to control the delivery of their health care ... and its cost. It also provides tax credits to certain working families and small businesses. Title I caps some types of out-of-pocket expenses and mandates that preventive benefits be covered by insurance without application of deductibles, copayments, and other out-of-pocket costs. Title I does not require individuals to change their current health insurance plan but it does offer those who want to purchase new or replacement coverage with many options and a number of markets.

---

1 https://www.healthcare.gov/

2 http://www.irs.gov/Affordable-Care-Act

3 http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/index.html?redirect=/Affordable-Care-Act/

4 http://www.dol.gov/ebsa/healthreform/#.UPRZ7ifBEXc

5 http://www.hhs.gov/opa/affordable-care-act/

6 http://kff.org/health-reform/

7 http://www.ncsl.org/research/health/health-reform.aspx

Title II: The Role of Public Programs

Title II extends Medicaid and treats all states in the same manner. It also protects CHIP, the Children's Health Insurance Plan that provides free or low-cost health insurance to more than 7 million children, including U.S. citizens and eligible immigrants.

Opportunities for states to expand home care services for those with long-term care needs are provided, as are enhancements to community-based care for the disabled. The costs of prescription drugs are also reduced.

Under Title II, the states are permitted to adopt their own Medicaid expansions and coordinate their services with Medicaid and Medicare. Per the Supreme Court ruling on June 28, 2012, the states will not lose current federal funding for Medicaid.

Title III: Improving the Quality and Efficiency of Health Care

Title III protects Medicare and allows those over age 65 to reduce their costs for prescription drugs by closing the "donut hole." The donut hole is a coverage gap that exists between a Medicare beneficiary's plan limit for prescription drugs and eligibility for catastrophic coverage. The out-of-pocket spending limit for this coverage gap exceeded $4,000 at the time the ACA was enacted.

Beginning in 2011, Medicare Part D provided a 50 % discount on all brand-name drugs in the donut hole; additional discounts will also be phased in and the donut hole will be eliminated by 2020 for all Medicare Part D enrollees.

Title III also provides incentives for medical providers and facilities that improve care to seniors and provides all Medicare beneficiaries with a free annual wellness visit and personalized prevention services. Certain geographical areas in the country are underserviced and Title III enhances access to health care services in these areas.

Title IV: Prevention of Chronic Disease and Improving Public Health

Title IV is responsible for promoting wellness and disease prevention. It also includes strategies that create national prevention health promotion. Preventions and screening are a priority in this portion of the Affordable Care Act, as is giving Americans tools for finding the best science-based nutrition information available. Title IV also waives copayments for Medicare beneficiaries.

Title V: Health Care Workforce

Title V establishes loan repayment programs, scholarships, and funding for increasing the number of health care providers in the United States. It focuses on primary care physicians (PCPs), nurses, physician assistants, mental health providers, and dentists within its goal to resolve our country's critical shortage of nurses. Title V also focuses on recruitment of public health professionals and the provision of enhanced educational opportunities.

Title VI: Transparency and Program Integrity

Title VI provides patients with access to more information so they can make better decisions about choosing their health care. It also requires nursing homes to enhance training for its staff so a high quality of care may be provided on a continuous basis. High-risk providers have disclosure requirements to help prevent waste, fraud, and abuse.

Title VI also grants the states authority to regulate medical providers that have been penalized by other states. It is hoped that the provisions of Title VI will help reduce health care errors, improve patient safety, encourage efficient dispute resolution, and improve access to medical malpractice insurance.

Title VII: Improving Access to Innovative Medical Therapies

Title VII's objective is to save consumers money. It offers drug discounts to hospitals and communities that serve low-income Americans. It also promotes generic versions of biologic drugs.

Title VIII: Community Living Assistance Services and Supports Act

Title VIII calls for additional options for the funding of long-term care services after an individual becomes disabled. The Act is self-funded and is voluntary. The goal of the CLASS Act is to reduce Medicaid spending. Taxpayer funds cannot be used to pay benefits under this provision of the ACA. This program was designed to allow individuals to continue working and living in their homes instead of being admitted to nursing homes.

> **Note**: On October 14, 2011 the Secretary of Health and Human Services issued a letter to Congress stating that implementation of the CLASS Act does not appear to be possible. A report is available with more details and can be found online at *http://kff.org/health-costs/issue-brief/health-care-reform-and-the-class-act/*.

Title IX: Revenue Provisions

Title IX offers tax credits for the middle class. These tax credits will reduce the cost of health insurance so it is more affordable. Families earning less than $250,000 are expected to realize significant tax savings.

Title X: Reauthorization of the Indian Health Care Improvement Act

Title X reauthorizes the Indian Health Care Improvement Act (ICHIA), which provides health care services to nearly 2 million American Indians and Alaskan Natives. Its goal is to modernize, and improve services within, the Indian health care system.

ACA Vocabulary[8]

In addition to establishing new requirements for how health plans operate, the ACA created new types of health plans. These changes generated new terms and vocabulary with which producers must be familiar. Either the following terms were introduced by the ACA or their meanings were altered by its enactment.

Health Plans

A health plan is health insurance, or group health insurance. It does not include self-insured plans or multiple employer welfare arrangements (MEWAs) that are not subject to state law.

Individual Health Plan

An individual health plan is one sold to individuals and families who do not have job-based coverage. Individual health plans are regulated by state law.[9]

Group Health Plan

A group health plan is one offered by an employer or employee organization that provides medical care to employees and their dependents; it includes self-insured plans. Multiple employer welfare arrangements (MEWAs) may be considered group health plans in order to comply with the private health requirements of the ACA. A group plan includes a self-employed person but does not include a plan that only insures one employee.

ERISA's definition of group health plan states that it must be "established or maintained by an employer." If an employer funds a plan, that fact alone does not automatically mean the plan

[8] https://www.healthcare.gov/glossary/

[9] https://www.healthcare.gov/glossary/individual-health-insurance-policy/

qualifies as a group health plan under ERISA. For example, a group plan converted to an individual plan—even if the employer pays the premium—is *not* an ERISA plan because it is *not* established or maintained by the employer.

Qualified Health Plan

A qualified health plan (QHP) is certified by the health insurance marketplace in which it is offered. It provides essential health benefits, follows established cost-sharing limits with respect to deductibles, copayments, and out-of-pocket maximum amounts, and meets other requirements.

Metal Tier Benefit Categories

The qualified health plans (QHPs) offered through a marketplace are separated into four major categories based on what percentage of *average overall benefit costs* a plan pays for essential health benefits. This is *not* the same as coinsurance.

Bronze Plan pays for an average of 60% of the plan's covered costs.

Silver Plan pays for an average of 70% of the plan's covered costs.

Gold Plan pays for an average of 80% of the plan's covered costs.

Platinum Plan pays for an average of 90% of the plan's covered costs.

Catastrophic Health Plan

A catastrophic plan is the fifth category of health plan that meets the requirements of a qualified health plan—except with respect to benefits covered by the plan. A catastrophic plan only insures three primary care visits per year before the plan deductible is met. The premium is usually lower than the premiums for other qualified health plans but the out-of-pocket costs are higher (i.e., costs for deductibles, copayments, and coinsurance). The only individuals eligible for catastrophic health plans are those who are under age 30 OR eligible for a hardship exemption because they cannot afford health insurance offered by a marketplace.

Grandfathered Health Plan

A grandfathered health plan is one that was issued or purchased on or before the date the ACA became law (March 23, 2010) and is exempt from some of the ACA's provisions. A plan may lose its status as a grandfathered plan if it makes significant changes that reduce its benefits or increase its costs. All grandfathered health plans must disclose to insured persons their status as a grandfathered plan and how to contact the Departments of Labor or Health and Human Services with any questions.

Essential Health Benefits

In order to meet requirements of the ACA, all health plans offered in the individual and small group markets must provide a comprehensive package of health care benefits and services referred to as essential health benefits (EHBs). This applies to plans offered both in the marketplace and by private insurers. It should be noted that in states that expanded Medicaid, Medicaid programs must offer essential health benefits for individuals who are newly eligible for coverage.

Essential health benefits must include the following 10 categories of care and services:

1. Ambulatory
2. Emergency
3. Hospitalization
4. Maternity and newborn

5. Mental health and substance use disorders
6. Prescription drugs
7. Rehabilitative and habilitative
8. Laboratory
9. Preventive, wellness, and chronic disease management
10. Pediatric (including dental and vision)

Health Insurance Marketplace (Exchange)

A health insurance marketplace is a resource for use by individuals, families, and small businesses to learn about health insurance options and compare, choose, and enroll health plans. The small business marketplace is called the Small Business Health Options Program (SHOP). Marketplaces also provide information about programs that help consumers with low to moderate income pay for insurance and can be run by the state, the federal government, or a partnership between a state and the federal government. The ACA originally referred to marketplaces as the American Health Benefit Exchanges.

Minimum Essential Coverage

In order for a person to comply with the individual mandate under the ACA, he or she must be insured by a health plan that offers minimum essential coverage. Plans that offer minimum essential coverage include:[10]

- Medicare
- Medicaid
- CHIP
- TRICARE
- Any marketplace plan or existing individual insurance plan
- Any employer plan, including COBRA continuation coverage, regardless of grandfather status
- Retiree health plans
- Veterans health care programs
- Peace Corps Volunteer plans
- Self-funded health coverage offered to students by universities for plan years beginning on or before December 31, 2014

The following insurance coverage is NOT considered Minimum Essential Coverage:[11]

- Standalone vision or dental coverage
- Workers' compensation
- Coverage that only insures a specific disease or condition
- Plans that only offer discounted medical services

[10] https://www.healthcare.gov/fees-exemptions/plans-that-count-as-coverage/
[11] https://www.healthcare.gov/fees-exemptions/plans-that-count-as-coverage/

Individual Mandate

The Requirement to Maintain Minimum Essential Coverage (individual mandate) requires all Americans, unless specifically exempt under the ACA, to maintain minimum essential coverage or pay a shared responsibility payment (i.e., a tax penalty) with the filing of their federal income tax returns. This requirement applies to all members of a family.

Employer Mandate

The Employer Requirements (employer mandate) impose an employer shared responsibility payment (i.e., tax penalty) on large employers that do not offer health insurance to at least 95% of their full-time employees and the dependents of those employees. In addition, some large employers that do offer insurance to their employees may be subject to the employer shared responsibility payment if the plans they offer are not affordable or if they do not offer minimum value.

Large Employer

The ACA defines a large employer as having a certain number of full-time employees or full-time equivalent employees.

- In 2015 a large employer has 100 or more full-time or full-time equivalent employees
- In 2016 and moving onward, that number is reduced to 50

Full-time Employee

A full-time employee works an average of at least 30 hours per week.

Full-time Equivalent Employee (FTE)

A full-time equivalent employee is not a person, it is a term that quantifies the "total number of hours of service for which wages were paid by the employer to employees during the taxable year" and dividing that number by 2,080. (2,080 hours per year represents the sum of 40 hours per week for 52 weeks.) Mathematically, the hours worked by both full-time and part-time employees are used in this calculation.

Example

If an employer had 45 full-time employees who each worked 37.5 hours per week and 10 part-time employees who each worked 10 hours per week, the employer would have 44 full-time equivalent employees:

37.5 hours x 52 = 1,950 hours per year, per full-time employee

45 employees x 1,950 hours = 87,750 hours for all full-time employees

10 hours x 52 = 520 hours per year, per part-time employee

10 employees x 520 hours = 5,200 hours for all full-time employees

92,950 total hours divided by 2,080 = 44 full-time equivalent employees (rounded down)

Although the hours worked by part-time employees are included in the calculation of full-time equivalent employees, the actual part-time employees themselves are not considered when assessing any applicable employer shared responsibility payment.

Affordable Coverage

Affordability is a factor of an individual's eligibility for premium tax credits. Employer-sponsored health insurance is considered affordable if the employee's share of the premium for employee-only coverage is no more than 9.56% of the employee's annual household income.[12] An employee who is offered affordable employer-sponsored health insurance that provides minimum value is not eligible for a premium tax credit.

Minimum Value

A health plan meets minimum value requirements if it is designed to pay at least 60% of the total costs of medical services for the standard population. If an individual is offered affordable employer-sponsored coverage that meets minimum value, he or she is *not* eligible for a premium tax credit.

Premium Tax Credit (Advanced Premium Tax Credit, or APTC)

Advanced premium tax credits help individuals lower their monthly health insurance premiums right away. Individuals must meet certain eligibility requirements and the premium tax credits only apply to health insurance purchased through the marketplace. This means that health insurance purchased *outside* the marketplace cannot be issued with premium tax credits.

The individual chooses how much of the premium tax credit to apply to the monthly insurance premium, up to a maximum amount. If the amount received for the year is less than the tax credit an individual is due, the difference will be paid as a refundable credit on the individual's federal income tax return. If the amount received is more than tax credit due, the excess must be paid on the tax return.

Actuarial Value

The actuarial value of a health plan is the percentage of total average costs for covered benefits it will pay for. If a health plan had an average actuarial value of 80%, insured individuals would be responsible for paying 20% of the costs of covered benefits. Each insured person may in fact be responsible for a higher percentage of the total costs of covered services based on their individual health care needs and policy terms.

Co-op

A Co-op is a non-profit organization owned by the people who are also insured by the organization. Co-ops offer insurance through a marketplace and can include doctors, hospitals, and businesses.

Federal Poverty Level (FPL)

The federal poverty level (FPL) is a measurement of income level used to determine an individual's eligibility for certain state and federal programs and benefits. The FPL is issued by the Department of Health and Human Services (HHS) on an annual basis and can be found online.

Open Enrollment Period

An open enrollment period is the length of time during which any eligible person may enroll in a qualified health plan offered through a marketplace. Open enrollment 2015 begins on November 1st and ends on January 31st.

[12] https://www.healthcare.gov/glossary/affordable-coverage/

Special Enrollment Period

A special enrollment period is the length of time during which a person may enroll in a qualified health plan *outside* of open enrollment—but ONLY IF he or she meets special eligibility requirements pertaining to qualifying life events. In the individual marketplace, a special enrollment period lasts 60 days from the date of the qualifying life event. In the SHOP marketplace, the special enrollment period is only 30 days.

Qualifying Life Event

A qualifying life event is a life change that makes a person eligible to enroll in a health plan during a special enrollment period. Qualifying life events include changes such as moving to a new state, marriage or divorce, the birth or adoption of a child, acquiring or losing a dependent, and certain changes in income.

Summary of Benefits and Coverage (SBC)

If essential health benefits are provided by a health plan, the insurer must prepare a summary of benefits and coverage (SBC) and the employer must distribute it to all participants in a timely fashion based on federal requirements. Separate state requirements cannot apply. The purpose of the SBC is to provide a uniform summary of important plan provisions to make it easier for consumers to compare plans.

Penalties of up to $1,000 per day, per insured person, may apply for the failure to distribute an SBC as required. SBCs can be distributed electronically; however, when an SBC is issued, it must contain the precise language of the template provided by the government—CMS posts SBC templates on its website.

Medical Loss Ratios (MLRs)

The ACA requires all health plans to achieve certain medical loss ratios or refund premium dollars to their policyholders. A medical loss ratio is a financial computation that illustrates how much of the premiums an insurer charges for health insurance are used to pay for the costs of health care expenses rather than being allocated as profits or to pay administrative costs.

Medical loss ratios are not computed on each separate policy; instead, they are computed on a statewide basis by each insurer for each of the markets in which health plans are issued. For example, if a health insurer issues health plans in the individual, small group, and large group markets, the MLRs for the health plans in each of those markets will be computed separately.

If a health plan has a MLR of 82%, it is using 82 cents of every premium dollar it collects to pay claims and improve the quality of care. The remaining 18% is spent on administrative costs (i.e., salaries, expenses) and, perhaps, allocated as profit.

The ACA has established the following minimum MLR standards:[13]

- Individual market – 80%
- Small group market – 80%
- Large group market – 85%

If an insurer fails to meet medical loss ratio requirements of the ACA in any year, it will be required to refund sufficient premiums to its policyholders, on a pro-rata basis, in order to achieve those requirements. The major reasons an insurer fails to meet MLR requirements are because its premiums are too high or it is paying too few claims.

13 http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/mlrfinalrule.html

Expansion of Medicaid and CHIP

The principal partnership for health care between the federal and state governments is Medicaid. The ACA simplified Medicaid eligibility standards and enrollment and allows each of the states to expand their Medicaid programs. The expansion allows eligibility to all adults between the ages of 19 and 64 if their household modified adjusted gross income (MAGI) is at or below 138% of the FPL. This expansion offers eligibility to some adults who were not previously afforded this opportunity.

It should be noted that even if the states that did NOT expand their Medicaid programs, pregnant women and children with household MAGIs above the poverty level will still be covered. In certain circumstances, children with household MAGIs at levels several times that of the FPL may even be eligible for coverage under the Children's Health Insurance Program (CHIP).

If a person is eligible for Medicaid, he or she does not need to purchase health insurance, either privately or in a marketplace.[14] The cost of health insurance, even in a marketplace, is more expensive than the cost of Medicaid and usually does not provide more comprehensive coverage or benefits. In addition, Medicaid-eligible individuals cannot receive premium tax credits.

It should also be noted that each *individual person* is evaluated for Medicaid eligibility. For example, if a husband and wife have three sons under age 24, and each of those children files his own tax return, one or more of the children may be eligible for Medicaid while the parents and brothers may not be eligible. Oftentimes, one family member may be eligible for Medicaid due to a disability. In these circumstances, the eligible family member(s) should enroll in Medicaid and the remaining family members should purchase health insurance.

Implementation of Major ACA Provisions

Implementations between 2010 and 2013

- Expanded dependent coverage for adult children until the end of the month in which they reach age 26:
    - The ACA defines the parent/child relationship as "a relationship between a child and the participant"
    - Health plans define "child" and, if definitions are too restrictive, may pose problems
    - Children do NOT include the children of children (i.e., grandchildren)
    - According to 26 U.S.C. § 152(f)(1), the following factors do NOT affect whether a child may be covered until age 26:
        - Tax dependency status
        - Marital or tax filing status
        - Residency, age, income, or employment
- Pre-existing Conditions Insurance Plans (these have been terminated)
- Medicare's 50% discount for name-brand drugs in the donut hole
- Small business tax credits
- Medicaid expansion (optional for each state)

[14] https://www.healthcare.gov/do-i-qualify-for-medicaid/

- Expansion of coverage for early retirees
- Online health insurance information for consumers (*www.HealthCare.gov*)
- Free preventive care (i.e., mammograms, colonoscopies, etc.)
- Prohibition of insurance companies rescinding coverage
- Appeal and grievance procedures established through an external review process
- Elimination of pre-existing conditions exclusions for children under age 19
- Early withdrawal tax penalty for withdrawing ineligible funds from a health savings account (HSA) increased from 10% to 20% (in addition to the funds being taxed as ordinary income)
- Administrative simplification to standardize billing and implement rules for the secure, confidential, electronic exchange of health information
- Value-Based Purchasing (VBP) program established to provide incentives to hospitals for improving the quality of care by evaluating public reports of measures relating to heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients' perceptions of care
- State Medicaid programs will receive new funds if they choose to offer preventive services at little or no cost. Primary care physicians who provide services under Medicaid programs must be paid no less than 100% of the Medicare payment rates
- The Children's Health Insurance Program (CHIP), which is a collaboration between the federal government and each of the states, was funded for an additional two years (CHIP provides health insurance coverage for children whose families cannot afford to buy health insurance but who are not eligible for Medicaid)
- The threshold for itemized deductions for medical expenses was increased to 10%, however if the taxpayer or taxpayer's spouse is 65 or older, the 7.5% threshold may be used through 2016
- The maximum contribution into a flexible spending account was capped at $2,500 per year and is indexed by the Consumer Price Index (CPI)
- Employer subsidies for retiree prescription drug programs substantially similar to Medicare Part D were eliminated
- High wage earners (those earning wages in excess of $200,000/individual filers and $250,000/joint filers) must pay an increased Medicare tax rate of .9%
- Individuals who earn investment income (i.e., interest, dividends, annuities, capital gains, etc.), are single filers, and whose modified adjusted gross income (MAGI) is more than $200,000/individual filers and $250,000/joint filers must pay an additional Medicare tax of 3.8% (this tax is paid on the lesser of the net investment income or the MAGI above $200,000)

Implementations in 2014

Restrictions on Underwriting and Rates

Although the rate-setting process for health insurance has undergone changes with the enactment of the ACA, insurance companies are still permitted to establish their rates with the approval of the state insurance departments so long as they comply with requirements of the ACA. A health insurer that offers coverage in the individual or small group markets must offer all approved products in

the applicable market to all eligible applicants. However, insurers may limit their offer of health insurance to specific enrollment periods. In addition, *health insurers are not permitted to charge higher rates or decline to issue coverage based on pre-existing medical conditions*.

As mentioned previously, a pre-existing condition is any type of physical or mental condition for which a person sought or received medical advice, treatment, care, or diagnosis before enrollment in a health insurance plan. The ACA defines a pre-existing condition under employer-sponsored coverage as one for which medical advice, treatment, care, or diagnosis was sought or received within the six-month period before enrollment in the group plan.[15]

An exception to the pre-existing condition restriction pertains to individual health plans that are also grandfathered plans.[16] If an individual is insured by such a grandfathered plan, he or she may cancel the grandfathered plan and purchase new coverage through a marketplace.

When rating health insurance, insurers are limited to certain guidelines when establishing premium rates. Specifically, insurers may only rate health insurance using four criteria: age, tobacco use, family composition (i.e., single versus family), and geographic rating area.

When establishing rates based on age, older people may be charged higher rates than younger people are. The oldest person covered by a health plan may not be charged any more than three times the rate charged to the youngest person. This 3:1 variance assumes the youngest person is age 21 and the oldest person is age 64. States may use the federal age curve or their own age curves. The three federal age bands are:

(1) Ages 0 to 20

(2) One-year bands for people between the ages of 21 and 63

(3) People age 64 and older

When establishing rates based on tobacco use, insurers may only charge the higher rate to individuals who use tobacco. This means that if a family is enrolled in a health plan, the family members who do not use tobacco must be charged a lower rate than the family member(s) who do use tobacco. Health plans in the small group market can avoid a tobacco surcharge if they participate in a tobacco cessation program.

Insurers may not charge tobacco users a rate that is more than 50% higher than the rate charged to individuals who do not use tobacco. However, insurers may vary the premium based on age—such as tobacco users under age 35 will be charged a lower rate than tobacco users over age 35 will.

Rates based on family composition must charge separate premiums for each family member based on each person's age and tobacco use. Family members who are contained in the rating include:

- One or two parents
- Up to three family members under the age of 21 (meaning the insurer cannot charge for more than three children under age 21)
- All dependent children age 21 and older

A health plan's rating area is based on geography. In the individual market, it is based on the insured's home address; in the small group market, it is based on the employer's primary place of business.

Once health insurance coverage has been issued, it is guaranteed renewable unless one of the following exceptions applies:

[15] https://www.healthcare.gov/glossary/pre-existing-condition-job-based-coverage/
[16] https://www.healthcare.gov/how-does-the-health-care-law-protect-me/pre-existing-conditions/

- Nonpayment of premium
- The insured individual or plan sponsor commits a fraudulent act with respect to coverage or makes a material misrepresentation on the insurance application
- In a group plan participation and/or contribution requirements are not met, meaning the required number of employees do not enroll or the plan sponsor does not make the minimum premium payments as required
- An insured person moves outside the health plan's coverage area
- A health insurer withdraws the health plan from the individual and/or small group market in compliance with law and after providing at least 180 days' advance notice, or
- A health insurer withdraws all products from the individual and/or small group market in a state—in this case, the insurer may not sell health plans in that market for at least five years after the last policy is nonrenewed.

Before enactment of the ACA, health insurers were permitted to limit the amount they paid for covered benefits and services during a calendar year and the insured person's lifetime. Now, insurers cannot impose lifetime coverage limits for *essential health benefits* under any type of plan, including grandfathered plans. With respect to annual limits, restrictions apply to most types of health plans but do NOT apply to grandfathered plans. However, all health plans may impose lifetime and annual limits on services and care that are NOT essential health benefits.

Individual Mandate

Most Americans are required to purchase health insurance for themselves and their dependents or pay a tax penalty called a "shared responsibility payment." The following circumstances exempt an individual from paying the shared responsibility payment:[17]

- Being uninsured for no more than two months of the year
- The lowest priced health insurance available costs more than 8.05% of the individual's annual household income
- The filing of a federal income tax return is not required because an individual's annual income is too low
- Membership in a federally recognized Indian tribe or eligibility for services through an Indian health care provider
- Membership in a recognized health care sharing ministry
- Membership in a recognized religious sect that has religious objections to insurance, including Social Security and Medicare
- Serving time in jail or prison and not being held while awaiting the disposition of charges
- Being present in the United States unlawfully
- Being a U.S. citizen living abroad or one of a certain type of non-citizen
- Qualification for a hardship exemption[18]

[17] https://www.healthcare.gov/fees-exemptions/exemptions-from-the-fee/
[18] https://www.healthcare.gov/fees-exemptions/hardship-exemptions/

Penalties are not imposed until an individual has been without health insurance for 90 days. When assessed, the shared responsibility payment will be pro-rated by the number of months without coverage—beginning in the fourth month without coverage. No tax penalty applies for the first 90 days a person is uninsured.

Penalties will be charged as a flat rate per person, with a family maximum, OR as a percentage of the household income—whichever is greater. After 2016, the penalty amounts will be adjusted by annual cost of living increases.

	2014	2015	2016 and later
Per adult	$95.00	$325.00	$695.00
Per child	$47.50	$162.50	$347.50
Family maximum	$285.00	$975.00	$2,085.00
% of family income	1	2	2.5

According to the ACA, the shared responsibility payment is to be included in the individual's federal income tax return and, if not paid, is subject to Chapter 68, Subtitle B of Internal Revenue Code with respect to assessing and collecting penalties. However, special rules apply; specifically, no taxpayer will be subject to criminal prosecution or penalty with respect to any failure to pay the shared responsibility payment. In addition, no liens or levies may be attached to any property owned by a taxpayer who fails to pay any required shared responsibility payment.

Individual Premium Tax Credit

If an individual is eligible for a premium tax credit, the credit reduces the cost of health insurance for the person and his or her dependents (as defined by IRS guidelines). A premium tax credit is only available to individuals who purchase a QHP through the marketplace. In addition, a person *cannot be eligible* for other minimum essential coverage, such as Medicare, Medicaid, or affordable employer-sponsored coverage.[19]

The person may opt to have the premium tax credit applied directly to the monthly cost of insurance on an advance basis or wait to receive it as a refund on his or her federal income tax return the following year. If someone chooses an advance premium tax credit, the marketplace will submit a monthly payment directly to the qualified health plan on the individual's behalf. If someone chooses to receive the premium tax credit on the federal income tax return, he or she cannot use the "Married Filing Separately" filing status. It should be noted that as a result of the Defense of Marriage Act (DOMA), the same eligibility rules for the premium tax credit that apply to opposite-sex spouses also apply to same-sex spouses.

Eligibility for an individual premium tax credit is based on the person's projected annual household income, the size of his or her family, and eligibility for other minimum essential coverage. Eligible individuals will have annual household incomes between 100% and 400% of the federal poverty level (FPL) for the previous year.

Advance premium tax credits will be paid directly to the health plan based on the calculated maximum monthly premium contribution for the second lowest Silver plan. The individual or family is free to choose any of the available plans but, if choosing a gold or platinum plan, must pay the difference between the silver, gold, or platinum premium minus the second lowest Silver plan tax credit. The individual or family can also select a Bronze plan or a less expensive Silver plan to maximize the available credit. Any applicable unused premium tax credits are refundable when the federal income tax return is filed in the following calendar year.

[19] http://www.irs.gov/uac/Newsroom/The-Premium-Tax-Credit2

It is expected that the majority of individuals and families receiving premium tax credits will be living in households with incomes less than 200% of the federal poverty level. Individuals and families eligible for premium tax credits are required to make contributions toward their health insurance premiums based on household income as follows:

Household Income % of FPL	% Income Contribution
Less than 133%	2.01%
133% to 149%	3.02% to 4.02%
150% to 199%	4.02% to 6.34%
200% to 249%	6.34% to 8.10%
250% to 299%	8.10% to 9.56%
300% to 400%	9.56%

Individuals who have at least one qualified health plan available to them through an employer-sponsored plan must be advised to use that benefit unless it is deemed unaffordable (the cost of employee-only coverage exceeds 9.5% of the household MAGI or the total cost exceeds 8% of household income). All other individuals should be directed to enroll through a marketplace in order to obtain the available tax credit.

Medicaid eligibility must be re-determined annually. It is important to keep in mind that if consumers have affordable employer-sponsored health insurance available to them, they are NOT eligible for premium tax credits or subsidies.

Employer Mandate

The ACA does not require employers to provide health insurance to their employees. However, in order to avoid the employer shared responsibility payment, large employers must offer health insurance that meets federal requirements to their full-time employees. As mentioned previously, the ACA and IRS define a large employer as one that:

- In 2015, has more than 100 full-time or full-time equivalent employees
- In 2016 and subsequent years, has 50 or more full-time or full-time equivalent employees

Most employer shared responsibility provisions apply beginning in 2015; however, they do not apply until 2016 to employers with 50 to 100 full-time employees--if the employer provides a required certification. Furthermore, the ACA requires employers with 200 or more employees that offer at least one health plan to enroll automatically *all* new employees, and to renew automatically all existing employees. Employees are permitted to decline coverage. Large employers will not be able to purchase health insurance through a SHOP Marketplace until 2017.

A calculation based on types of employees (i.e., full-time, part-time, seasonal, and temporary), and the average number of hours they work during a year, will determine the number of full-time equivalent employees. Applicable hours of service are only those worked in the 50 states and District of Columbia. A full- time worker is defined as one who works at least 30 hours per week during a month or who works 130 hours in a calendar month. Employers must apply hour and equivalency rules on a consistent basis and payroll periods can be used instead of calendar months.

The following individuals are not considered employees:

- Bona fide volunteers
- An individual working under a Federal Work-Study Program, or a similar state program
- A member of a religious order subject to a vow of poverty
- Those earning income outside the U.S.

The employer shared responsibility payment, or tax penalty, will apply if a large employer meets one of the following two conditions:

1. The large employer does not offer *affordable* health insurance to at least 95% of its full-time employees (including their dependents) and at least one employee purchases a qualified health plan on a marketplace and receives a premium tax credit. (In 2015, large employers must only offer affordable coverage to 70% of their full-time employees, including dependents.)
2. The large employer *does* offer health insurance to at least 95% of its full-time employees (70% in 2015), however, at least one employee purchases a qualified health plan on a marketplace and receives a premium tax credit BECAUSE:
    - The employer did not offer health insurance to that particular employee
    - The health insurance offered did not meet the definition of *affordable*, OR
    - The health insurance offered did not provide *minimum value*

When the employer shared responsibility payment applies, it will be assessed against full-time employees in excess of 30, meaning the penalty only applies to employers with 31 or more *full-time* employees; penalties will *not* be charged against part-time workers. For employers NOT offering health insurance to employees, the annual penalty is $2,000 multiplied by the number of full-time employees (minus up to 30).[20]

Example

If an employer has 50 full-time employees and 10 part-time employees, the penalty will be:

- $2,000 x 20, or $40,000
- 50 FT employees – 30 FT employees = 20 employees against whom the tax is imposed

The penalty is calculated separately for each month during which health insurance was not offered and the monthly penalty is one-twelfth (1/12) of the annual penalty. The penalty will be indexed by a premium adjustment percentage for each calendar year beginning in 2015.

For employers that *do* offer health insurance to employees and *still* owe a shared responsibility payment, the monthly penalty is $3,000 per employee receiving a tax credit for that month multiplied by one-twelfth (1/12) of $3,000. The maximum penalty is capped at the number of full-time employees for the month (minus up to 30) multiplied by one-twelfth (1/12) of $2,000. Essentially, employers offering coverage that does not meet requirements cannot be penalized in an amount higher than the amount that would be taxed if they did not offer coverage. The penalty is calculated separately for each month and will be indexed by a premium adjustment percentage for each calendar year beginning in 2015.

Two **safe harbors** exist for employers:

1. The "affordability" test: which is based on 9.56% of the employee's household income in 2015; this amount appears in Box 1 on the employee's Form W2[21]
2. The employee is eligible for Medicaid

It should be noted that employers are NOT entitled to the employee's taxpayer income return, per

[20] http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act#Calculation

[21] http://www.irs.gov/pub/irs-drop/rp-14-37.pdf

ACA Section 1411(f)(2)(B). It is expected that some issues concerning the applicability of the penalty and safe harbors will arise in light of the fact that employers will not *know* if their health plans are affordable until after an employee's tax return is filed. For this reason, employers will be permitted to appeal tax penalties that are imposed based on an employee's adjusted gross income.

Because of the financial and administrative burden of some of the provisions contained in the employer mandate, the IRS postponed three reporting requirements. IRS Notice 2013-45 was issued to provide transitional relief for the following three requirements of the ACA:

1. Reporting requirements for insurers, self-insuring employers, and certain providers of MEC
2. Reporting requirements for large employers
3. Provisions of the employer shared responsibility payment

This transitional relief did NOT change any of the provisions of the employer mandate; it simply deferred implementation of the preceding three requirements for 2014. It should also be noted that the employer shared responsibility payment is *not* tax-deductible.

Beginning in 2016 (for calendar year 2015), large employers must file a return to the IRS that contains the following information:

- Employer's name, address, and FID
- Statement relating to the offer to employees and dependents about the opportunity to enroll in MEC under an eligible employer-sponsored plan
- Length of the plan's waiting period
- Number of months the coverage was available during the reporting period
- The monthly cost for the least costly option
- The percentage of cost paid by employer
- The number of full-time employees—*with their names, addresses, and tax ID numbers*

W2 reporting of health insurance information does not apply to employers who file fewer than 250 W2s—at least until further notice. When reported, the value of healthcare coverage must be shown in Box 12 with code DD; this amount does not need to be reported on Form W3. The amount reported should include costs paid by both employer and employee.

Small Employers

Small employers are NOT subject to the employer shared responsibility provisions of the ACA. The ACA and IRS define **small employer** as an employer with fewer than 50 full-time or full-time equivalent employees. This means that small employers are not subject to the employer shared responsibility payment (tax penalty) if they do not offer health insurance to their employees.

Small Business Tax Credits

Eligible small businesses may receive a tax credit that equals up to 50% of their contributions to health insurance provided to employees. The maximum credit for non-profit organizations is 35%. It is important to keep in mind that small employers are only eligible for health insurance purchased on the SHOP marketplace.

In order to be eligible to purchase coverage in the SHOP marketplace, the employer must:

- Have its primary place of business located in the SHOP marketplace's service area

- Have at least one common-law employee on the payroll (this does not include the employer's owners or the owners' spouses and dependents)
- Have no more than 50 full-time equivalent employees on the payroll
- Offer coverage to ALL full-time employees

In order to be eligible for a small business tax credit, the small employer must:

- Employ an average of fewer than 25 full-time equivalent employees (this is based on a 40-hour work week and excludes the business' owners, the owners' family members, and seasonal employees)
- Pay average annual wages of less than $50,000 (this does not include the salaries of the business' owners)
- Pay a uniform amount of the premiums for employee-only coverage that is at least 50%.

The SHOP Tax Credit Estimator tool is available at HealthCare.gov to give employers an estimate of what their health care tax credit could be if they are eligible.

Health Insurance Marketplace (Exchange)

Health insurance is available through the Health Insurance Marketplace to United States citizens and legal immigrants who are not serving time in jail or prison. The marketplace is not a variety of insurance companies; instead, it is a resource that offers eligible individuals and small businesses access to qualified health plans. The purpose of the marketplace is to provide consumers with easier access to health insurance and help them compare available health plans, obtain answers about coverage options, determine eligibility for specific programs and tax credits, and actually enroll for coverage.

Separate marketplaces exist for individuals and small businesses with up to one hundred employees. The small business exchanges will be called Small Business Health Options Program (SHOP) Marketplace. Large businesses (those with more than 100 employees) will be eligible to purchase health insurance through the SHOP exchanges beginning in 2017. States can treat employers with **fewer than 50** employees as "small" for plan years beginning BEFORE 2016, however beginning January 1, 2017, the federal definition of large and small employer becomes effective across the country:

- Small Employer = 100 or fewer employees
- Large Employer = at least 101 employees

The marketplaces are administered by the state or federal government, by a partnership between the state and federal governments, or by a non-profit organization. States will be permitted to form regional marketplaces and will also allow marketplaces to operate in each state so long as each marketplace serves a specific geographical area.

Among other requirements, the ACA calls for the marketplaces to:

- Adopt procedures to certify, recertify, and decertify qualified health plans
- Operate a toll-free hotline
- Operate a website so consumers may compare qualified health plans offered through the exchange
- Assign each qualified health plan with a rating based on criteria established by the Secretary of Health and Human Services

- Adopt a standard format for illustrating health plan options
- Provide eligibility requirements for Medicaid, CHIP, and other state or local programs (if an individual is eligible for a particular program, the marketplace must enroll the individual)
- Provide a calculator that determines the actual cost of insurance after considering pertinent premium credits and cost-sharing subsidies
- Certify exemptions from the individual mandate and submit the list of exempt individuals to the Secretary of the Treasury
- Provide employers with the names of employees who terminated coverage and received premium tax credits because the employer's health insurance plan was not affordable or did not provide the required minimum value
- Establish the Navigator program

Procedures have been established to permit insurance agents and brokers to enroll individuals in qualified health plans on the marketplaces and to help those individuals apply for premium credits and cost sharing subsidies.

The Secretary of Health and Human Services has the power to conduct annual audits of the marketplaces. If an audit reveals serious misconduct on the part of a marketplace, a certain percentage of payment due to the marketplace will be revoked until corrective action has been taken and approved by the Secretary.

Employers have rolling enrollment through the SHOP marketplaces; however, once they are enrolled, they are locked into the plan and its premiums for one-year periods. Qualified health plans offered through the marketplaces must be certified to include essential health benefits and their insurers MUST:

- Be licensed and in good standing with the state
- Offer one QHP at the silver and gold level in each marketplace
- Charge the same premium for the QHP, wherever it's offered (in or outside an exchange)
- Comply with HHS regulations concerning marketplaces

Enrollment

Insurance coverage offered by a marketplace is made available by plan year (i.e., a calendar year). To enroll in coverage for a plan year, applications must be submitted to the marketplace during open enrollment, which begins on November 15 before the plan year and runs through February 15 of the plan year. In other words, if an individual wishes to purchase health insurance for plan year 2016, he or she must apply during open enrollment, which runs from November 15, 2015 through February 15, 2016.

Once open enrollment ends, an individual is only able to apply for coverage on the marketplace in one of two ways:

1. By qualifying for a special enrollment period due to specific life changes referred to as **life events**
2. Through Medicaid or CHIP

Qualifying life events include:[22]

[22] https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/

- Marriage
- The birth or adoption of a child
- Placement of a child for adoption or foster care
- Losing certain types of health insurance, such as:
    - Losing employer-sponsored coverage for any reason
    - Losing coverage through divorce
    - COBRA coverage is terminated for reasons other than the insured cancelling it before expiration)
    - Turning age 26 and losing coverage through a parent's plan
    - Losing eligibility for Medicaid or CHIP
- Moving outside the coverage area on a permanent basis
- Becoming a citizen of, or lawfully present in, the United States
- Becoming a member of, or continuing membership in, a federally recognized Indian tribe or gaining/continuing status as an Alaska Native
- Leaving jail or prison
- Once a marketplace plan is issued, having a change in income or household size that affects eligibility for a premium tax credit or cost-sharing reduction

In order to enroll in coverage during a special enrollment period, individuals must apply for coverage within 60 days of the qualifying life event. The special enrollment period for marketplace coverage issued by small employers is 30 days.

Agent/Broker Role

The role of agents and brokers in the marketplaces is addressed in 45 CFR 155.220 (a)(3). The following is a brief description of the role of agents and brokers in the marketplaces:

- Agents and brokers may enroll individuals, employers, and employees in QHPs on their own websites IF the party receives an eligibility determination from the marketplace
- Private websites must comply with HHS and marketplace standards, including privacy and security
- Private websites can sell QHPs and other, non-exchange products
- Agents must be certified by CMS, or trained by issuers, in all QHP options
- Agents and brokers may enroll individuals and small businesses in QHPs and assist with applications for premium tax credits and cost-sharing reductions
- If the marketplace is the federal marketplace, supported by the federal marketplace, or a partnership marketplace, all its agents and brokers must register with CMS before assisting consumers—and before the agent receives a commission from the issuer for the sale
- Agents and brokers may NOT perform eligibility determinations—these must be made through the marketplace
- Federal, federally-supported, and partnership marketplaces CANNOT pay commissions

to, or establish commission schedules for, agent and brokers. Payment in these states will be established between each insurer and the agents/brokers. In state marketplaces, the marketplace may establish its own rules for agent/broker commissions and compensation.

Medicaid Expansion

Some states opted to expand their Medicaid programs under the ACA; other states did not. The states that chose to adopt the Medicaid expansion receive additional federal funding for coverage to adults under age 65 who have income up to 138% of the federal poverty level.

In states that expanded Medicaid, individuals with incomes below a stated amount will be able to receive free or low-cost health insurance coverage regardless of family status, disability, or financial resources. The following states elected to expand their Medicaid programs:[23]

[23] https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/

Arizona	Arkansas	California	Colorado
Connecticut	Delaware	District of Columbia	Hawaii
Illinois	Indiana	Iowa	Kentucky
Maryland	Massachusetts	Michigan	Minnesota
Nevada	New Hampshire	New Jersey	New Mexico
New York	North Dakota	Ohio	Oregon
Pennsylvania	Rhode Island	Vermont	Washington
West Virginia			

Four eligibility groups exist for Medicaid enrollment purposes:

1. Pregnant women
2. Children (must generally be enrolled in CHIP or another program for which the child is eligible)
3. Parents and caretaker relatives (i.e., custodial parents and caretaker relatives who live with dependent children)
4. Adults between the ages of 19 and 64 who are not pregnant (this is a new group)

Medicaid income qualification is based on a reasonable expectation of future income and household size for the year, rather than the previous year's actual income and household size. In states that did not expand their Medicaid programs, individual eligibility for Medicaid and CHIP is based on income, household size, disability, family status, and other factors.[24] In states that expanded Medicaid to all low-income adults, individual eligibility is only based on income and family size.

The following chart illustrates some major differences between the states that did and did not adopt the Medicaid expansion with respect to eligibility for Medicaid and eligibility for premium tax credits and cost-sharing reductions for qualified health plans purchased from a marketplace:[25]

States that DID Expand Medicaid	States that did NOT Expand Medicaid
Eligibility is only based on income and household size	Eligibility is based on existing rules
A chart on HealthCare.gov provides the income levels/household size figures that apply in all states. For example: • Individuals with income below $16,243 may qualify for Medicaid • Families of four with income below $33,465 may qualify for Medicaid • Individuals with income between $11,670 and $29,175 may qualify for premium tax credits and cost-sharing reductions • Families of four with income between $23,850 and $59,625 may qualify for premium tax credits and cost-sharing reductions	Eligibility rules vary by state

In most cases, if an individual is not eligible for Medicaid, he or she will be able to purchase a

[24] https://www.healthcare.gov/medicaid-chip/eligibility/
[25] https://www.healthcare.gov/qualifying-for-lower-costs-chart/

qualified health plan on the marketplace. However, if all of the following conditions apply, an individual is not eligible for premium tax credits or cost-sharing reductions on a marketplace QHP:[26]

- The state did not expand Medicaid
- Annual income is below 100% of the federal poverty level
- The individual does not qualify for Medicaid under the state's current rules

Although no law exists preventing a Medicaid-eligible individual from purchasing a QHP on the marketplace, doing so is not in the best interests of the individual. Marketplace coverage is more costly than Medicaid and seldom offers additional coverages and benefits. **No premium tax credits or cost-sharing reductions are available to Medicaid-eligible individuals who purchase health insurance on the marketplace**.

Individual Premium Tax Credits

The premium tax credit will lower monthly premiums for insurance purchased through marketplace plans rather than requiring taxpayers to wait until filing taxes each year. The tax credit is also refundable, which means even those earning moderate levels of income will be able to receive some credit. Individuals who are eligible for tax credits may need to qualify for reduced cost sharing in the form of deductibles, copayments, and coinsurance.

Premium tax credits are determined by the household's size and the percentage its income bears to the federal poverty level (FPL); as the household income increases, and its percentage of the FPL increases, the premium tax credit decreases—because the percentage of income that may be used to pay insurance premiums increases. It should be noted that most individuals who are eligible for Medicare, Medicaid, CHIP, health insurance in the military (TRICARE), employer-sponsored health insurance, a grandfathered plan, and other forms of recognizable health insurance are not be eligible for premium tax

Americans are eligible for premium tax credits if their household incomes range between 100% and 400% of the federal poverty level. The Department of Health and Human Services updates the figures annually during the last week of January and they can be found at: *http://aspe.hhs.gov/poverty/15poverty.cfm*.[27] In 2015, the federal poverty thresholds are (the guidelines for Alaska and Hawaii are different ... and higher):

People in the Household/Family	Poverty Guideline
1	$11,770
2	$15,930
3	$20,090
4	$24,250
5	$28,410
6	$32,570
7	$36,730
8	$40,890
9 or more	$4,150 for each additional person over 8
http://aspe.hhs.gov/poverty/15poverty.cfm#thresholds	

When determining eligibility for premium tax credits, affordability is an issue and is determined by the marketplace at the time the individual enrolls. With respect to the premium tax credit:

- It is an advance credit payment, referred to as a "monthly premium assistance amount"
- When an individual is eligible, the exchange makes subsidy payments to the health plan on

[26] https://www.healthcare.gov/medicaid-chip/eligibility/

[27] http://aspe.hhs.gov/poverty/15poverty.cfm

behalf of the individual

- Subsidy payments are made monthly and are reconciled when the individual files the federal tax return for the year; however, individuals may report income changes to Healthcare.Gov at any time throughout the year
- Repayment of subsidy overages is capped for those who earn less than 400% of the FPL; caps for families range between $600 and $2,500 and caps for single persons are one-half those applicable to families

Implementations in 2015

Beginning in 2015, physicians who provide a higher quality of care will receive higher payments than physicians who provide lower quality care.

Implementations in 2016

Beginning in 2016, states will be permitted to enter into compacts that allow individual health plans to be offered in all states that participate in the compact. Plans will be subject to the state laws in the jurisdictions of which they are written.

Implementations in 2017

Beginning in 2017, large employers will be permitted to offer qualified health plans through the marketplaces. The states will also be permitted to apply to the Department of Health and Human Services for a state innovation waiver. These waivers will allow the states to opt out of specific provisions of the ACA. Provisions for which states may request waivers include:

- State health insurance exchanges
- The establishment of qualified health plans
- Reduced cost sharing for individual enrollees of qualified health plans
- Refundable credits for coverage under a qualified health plan
- Shared responsibility for employers
- The requirement to maintain minimum essential coverage

Implementations in 2018

Beginning in 2018, health plans known as “Cadillac” plans will be taxed. A Cadillac health insurance plan is one that provides few, if any, cost sharing mechanisms such as deductibles, pre-authorization requirements, copayments, and coinsurance. As a result, their premiums are quite high and they tend to be abused. Essentially, if the annual premium for an individual health plan exceeds $10,200, or the annual premium for a family health plan exceeds $27,500, an excise tax will be imposed on the insurer.

The premium thresholds for Cadillac plans insuring employees working in dangerous occupations (i.e., law enforcement, construction workers, EMTs and paramedics) are increased to $11,850 and $30,950 per year. The ACA imposes the tax based on the Cadillac plans’ premium costs rather than their benefits—which has generated some concern.

Chapter 2 Review Questions

1. Which of the following is NOT a benefit category for health plans that will be offered through the marketplaces?
   a. Silver
   b. Bronze
   c. Gold
   d. Copper

2. What term is defined as "the total number of hours of service for which wages were paid by the employer to employees during the taxable year...then dividing that number by 2,080"?
   a. Minimum essential coverage
   b. Essential health benefits
   c. Full-time equivalent employee
   d. Full-time employee

3. What provision of the ACA requires a shared responsibility payment from Americans who are not covered by health insurance as required by law?
   a. Individual mandate
   b. Employer mandate
   c. Cadillac plan
   d. Medicaid expansion

4. What program provides health insurance coverage for children whose families cannot afford to buy health insurance but who are not eligible for Medicaid?
   a. Medicare
   b. TRICARE
   c. CHIP
   d. COBRA

5. Which of the following is the ONLY acceptable reason for charging a higher premium rate for health insurance?
   a. Gender
   b. Tobacco use
   c. Participation in a clinical trial
   d. Pre-existing condition

6. Under the ACA, which employers will be required to offer health insurance to employees or pay a shared responsibility payment?
   a. All employers
   b. Large employers
   c. Small employers
   d. Non-profit organizations

7. Which of the following statements BEST describes how health plans may treat individuals who participate in clinical trials for cancer?
   a. They may exclude them from coverage
   b. They may impose annual coverage limits for them
   c. They may not cancel or deny coverage
   d. They may refuse to issue coverage

8. Which of the following persons is NOT exempt from the Individual Mandate beginning?
   a. A member of a religion opposed to accepting health care benefits
   b. A documented immigrant
   c. A member of a federally recognized Indian tribe
   d. A person serving time in jail

9. What did the ACA create as marketplaces to offer eligible individuals and small businesses access to qualified health plans?
   a. Group health plans
   b. Unqualified health plans
   c.. Equivalent employees
   d. Health insurance marketplaces

10. Americans may be eligible for premium tax credits if they meet which of the following requirements?
   a. They do not buy health insurance
   b. They are unemployed
   c. Their income is between 100% and 400% of the FPL
   d. Their adjusted gross income is less than $2,000,000

Review Questions Answer Key

Chapter 1

1. B Immediately upon enactment of the Affordable Care Act, the state of Florida filed a lawsuit in federal court that challenged the constitutionality of two portions of the ACA: the individual mandate and the expansion of Medicaid.
2. C The Social Security Act into law in 1965 and created Medicare and Medicaid.
3. A All health insurance plans include deductibles, which are cost-containment measures that require the insured person to share with the insurer in all losses.
4. D A pre-existing condition is a medical condition for which an applicant for health insurance was either diagnosed or treated before being insured by a new health insurance plan.
5. D Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs), and Point of Service (POS) plans are managed care plans.
6. C The health insurance exchanges are intended to be online state insurance marketplaces in which individuals and small businesses may view competitive private health insurance plans.
7. D Because insurance companies realized that different segments of the population experienced fewer losses than other segments, they began charging premiums based on an individual's health risk rather than charging one rate for all enrollees.
8. A A PPO is an organization of medical providers that delivers medical treatment and services to enrollees based on a fee schedule and guidelines for managed medical care.
9. B An HMO is an organization of medical providers (including physicians, hospitals, and other medical facilities) who are employed or contracted by the insurer to provide health care to its members.
10. D A Point Of Service (POS) plan is a combination PPO/HMO.

Chapter 2

1. D The ACA created four discrete categories of health plans: bronze, gold, silver, and platinum.
2. C Full-time equivalent employees is a term that quantifies the "total number of hours of service for which wages were paid by the employer to employees during the taxable year" and dividing that number by 2,080.
3. A The ACA calls the individual mandate the "requirement to maintain Minimum Essential Coverage" and the penalty is called a "shared responsibility payment."
4. D CHIP provides health insurance coverage for children whose families cannot afford to buy health insurance but who are not eligible for Medicaid.
5. B Increased premiums may not be charged for any reason other than the enrollee's age, the geographic area of the enrollee's residence, family composition, and tobacco use.
6. B Large employers are required to offer health insurance to employees as mandated, or pay a shared responsibility payment.
7. C Health plans may not cancel or deny coverage because of the enrollee's participation in clinical trials for cancer or other life-threatening conditions.
8. B Undocumented immigrants will be exempted from the individual mandate; documented immigrants are not exempt.
9. D Health insurance marketplaces (exchanges) were created by the ACA to offer eligible individuals and small businesses access to qualified health plans.
10. C Certain Americans may be eligible for tax credits if their household incomes range between 100% and 400% of the federal poverty level.