Affordable Care Act (ACA)
Frequently Asked Questions

Grandfathered policies

Q1: What is grandfathered health plan coverage?

A: The interim final rule on grandfathering under ACA generally defines "grandfathered health plan coverage" as coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010.

Q2: Is grandfathered health plan coverage limited to individuals who were enrolled on March 23, 2010?

A: No, an individual who is enrolled in a group health plan or health insurance coverage on March 23, 2010 may enroll family members under the terms of the plan or coverage after March 23, 2010. New employees and their families may also enroll in a grandfathered group health plan.

Q3: Are group health plans and health insurance issuers required to maintain grandfathered health plan coverage?

A: No

Q4: What 2010 health insurance reform provisions must grandfathered group health plans comply with?

A: Both insured and self-funded grandfathered group health plans must comply with the following requirements for plan years beginning on or after September 23, 2010:

- Prohibition of preexisting condition exclusion or other discrimination on health status for enrollees under age 19
- Prohibition on excessive waiting periods
- No lifetime limits on "essential benefits"
- "Restricted" annual limits on the dollar value of "essential benefits"
- Prohibition on rescissions except for fraud or intentional misrepresentation
- Extension of dependent coverage until age 26

Q5: What changes will result in a cessation of grandfather status?

A: The following changes to a grandfathered health plan will result in a loss of grandfathered status:

- The elimination of all or substantially all benefits to diagnose or treat a particular condition

- Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (e.g. coinsurance)
- Any increase, measured from March 23, 2010, in a fixed-amount cost-sharing requirement other than a copayment (e.g. deductible or out-of-pocket limits) that exceeds the sum of medical inflation plus 15%
- Any increase, measured from March 23, 2010, in copayment that exceeds the greater of (a) the sum of medical inflation plus 15%, or (b) $5 increased by medical inflation
- Any decrease, measured from March 23, 2010, in contribution rate by an employer or employee organization that exceeds 5%
- The addition of an overall annual limit if the group health plan did not impose an overall annual or lifetime limit as of March 23, 2010, or the addition of an overall annual limit that is less than an overall lifetime limit that was imposed as of March 23, 2010

Q6: What are the notice requirements associated with grandfathered group health plans?

A: A grandfathered group health plan must include a statement in plan materials provided to a participant or beneficiary describing the benefits, that the plan believes it is a grandfathered health plan, and must provide contact information for questions and complaints. ODS will include the model language in member handbooks for any grandfathered group health plan.

Q7: What are the record keeping requirements associated with grandfathered group health plans?

A: A grandfathered group health plan must maintain records documenting the terms of the plan in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan, for as long as the plan takes the position that it is a grandfathered health plan. ODS will maintain such records in its possession pursuant to this, and any other federal record retention requirements.

Excepted Benefits

Q1: Are my dental (or vision) benefits subject to ACA's market reforms?

A1: If benefits constitute excepted benefits under HIPAA, the requirements of the ACA's market reforms do not apply. Under HIPAA, dental (and vision) benefits generally constitute excepted benefits if they:

- Are offered under a separate policy, certificate, or contract of insurance; or
- Are not an integral part of the plan. For dental (or vision) benefits to be considered not an integral part of the plan (whether insured or self-insured), participants must have a right not to receive the coverage and, if they do elect to receive the coverage, must pay an additional premium.

Accordingly, if a plan provides its dental (or vision) benefits pursuant to a separate election by a participant and the plan charges even a nominal employee contribution towards the coverage, the dental (or vision) benefits would constitute excepted benefits, and the market reform provisions would not apply to that coverage.

Dependent eligibility

Q1: How has ODS implemented the dependent eligibility provision?

A1: ODS Oregon and Alaska implemented the federal Health Care Reform dependent eligibility up to age 26 provision effective June 1, 2010 based on the following guidelines:

- The dependent age was extended for all new and existing individual and group policies* (medical, dental, vision and pharmacy), regardless of student status
- Any dependent who would have aged off their parents policy May 31, 2010 or after is eligible to remain on the plan up to their 26th birthday
- Any dependent who aged off their parents policy prior to May 31, 2010will be required to wait until the policy renews on or after September 23, 2010 to re-enroll
- Federal reform requires that dependents are eligible to remain on the parents policy regardless of marital status
  - If the date of marriage was on or after June 1, 2010 the dependent will be allowed to remain on their parent's coverage
  - If the date of marriage is prior to June 1, 2010 the dependent will be required to wait until the policy renews on or after September 23, 2010 to re-enroll

- In either of the above scenarios neither the children, spouse or domestic partner of the eligible dependent will be covered by the policy

- Federal reform indicates that health plans can deny coverage to a dependent that is eligible for other group coverage
  - ODS will not investigate other coverage for the purposes of eligibility determination
  - ODS will investigate other coverage for purposes of determining coordination of benefits
  - Standard coordination of benefits provisions will apply

*ASO, union negotiated and large employers (100+) may choose to wait to implement this provision. Please contact your ODS marketing representative if you have questions related to your specific plan.

Q2: Does the extension of the dependent stop age change to dental plans result in imputed tax issues?

A2: Per IRS Notice 2010-38, IRS had extended the pre-tax salary reduction to employer-provided reimbursements for medical care, including standalone dental plans. By definition under the Code, medical care includes dental.

Q3: Will children at student age have to pay more for coverage or accept a different health plan?

A3: No, the premiums charged and the health plan offered should be the same for dependent children of all ages.

Q4: For children who aged off the parents' policy and switched to COBRA prior to May 31, 2010, can they switch back to the active coverage?

A4: Yes, the children can switch to the active plan when the policy renews on or after September 23, 2010.

Q5: For children who aged off their parents' COBRA coverage prior to May 31, 2010, can they re-enroll?

A5: Yes, the children can re-enroll on COBRA when the policy renews on or after September 23, 2010 (provided their parents, the COBRA participants, are still on COBRA and the dependents are under age 26).

Q6: In Oregon, if a primary applicant drops coverage, how will this affect dependent coverage?

A6: A subscriber may terminate his or her coverage, or coverage for any enrolled dependent, by giving ODS 30 days prior written notice. Coverage will end on the last day of the month through which premiums are paid. If a subscriber terminates his or her own coverage, coverage for all enrolled dependents also ends.

This provision clarifies that if a family is enrolled and the parent or parents drop coverage leaving no parent on the contract, the coverage for any dependent children would also end. If coverage for a child(ren) is intended to continue, they may re-apply during the state open enrollment periods following the 12 month disenrollment period.

However, if the loss of coverage for a primary applicant causes a dependent spouse to lose coverage, and that spouse is over age 19, the primary applicant may request that the spouse retain coverage and become the primary policyholder upon written request.

Q7: When can persons under 19 years of age enroll in an individual health insurance policy?

A7: In Oregon, a person under the age of 19 years can enroll as a dependent or as the primary policyholder if eligible, and obtain individual health insurance coverage during the following time periods:

- The month of February each year
- The month of August each year
- The 30-day period after the date the insurer receives notice of loss of other *individual* coverage if (i) such notice is provided to the insurer no later than the 60th day after the loss of coverage, (ii) the person under 19 years of age is not eligible for group coverage, and (iii) the loss of other coverage results from legal separation, divorce, cessation of dependent status, death of the primary policyholder, or incurrence of a claim that meets or exceeds a lifetime limit on all benefits

Lifetime & annual maximums

Affordable Care Act (ACA) Frequently Asked Questions

Q1: What restrictions does the ACA impose on lifetime and annual maximums?

A1: The ACA prohibits group health plans and group and individual health insurance issuers from establishing any lifetime limit on the dollar amount of benefits. In addition, group health plans and group and individual issuers may only establish "restricted" annual limits on essential benefits. Annual and lifetime limits are allowed for non-essential benefits and an exclusion of all benefits for a condition is not considered to be an impermissible annual/lifetime limit.

Q2: Our group policy has a member that has met their lifetime maximum benefit, when will this member again be eligible for benefits?

A2: As long as the member continues to be eligible for the health plan, they will be eligible for benefits to begin paying upon the policies renewal that is on or after October 1, 2010.

- Example, the policy renews January 1st of each year, the member would be eligible for benefits beginning January 1, 2011

Essential Benefits

Q1: What are the essential benefits?

A1: The Department of Health and Human Services have yet to define the essential health benefits; however, the ACA requires that the essential benefits include at least the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

Retroactive termination

Q1: Can you give an example of situation that cannot be processed retroactively?

A1: If an employee loses eligibility due to a reduction in hours, but the employer, in error, continues to collect any employee contribution and pays the carrier, once the error is discovered, the termination can be processed only prospectively.

Q2: Can you give an example of a member found to be ineligible?

A2: In a situation where a member is found to be ineligible and did not report this fact to their group/employer, we will research for possible fraud. The termination will be processed prospectively initially while research is underway. Depending on our findings and after sending out the required 30-day advance notice, a retroactive termination may be processed.

Situations where this may occur could be divorce, change in domestic partnership, becoming Medicare-eligible while on COBRA or any non-eligible dependent.

Q3: Can you give an example of a subscriber request?

A3: If on October 20th, an employee requests coverage be dropped on a dependent and for some reason it doesn't get sent to the carrier until December 2nd, the retroactive request can still be processed.

Q4: An employee's spouse who was divorced last year just reported this to us. The spouse is taking COBRA. Is that a retroactive termination?

A4: If a member is switching his or her status from active to COBRA it is not a retroactive termination since coverage is still in effect.

General questions

Q1: We self-fund our health plan which renews January 1st. When will our plan be required to comply with the new legislation?

A1: Plans are required to comply with the new legislation based on their policy renewal date beginning with October 1, 2010 renewals.

Q2: When will ODS' Portability plans be required to comply with the new legislation?

A2: ODS' Portability plans are required to comply with the new legislation on January 1, 2011.

Q3: Does ODS offer management only plans?

A3: In late December, the Internal Revenue Service, Department of Labor, and Health and Human Services released Notice 2011-1, delaying the ACA discrimination rules for insured health plans.

As a result of this notice, ODS will continue to offer our groups, 26+, the option of management only plans.

Small Employer Tax credits

Q1: Does this only apply to small employers that have not offered coverage in the past or does it apply to all small employers?

A1: The tax credit applies to all qualified small employers (note: a governmental employer may not be a qualified employer). Qualified employers can claim the credit as part of the general business credit starting with the 2010 income tax return they file in 2011. The credit is worth up to 35 percent (25 percent for tax-exempt small employers) of their premium costs in 2010. On Jan 1, 2014, the rate will increase to 50 percent (35 percent for tax-exempt employers). The credit phases out gradually for employers with average wages between $25,000 and $50,000 and for employers with the equivalent of between 10 and 25 full-time employees.

Q2: What are the eligibility rules?

A2: A qualified employer can be a for profit or tax-exempt small employer.

- The employer must have 25 or fewer full-time equivalent (FTE) employees in a tax year (e.g., an employer with fewer than 50 half-time workers may be eligible).
- The average annual wage for employees is less than $50,000 per FTE
- The employer contributes at least 50 percent of the premium cost based on the single rate
- The coverage meets the federal minimum standards

Q3: Can small employers that are currently taking the small employer tax credit take a deduction?

A3: In determining the small employer's deduction for health insurance premiums, the amount of premiums that can be deducted is reduced by the amount of the credit.

Q4: Where can a small employer find more information?

A4: Go to the IRS website on the Affordable Care Act to locate news release, Revenue Ruling 2010-13 and FAQs.

Temporary retiree reinsurance program

Q1: Who is eligible to submit for the temporary retiree reinsurance program?

A1: Eligible entities include plan sponsors who offer health coverage to early retirees who are 55 and older but not yet eligible for Medicare. Such retiree health plans must include programs and procedures that have generated, or have the potential to general, cost savings for chronic and high-cost conditions. Next, each health plan must be certified by HHS prior to submitting any claims. Applications to HHS can be submitted beginning June 1 and will be processed in the order received.

Q2: Will ODS support group policy holders with data in order to file for reimbursement under this program?

A2: Groups must ensure there is a written agreement with ODS regarding the disclosure of information, data, documents and record to HHS, and ODS will agree to disclose that information in compliance with the regulations. However as this may require additional resources ODS reserves the right to evaluate the cost and may pass along these costs to our clients.

Q3: What are the requirements in the application process to HHS?

A3: The actual application will be available at beginning of June, and it will be similar to the application for the retiree drug subsidy under Medicare Part D. To get ready for the submission, the application should:

- Be signed and certified by an authorized representative who has the authority to bind the plan sponsor to a contract or agreement.
- Include separate application for each plan identifying the plan year start and end date cycle (e.g., 1/1 to 12/31).
- Include the plan sponsor's tax identification number, name, address and contact information.
- Include a plan sponsor agreement stipulating to the disclosure of applicable information and documents to HHS. The agreement should include a certification that the plan sponsor acknowledges that the application is being used to procure federal funds (and that subcontractors acknowledge the same); an attestation regarding the plan sponsor's policies and procedures to detect and reduce fraud, waste and abuse; and an agreement to produce both these procedures

and information to substantiate the existence of the policies and their effectiveness to HHS.

- Include a summary regarding the plan sponsor's intended use of the reimbursement to reduce participant and/or sponsor costs; describe in the summary how the sponsor will use the reimbursement to maintain its level of contribution to the plan; include a description of the programs in place to generate cost savings for plan participants with chronic and high-cost conditions.
- Project the amount of reimbursements to be received under the program for each of the first two plan cycles.
- Include a list of all benefit options under the plan for which early retirees are eligible.
- Any other required information released after the interim final regulations.

Q4: Is a self-funded (ASO) public entity eligible for the Early Retiree Reinsurance Program?

A4: ODS cannot confirm if a public entity is eligible. However, the rules do not differentiate between health benefits provided by self-funded plans or through the purchase of insurance. Furthermore, the rules define eligible employment-based plans to include a group benefit plan providing health benefits that is maintained by private employers, State or local governments, employee organizations, voluntary employees' beneficiary association, a committee or board of individuals appointed to administer such plan, or a multiemployer plan.

<u>Individual and employer responsibility requirements</u>

Q1: What is the hourly requirement, if any, under the mandate for an employer to have to offer coverage to an employee? From what I have read it looks like any employee working an average of 30 hours per week calculated over a 30 day period must be offered coverage by the employer?

A1: Effective January 1, 2014 the federal requirement for coverage is an employee working an average of 30 hours per week.

Q2: What is the waiting period for an employee to be eligible for group coverage?

A2: Effective Jan 1, 2014, waiting periods cannot exceed 90 days for all group sizes.

Q3: When and what would the penalty be if an employer that has over 50 employees were to discontinue their group plan in 2010?

A3: The penalty will apply effective January 1, 2014. Two assessments on such large employers (51+):

1. If at least one full-time employee receiving a premium assistance tax credit, pay $2,000 per full-time employee and the first 30 employees are exempt from the payment calculation.
2. If at least one full-time employee receiving a premium assistance tax credit, the amount to be paid is the product of the number of full-time employees for that month and 1/12 of $3,000.