Regulatory ADVISORY
American Hospital Association™

Thursday March 21, 2013

Update on Implementation of ACA Insurance Reforms

At a Glance

The Issue:

Since March 23, 2010, when President Obama signed the *Patient Protection and Affordable Care Act* (ACA) into law, there has been a steady stream of regulations, sub-regulatory guidance documents, responses to Frequently Asked Questions (FAQs), and other documents related to how the Department of Health and Human Services (HHS) intends to implement the health insurance reforms.

In many cases, the administration has granted a remarkable level of flexibility to state governments by allowing them to make their own decisions on major implementation questions. Despite that flexibility, 26 states (AL, AK, AZ, FL, GA, IN, KS, LA, ME, MO, MS, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, VA, WI, WY) have chosen to let the federal government operate the health insurance exchange in their state, at least initially. The Jan. 1, 2014, effective date for many of the reforms, especially the new health insurance exchanges, is rapidly approaching. The delays in issuing regulatory guidance raise questions about whether all the rules and infrastructure needed for implementation will be in place by Oct. 1, 2013, when open enrollment for 2014 coverage is slated to begin.

This advisory provides an overview of the status and approach being taken by HHS for the main ACA insurance reform provisions of interest to AHA members – as providers and as employers. A detailed companion chart, covering all of the related issuances as of Feb. 22, linking to the HHS source documents, can be found at: http://www.aha.org/content/13/130321advchart.pdf. This advisory identifies issues being addressed at the federal level and those that HHS has left open for state-by-state decisions, as well as which provisions apply only within the new health insurance exchanges and which apply outside the exchanges. The attachment also helps sort out which key provisions apply to different types of plans and employers and how "grandfathering" affects who must comply and when. This information is especially important for hospitals and health systems that offer self-insured health plans to their employees. Finally, we have identified key opportunities or challenges that hospitals and health systems face as implementation proceeds.

AHA's member advisories are produced whenever there are significant developments that affect the job you do in your community. A 16-page, in-depth examination of this issue follows.

At a Glance (cont.)

Implications for Hospitals:

With the many moving parts involved in the implementation of the health insurance exchanges and the amount of flexibility granted to states, there are likely to be a variety of implications for providers in terms of both state regulation and actions taken by health plans in response. Examples (discussed in more depth on pages 10-11) include:

- ***Changes in Health Plan Network Contracting.*** Several health plan strategies are already taking shape, including more narrow networks and tiered provider networks, with a greater focus on value-based purchasing approaches.

- ***Changes in Health Plan Payment Methods for Providers.*** Plans are taking a variety of approaches to address affordability issues, especially for products that will be offered through the health insurance exchanges, including provider rate reductions, different payment methods such as capitation, and increased discussion about state-level provider rate review/setting programs and provider rate transparency.

- ***Administrative Simplification.*** There are general administrative simplification requirements in the ACA being implemented separately, but others are central to the establishment and functioning of health insurance exchanges and how they will interact with state Medicaid programs.

- ***Covered Benefits.*** The debate around the establishment of Essential Health Benefits (EHBs) may present both positive and negative effects on whether specific services are likely to be covered, and under what circumstances.

- ***Streamlined Quality Reporting and Metrics.*** The coming establishment of quality reporting requirements for health plans provides an opportunity to streamline and make more consistent the quality metrics and quality reporting requirements applied across health plans and the resulting demands put on providers.

What You Can Do:

- ✓ Share this advisory with those in your organization responsible for payer contracting, human resources, and government relations so that they can evaluate any potential impact on your organization's operations.
- ✓ Where decisions are left to state governments, check with your state hospital association on where things stand in making those decisions.

Further Questions:

If you have questions, please contact Ellen Pryga, director for policy, at (202) 626-2267 or epryga@aha.org, or Molly Collins Offner, director for policy, at (202) 626-2326 or mcollins@aha.org.

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UPDATE ON IMPLEMENTATION OF ACA INSURANCE REFORMS

BACKGROUND

Jan. 1, 2014, looms large over the administration to ensure that the infrastructure is in place and the stakeholders (especially the states) are prepared to implement the insurance market reforms and coverage mechanisms intended to expand coverage and access to affordable health insurance. The Department of Health and Human Services (HHS) and its Center for Consumer Information and Insurance Oversight (CCIIO) have been issuing key rules at a rapid rate as the Oct. 1, 2013, start for the 2014 open enrollment process approaches. A variety of companion rules have been issued by the departments of Treasury and Labor as well. Recently issued rules focus on essential health benefits, health insurance exchanges[1], insurance market rules, wellness programs and quality initiatives, with more to come.

Since the enactment of the *Patient Protection and Affordable Care Act* (ACA), HHS has released a series of rules and sub-regulatory materials to implement components of the insurance market reforms and expanded Medicaid eligibility. While the pace of new regulatory issuances has gained speed as the Oct. 1, 2013, date approaches, a number of questions remain unresolved, and states, insurance issuers, employers and providers await final guidance. State decisions on whether to form and operate an insurance exchange were initially slow as many awaited the outcome of the Supreme Court decision on constitutional challenges to the ACA, but are now mostly complete. However, the Supreme Court's ruling that HHS could not penalize states that did not adopt the law's Medicaid expansion has left providers and other stakeholders in limbo as they wait for their states to decide whether to expand their Medicaid programs and to ponder what will happen on Oct. 1, 2013, when the open enrollment period for the insurance exchanges begins. As of Feb. 22, 2013, 18 states had decided to expand and 12 had decided not to expand, although the numbers change frequently. The remaining states are undecided or leaning one way or the other.

[1] HHS Secretary Kathleen Sebelius recently announced that the department will be using the more consumer-friendly term "health insurance marketplaces," but HHS policy documents continue to use the term "exchange."

This advisory provides an overview of the status and approach being taken by HHS as of Feb. 22, 2013, for the main ACA insurance reform provisions of most interest to AHA members. A detailed companion chart covering related issuances and links to the HHS source documents can be found at: http://www.aha.org/content/13/130321advchart.pdf. It also tries to sort out issues being addressed at the federal level from those that HHS has left open for state-by-state decisions, as well as which provisions apply only within the new health insurance exchanges and which apply outside of the exchanges. Finally, we have identified key opportunities or challenges that hospitals and health systems face as implementation proceeds.

AT ISSUE

Health Insurance Exchanges

Central to coverage expansion and access are the health insurance exchanges. They are not insurance companies and do not offer insurance products that they develop and underwrite themselves. They are marketplaces through which, beginning in 2014, individuals (who do not have an offer of qualifying and affordable coverage from their employers) and small businesses may purchase coverage from private insurance companies. Individuals who purchase coverage through an insurance exchange may be eligible to receive federal subsidies that make the insurance more affordable. There also are special temporary tax credits available to certain very small employers to provide coverage to their employees.

The ACA calls for the establishment of two types of exchanges in each state: one for individuals and one for small businesses. The exchange for individual coverage operates separately from the small employer exchange, unless a state decides to merge them into a single exchange. The small business insurance exchange is known as the Small Business Health Options Program (SHOP). For purposes of this advisory we use the term "exchange" to include both individual and small group exchanges.

States have the flexibility to decide the nature of the exchanges in their state. There are three choices; they can:

- establish a State-Based Exchange (SBE);
- participate in a State-Federal Partnership Exchange (SPE); or
- allow the federal government to run a Federally-Facilitated Exchange (FFE) in the state.

The following chart outlines these options for states. In each option, either the state or the federal government has the overall responsibility for operation of the exchange, but each option allows certain tasks to be performed by either the state or the federal government.

Exchange Options for States		
Type of Exchange	**Level of Government Responsible Overall for Operations**	**Flexible Functions**
State-Based (SBE)	State	State may use Federal government services for: • Premium tax credit & cost sharing reduction • Exemptions from tax penalties • Risk Adjustment Program • Reinsurance Program
State-Federal Partnership (SPE)	Federal	State can accept responsibility for: • Plan Management • Consumer Assistance
Federally-Facilitated (FFE)	Federal	State may elect to operate: • Reinsurance Program • Medicaid and CHIP eligibility determinations

Deadlines for states to declare their exchange decisions to HHS and submit their applications to HHS officials have been extended multiple times. Those deadlines have now passed and initial decisions are mostly in place. While Feb. 15, 2013, was the final deadline for states to send in a declaration letter and application for an SPE, HHS officials are approving individual state requests to assume certain "exchange-related" functions, e.g., certification of qualified health plans. If a state chooses not to create its own exchange, the federal government will operate the exchange (FFE). States that are not ready to operate an exchange by Oct. 1, 2013, may apply later to operate their own exchanges for plan years 2015 and beyond.

As of Feb. 22, 2013, 17 states and the District of Columbia declared their intention to create a state-based exchange, seven states have asked to form a partnership exchange, and the remaining states will have federally facilitated exchanges, at least initially (see chart below).

Exchange Type	State
State-Based	CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, UT, VT, WA
State-Federal Partnership	AR, DE, IL, IA, MI, NH, WV
Federal	AL, AK, AZ, FL, GA, IN, KS, LA, ME, MO, MS, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, VA, WI, WY

Source: Kaiser Family Foundation, www.kff.org

Exchanges have to be ready to accept enrollees Oct. 1, 2013, through March 31, 2014 (the initial open enrollment season), and be fully operational on Jan. 1, 2014. A number of rules have yet to be finalized. One of the biggest open questions is exactly how the FFE will operate. Little official information had been released by Feb. 22. Upcoming deadlines include:

Date	Action
April 1, 2013	QHP application to participate in FFE becomes available
April 30, 2013	QHP applications due to FFE
July 2013	QHPs certified to participate in FFE
October 1, 2013	Initial open enrollment period starts
January 2, 2014	Effective date for coverage by health plans offered through the exchange
January 2015	Exchange must be financially self-sufficient

Qualified Health Plans

The 17 states (and DC) that have moved ahead with establishing state-based exchanges are adopting a range of approaches to controlling how many Qualified Health Plans (QHPs) will be offered to consumers through the exchange. The most liberal approach is that of a clearinghouse where all QHPs are allowed to participate; the most restrictive approach is for the exchange to be an active purchaser with the ability to limit the number and/or types of plans that can participate. The chart below indicates decisions made by these SBEs to the extent the details were known as of Feb. 22.

State	Exchange Operated By	QHP Selection
CA	Independent State Agency	Active Purchaser
CO	Non-Profit	Clearinghouse
CT	Quasi - Public	Active Purchaser
DC	Independent Authority	Active Purchaser
HI	Non-Profit	Clearinghouse
ID	TBD	TBD
KY	Operated by State	TBD
MD	Independent State Agency	Clearinghouse
MA	Independent State Agency	Active Purchaser
MN	TBD	TBD
NM	Quasi-Governmental	TBD
NV	Independent State Agency	Clearinghouse
NY	Operated by State	TBD
OR	Quasi-Governmental	Active Purchaser
RI	Division in Exec Branch	Active Purchaser
UT	Existing Agency	Clearinghouse
VT	Existing Agency	Active Purchaser
WA	Quasi-Public	Clearinghouse

Essential Health Benefits (EHB)

The ACA requires that an EHB be established against which health plans in the small group and individual markets can be compared. The EHB package must offer a robust set of benefits that cover 10 general categories. The levels of coverage are defined based on their actuarial equivalence to the benchmark metal levels: Bronze Level (60 percent), Silver Level (70 percent), Gold Level (80 percent) and Platinum Level (90). The metal levels represent the health plan and plan enrollee costs. For example, in the Silver Level the health plan will pay 70 percent of the health care expenses with the enrollee paying 30 percent through some combination of deductibles, copays and coinsurance. HHS regulations gave states the ability to set their own EHB benchmarks within certain federal parameters (see AHA's *Special Bulletin* on EHB at: http://www.aha.org/hospital-members/advocacy-issues/bulletin/2013/130221-bulletin.shtml).

Beginning in 2014, some health plans must meet the EHB requirements depending on whether they hold "grandfathered" status and whether they are fully insured or self-insured. Employer plans are allowed to maintain their grandfathered status only until significant changes are made. The attachment to this advisory describes how grandfathering works and which ACA provisions apply to which employers and when. The bottom line is that it will be difficult for health plans to maintain grandfathered status over time, so that health plans ultimately will have to meet the EHB requirements.

Consumer Operated and Oriented Plan (CO-OP) Program

The ACA encouraged the creation of new health insurance cooperatives and authorized up to $6 billion (later reduced to $3.8 billion) in funding under the CO-OP program to foster the creation of new nonprofit member-run health insurance issuers that offer QHPs in the individual and small group markets. However, the *American Taxpayer Relief Act of 2012*, enacted on Jan. 2, 2013, rescinded all but 10 percent of the unobligated funds under the program (roughly half of the reduced funding level) to help pay for other provisions in the Act. The remaining 10 percent will be used to administer, monitor and support CO-OPs that had already received loans (24 entities in 24 states as of Dec. 21, 2012). No further loans will be awarded under the program, which disappointed several entities that had applications pending.

Insurance Market Reforms and Patient Protections

The ACA required that certain insurance market reforms be adopted soon after enactment. The effective date for these immediate insurance market reforms was plan years (PYs) beginning on or after Sep. 23, 2010, and included:

- No lifetime limits
- Restricted annual limits
- Restrictions on rescission of coverage
- First dollar coverage of preventive services
- Extended dependent coverage to age 26
- No pre-existing condition exclusions for children
- Disclosure of justifications for premium increases

Other ACA insurance market reforms become effective on Jan. 1, 2014, including:

- No pre-existing condition exclusions for adults
- Limitations on rate variations state-wide
- Required separate state-wide risk pools for individual market and for small group market

Premium Rate Review

As part of the goal to promote transparency and accountability, insurance companies that plan to increase premium rates in the individual or small group markets are required to justify and submit for review the need for a rate increase by providing information on the factors contributing to the proposed increase. Rate review took effect Sept. 1, 2011. Even if the premium increase is not deemed justified, the ACA does not convey any power to HHS or the states to block or reduce an insurance company's planned increase, although some states have that power under state law.

In its September 2012 Annual Rate Review Report (available at: http://www.healthcare.gov/news/reports/rate-review09112012a.html), HHS reported that 44 states have programs to review proposed premium increases that are effective for at least some of their markets. The states identified with no effective rate review include Alabama, Arizona, Louisiana, Missouri, Montana and Wyoming. HHS reviews proposed increases in states that do not have effective rate review programs or where a state's rate review program is not effective in the individual or small group markets. HHS also reported that as of September 2012, an estimated $1 billion in reduced premiums had resulted from the rate reviews conducted by the states and HHS.

The ACA also requires that the explanations of proposed increases submitted by the insurance companies, and the state or HHS's judgments related to the increases, be made available to the public on HealthCare.gov. Initially, plans were required to disclose only those planned increases that exceeded 10 percent per year. In the final rules just published, all proposed increases must be justified and reported to HHS. That segment of HealthCare.gov provides the ability to review summary and detailed information on proposed increases by individual insurers, as well as on a state-wide basis.

Preventive Services

For PYs beginning Sept. 23, 2010, all new group and individual health plans must cover certain specified preventive services without charging a deductible, co-pay or coinsurance. The requirement applies to all plans, including self-funded plans, except those that are grandfathered. A health plan may require that the preventive services be provided only through an in-network provider; and the consumer may be liable for paying for the office visit if the preventive service is not the primary purpose of the visit.

Medical Loss Ratio (MLR)

Since 2011, carriers have been reporting to HHS the ratio of incurred losses (incurred claims) plus loss adjustment expenses (changes in contract reserves)

to earned premiums, also known as the MLR. The ratio includes the percentage of total premium revenue (after accounting for risk adjustment, premium corridors and payments of reinsurance) that is expended on:

- Reimbursement for clinical services;
- Activities that improve health care quality; and
- All other non-claims expenses, including the nature of the costs, excluding federal and state taxes and licensing or regulatory fees.

Beginning in August 2012, insurers began providing rebates to consumers (employers) if the percentage of premiums expended for clinical services and quality activities was less than 85 percent of premiums in the large group market and 80 percent in the small group and individual markets. In that same September 2012 report, HHS stated that in the first year of MLR implementation, approximately 13 million Americans were benefitting from $1.1 billion in rebates made possible by the MLR.

The 3 R's

Beginning in 2014, the ACA establishes a premium stabilization program that includes three components: a transitional reinsurance program, temporary risk corridors, and permanent risk adjustment. Each has specific requirements and standards and is intended to mitigate risk associated with implementing the ACA reforms.

Reinsurance. The entire insurance market (including self-insured employer plans) will be assessed in 2014 to pay for a reinsurance program that will total approximately $10 billion over the three years of the program and protect the individual insurance market. The reinsurance program is a transitional program that generally follows typical stop-loss reinsurance insurance, except that the attachment point (the point at which the reinsurance applies) is relatively low compared to commercial reinsurance. Allowable payment amounts under the reinsurance program will be capped because no more can be paid out than was contributed to the fund. The protection will not be for the highest cost individuals, but for experiencing a disproportionate share of "higher cost individuals." The reinsurance assessments will be collected by either the states or the federal government (for all self-insured employer plans and by default in states unwilling or unable to do so).

Risk Corridors. HHS temporarily will provide pro-rata, plan-specific payments or collect assessments from QHPs when they experience claims that are at least 3 percent more or less than the target amount built into the premium. For the first three years of exchange operation, when actual health plan experience differs from 3 percent to 8 percent, HHS will assume 50 percent of favorable (gain) or unfavorable (loss) experience. Above a difference of 8 percent, HHS will assume 80 percent of favorable or unfavorable experience. The risk corridor program will apply to non-grandfathered individual or small group QHPs, including those offered outside the exchange if they are similar to those offered within the exchange. The risk corridor program will apply at the benefit plan level, which is the most detailed level at which the program could be applied.

These risk corridors are intended to address the difficulty of initially making accurate actuarial projections under the new insurance reforms.

Risk Adjustment. Risk adjustment is a permanent program that begins in 2014. The program is intended to protect health plans operating in the individual and small group markets both inside and outside the exchange from attracting a higher than average health risk population after consideration of the allowable rating variables: family size/composition, tobacco use, geographic areas and age. Under the risk adjustment program, assessments are collected from plans with favorable selection and then distributed to plans with adverse selection.

A state that does not operate an exchange may not operate a risk adjustment program, but HHS will do it on the state's behalf. Otherwise, the state decides whether the risk adjustment functions are performed by the exchange or another eligible entity, including the Medicaid agency. HHS will develop a federal model that will be used when it is administering risk adjustment on a state's behalf. States can use the federal model or can file their own model or use another state's model if that model has been filed and has received HHS approval.

Premium Tax Credits

Beginning in 2014, qualified individuals and families can take a new premium tax credit on their federal income taxes to help them afford health insurance coverage purchased through an exchange. The premium tax credit is refundable so taxpayers who have little or no income tax liability can still benefit. The credit also can be paid in advance by the exchange to a taxpayer's insurance company to help cover the cost of premiums.

Since tax year 2010, some small businesses and small tax-exempt organizations have been eligible for an employer premium tax credit if their plans provide minimum essential benefits, as defined in federal rules. This credit is designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have. In general, the credit is available to small employers that pay at least half of the cost of single coverage for their employees and their employees' average wages are modest. If the employer has fewer than 25 employees and provides health insurance, it may qualify for a tax credit of up to 35 percent (up to 25 percent for non-profits) to offset the cost of the insurance. This credit will increase in 2014 to 50 percent (35 percent for non-profits). This special credit is available for only two consecutive tax years for any small business or small tax-exempt organization that qualifies.

Medicaid Eligibility, Enrollment and Expansion

The ACA changed many Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment provisions to:

- Expand Medicaid eligibility for non-elderly adults with incomes up to 133 percent of the Federal Poverty Level (FPL) (138 percent FPL when taking into account a 5 percent income disregard);
- Simplify Medicaid eligibility categories;
- Modernize eligibility verification rules, relying primarily on electronic data sources;

- Base income eligibility on a new income methodology known as Modified Adjusted Gross Income (MAGI) to make it consistent with federal subsidy eligibility determinations in the exchanges;
- Streamline Medicaid and CHIP applications and renewals; and
- Coordinate eligibility across Medicaid, CHIP and the exchanges.

States have flexibility to design their eligibility determination process, but they must ensure that the eligibility determination process for all Insurance Affordability Programs (IAPs), including Medicaid programs is simple, coordinated, seamless and timely. The goal is to ensure that the eligibility determination process is consistent between state Medicaid agencies and insurance exchanges, whether the Medicaid agency is accepting an eligibility determination from an exchange or whether the exchange is conducting an initial assessment and transferring the information and findings to the Medicaid agency.

The June 2012 Supreme Court decision allows states to decide to expand or not expand their Medicaid programs without penalty. HHS Secretary Sebelius issued a series of FAQs in December 2012 to address key implementation issues post-Supreme Court decision. To date, 18 states have declared that they will expand their Medicaid program with another eight states leaning in favor. Twelve states have declared they will not expand, another nine states are leaning against and the remaining four states are undecided.

Basic Health Plan (BHP)

The BHP is an optional program under the ACA whereby states can establish a program using federal dollars to offer subsidized coverage for uninsured individuals with incomes between 139-200 percent of FPL (for a family of four the income ranges from $32,734 to $47,100). States have the flexibility to define benefits, cost-sharing, delivery systems and procurement strategies. The eligibility requirements include:

- Income between 139 and 200 percent of FPL and not eligible for Medicaid;
- US citizens or legal immigrants below 139 percent of FPL who are not eligible for Medicaid;
- Under age 65; and
- No access to government or employer-sponsored minimum essential coverage (Medicaid, Medicare, CHIP, military or Employer-Sponsored Insurance (ESI)).

HHS recently announced that the BHP program is delayed until 2015. To date, only a few states have considered establishing a BHP (e.g., California).

Uniform Explanation of Benefits, Coverage Facts and Standardized Definitions

Beginning Sept. 23, 2012, the ACA required that insurers and plan sponsors distribute “plain English,” four-page (two-sided for eight pages) benefit summaries (“summaries of benefits and coverage,” or SBC) to health plan

enrollees that include a variety of information in a standard format using standardized terms. The new forms include: the SBC and a uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment."

IMPLICATIONS FOR PROVIDERS

With the many moving parts involved in the implementation of the health insurance exchanges and the amount of flexibility granted to states, there are likely to be a variety of implications for providers in terms of both state regulation and actions taken by health plans in response. Examples include:

- ***Changes in Health Plan Network Contracting.*** Several health plan strategies are already taking shape, including more narrow networks and tiered provider networks where in-network providers are separated into preferred and non-preferred tiers (often based on cost) with different cost-sharing for each tier and for non-network providers. Part of this strategy involves a greater focus on the application of quality metrics and elements of a value-based purchasing approach.

- ***Changes in Health Plan Payment Methods for Providers.*** To address affordability issues, some health plans are asking providers to accept Medicare-like payment rates or other types of rate reductions for plans offered through the insurance exchanges. Others, in response to the administrative cost limitations of the MLR requirements, are moving more providers toward capitated payment arrangements where certain administrative costs are embedded in the delivery of care, thereby removing them from the health plan. We also may see pressure on state governments to enact provider rate review/setting requirements as plans address the premium rate review and disclosure requirements of the ACA.

- ***Administrative Simplification.*** There are general administrative simplification requirements in the ACA being implemented separately, but others are central to the establishment and functioning of health insurance exchanges. Chief among them is how Medicaid programs will interact with the exchanges, especially on eligibility and enrollment processes. A more standardized and coordinated process for helping uninsured patients achieve coverage will reduce provider administrative and uncompensated care costs.

- ***Covered Benefits.*** The debate around the establishment of EHBs may present both positive and negative effects on whether specific services are likely to be covered, and under what circumstances, depending on how individual states and the federal government define EHB benchmarks and the issuers' plan designs. Final EHB rules were just published. For specifics, see AHA's *Special Bulletin* at: http://www.aha.org/hospital-members/advocacy-issues/bulletin/2013/130221-bulletin.shtml.

- ***Streamline Quality Reporting and Metrics.*** The coming establishment of quality reporting requirements for health plans provides an opportunity to streamline and make more consistent the quality metrics and quality reporting requirements applied across health plans. The AHA pushed for this in comments (see the AHA's comment letter at: http://www.aha.org/advocacy-issues/letter/2012/122712-cl-cms-0062-nc.pdf) late last year and, if adopted, these provisions have the potential to reduce the administrative burden associated with the current inconsistencies from one health plan or program to another.

NEXT STEPS

The AHA will continue to monitor and engage in discussions with the administration, and provide updated information to AHA members and the state, regional and metropolitan hospital associations.

FURTHER QUESTIONS

If you have questions, please contact Ellen Pryga, director for policy, at (202) 626-2267 or epryga@aha.org, or Molly Collins Offner, director for policy development, at (202) 626-2326 or mcollins@aha.org.

Which ACA Insurance Provisions Apply to Which Employers and When

From an employer perspective, the grandfather provisions in the ACA can be especially difficult to sort through to determine which requirements apply and when they might apply.

Understanding How Grandfathering Works

The ACA distinguishes between health plans that existed prior to the March 23, 2010, enactment date and those that exist afterwards. Individual and group health plans already in existence prior to ACA enactment are referred to as "grandfathered" plans, and new health plans (or plans that have been materially modified after March 23, 2010) are referred to as "non-grandfathered" plans. The distinction is important because in some cases "grandfathered" plans are insulated from some key health reform insurance market mandates. The federal rules make it difficult for a grandfathered plan to retain its status. Actions such as eliminating a benefit, increasing cost-sharing percentages, increasing fixed dollar cost-sharing amounts more than 15 percent above the inflation rate, including or reducing annual maximum on all benefits or reducing the rate of employer contributions (more than 5 percent) cause the plan to lose grandfather status.

Grandfathered individual and group health plans are subject to the following requirements for plan years beginning on or after Sep. 23, 2010:

- No pre-existing condition exclusions for individuals under age 19 (groups only, not applicable to grandfathered individual health coverage). No lifetime dollar limits on "essential health benefits."
- No restrictive annual dollar limits on essential benefits until 2014 when annual dollar limits of grandfathered individual plans are enforceable as well.
- No rescissions of coverage except for fraud or misrepresentation.
- Extended coverage for dependents up to age 26. (After 2014, grandfathered group plans are not required to cover dependents who are eligible for employer-sponsored health coverage other than a group health plan of a parent.)
- Spending no less than 80 percent of premiums on medical costs (small and individual markets) or 85 percent in large group employer plans.

Grandfathered plans do not have to comply with the following:

- Offer an essential benefit package in the individual and small markets;
- Eliminate cost-sharing for preventive services; and
- Report on quality improvement activities and guarantee access to emergency, pediatric and OB-GYN services.

The following chart sorts these provisions.

Insurance Issues and Applicability	Individual & Small Group /Fully Insured		Large Group/Fully Insured		Self-Insured Small Group/Large Group	
	Grandfather	Non-Grandfather	Grandfather	Non-Grandfather	Grandfather	Non-Grandfather
Which plans have to offer Essential Health Benefits beginning in 2014?	No	Yes, it applies to these plans in & out of Exchange	No	No, but must meet cost sharing and benefit levels	No	No
Which Plans have to eliminate annual dollar limits applicable for plan years (PY) beginning on/after September 23, 2010	No	Yes	Yes, but only applies to any EHB	Yes, but only applies to any EHB	No, but applies to any EHB	No, but applies to any EHB
Which Plans have to eliminate lifetime dollar limits on EHB for PY beginning on/after September 23, 2010	Yes	Yes	Yes, but only applies to any EHB	Yes, but only applies to any EHB	No, but applies to any EHB	No, but applies to any EHB
Which Plans have to eliminate annual & lifetime dollar limits on EHB in 2014.	Yes	Yes	Yes, but only applies to any EHB	Yes, but only applies to any EHB	No, but applies to EHB	No, but applies to any EHB
Which Plans are prohibited from rescinding the insurance contract, with limited exceptions for PY beginning on/after September 23, 2010?	Yes	Yes	Yes	Yes	Yes	Yes
Which Plans are required to offer coverage to dependents up to 26 beginning with PY or/after September 23, 2010?	Yes. After 2014 No if child is eligible for employer-sponsored plan	Yes	Yes, After 2014 No if child is eligible for employer sponsored plan	Yes	Yes, After 2014 No if child is eligible for employer sponsored plan	
Which Plans are required to have Internal & External Appeals, beginning January 1, 2011?	No, applies to individual	Yes	Yes	Yes	No, includes a safe harbor	Yes

Insurance Issues and Applicability	Individual & Small Group /Fully Insured		Large Group/Fully Insured		Self-Insured Small Group/Large Group	
	Grandfather	Non-Grandfather	Grandfather	Non-Grandfather	Grandfather	Non-Grandfather
Which Plans are required to submit annual data to HHS & state insurance commissioner regarding claims, cost sharing, etc. beginning with PY on/after September 23, 2010?	No	Yes	No	Yes	No	Yes
Which Plans are required to provide access to emergency services beginning with PY September 23, 2010	No, applies to individual market	Yes	Yes	Yes	Yes	Yes
Which Plans are required to provide access to Pediatricians & OB/GYNs beginning with PYs on/after September 23, 2010?	No	Yes	Yes	Yes	Yes	Yes
Which Plans are prohibited from denying coverage to kids based on a pre-existing conditions beginning with PY on/after September 23, 2010?	No, but does apply to individual insurance	Yes	Yes	Yes	Yes	Yes
Which Plans are prohibited from denying coverage to anyone based on a pre-existing condition beginning January 1, 2014?	No, but does apply to individual insurance	Yes	No	Yes	No	No
Which Plans are required to participate in the rate review process beginning October 1, 2010?	No	Yes	No	Yes	No	No
Which Plans are required to provide rebates in August 12, 2012, for failure to meet the statutory Medical Loss	Yes	Yes	Yes	Yes	No	No

Insurance Issues and Applicability	Individual & Small Group /Fully Insured		Large Group/Fully Insured		Self-Insured Small Group/Large Group	
	Grandfather	Non-Grandfather	Grandfather	Non-Grandfather	Grandfather	Non-Grandfather
Ratio Standards?						
Which Plans are required to use Adjusted Community Rating beginning January 1, 2014?	No	Yes	No	Yes, applies to fully insured small group plans	No	No
Which Plans are required to implement the guaranteed issue requirements beginning January 1, 2014?	No	Yes	No	Yes	No	No
Who has access to purchase coverage through the exchanges when they open for business	Yes	Yes	No	No	No	No
Which Plans are required to pool their risk in the individual and small group markets both in/out of the Exchange beginning January 1, 2014?	No	Yes	No	No	No	No
Which Plans have to offer certain Preventive Health Services with no cost sharing	No	Yes	No	Yes	No	Yes
The 3 R's (Effective 1-1-2014)						
Which Plans are required to contribute to the Transitional Reinsurance Program?	Yes	Yes	Yes	Yes	Yes	Yes
Which Plans are eligible to receive payments under the reinsurance program beginning January 1, 2014?	No	Yes, but only applies to individual plans	No	No	No	No

Insurance Issues and Applicability	Individual & Small Group /Fully Insured		Large Group/Fully Insured		Self-Insured Small Group/Large Group	
	Grandfather	**Non-Grandfather**	**Grandfather**	**Non-Grandfather**	**Grandfather**	**Non-Grandfather**
Which plans are protected by the federal Risk Corridors program beginning Jan. 1, 2014?	No	Yes, and applies both inside and outside of the Exchange	No	No	No	Yes for small groups (fully insured & self-funded)
Which plans are subject to the risk adjustment program?	No	Yes, applies both inside & outside the Exchange	No	No	No	No
Which Plans sponsored by large employers are required to enroll new employees automatically beginning Jan. 1, 2014?	NA	NA	NA	Yes	Yes	Yes
Which employers are responsible for providing minimum essential coverage to their employees?	NA	No for employers with fewer than 50 FTEs	No	Yes	Yes	Yes