

**Affordable Care Act
Implementation Update
June 17, 2013**

The purpose of this document is to provide insurers doing business in Kentucky with guidance from the Department of Insurance (DOI) for implementing the Affordable Care Act. This Implementation Update is not legally binding on the Department or the reader. The ultimate authority for the interpretation of the Affordable Care Act lies with the Department of Health and Human Services.

Frequently Asked Questions #3

1. Can you please confirm that when rating family members in both the individual and SHOP exchanges, there will be a charge per person? In other words, a family with five children will be paying more than a family with two children.

Correct, the rating is going to be per person in both individual and small group market (inside and outside the Exchange). However, there is a cap on the rating of dependents under the age of 21 and only the first three dependents under age 21 will be charged. If you have dependents 21 or older, those are rated on a per person basis just like all adults.

2. Can you please confirm that there will not be a charge for children between the ages of 21 through their 26th birthday?

Please see the answer to number 1 – for children under 21 there is a limit on charging for only three dependents. Dependents age 21 and over will be charged a specific premium based on age.

3. If I have a wife and two children, but the children are 21 and 23, do I just purchase employee and spouse coverage and my children are covered? Is this rule just inside the Exchange?

Please see answers to questions 1 and 2. All these rules apply both inside and outside the Exchange.

4. Is the information on an association's election to be large group or small group available to the public? When does an association have to make its election? If an employer has five employees, and the association elects to be a large employer, then I assume that employer is subject to pay or play rules, COBRA, etc.? If I have over 50 employees and my association elects to be a small employer, then is it correct that pay or play rules, etc., would not apply?

Associations will not be making a specific election regarding whether they are a large employer or a small employer. Rather, their structure and the manner in which health benefit plans are

provided to association members will determine whether the product is subject to the requirements for the small group market or the requirements for the large group market. Insurers are responsible for ensuring that the health plan issued to the association is in compliance with the appropriate market rules (small group or large group).

The federal guidance on associations is available at http://cciio.cms.gov/resources/files/association_coverage_9_1_2011.pdf.pdf. It is important to note that this guidance addresses the federal market rules, including benefit and rating requirements, for the health benefit plan products sold to association members. However, it is not applicable for the employer-shared responsibility requirements. Coverage through an association is simply a way in which coverage can be offered to employees. However, each employer must determine whether it is required to offer health insurance coverage to its employees under the shared responsibility requirements, separately from its membership in an association.

5. What are the key elements of a catastrophic plan?

The definition of a catastrophic plan is included in the Final Rule on Health Insurance Market Rules and Rate Review. The key elements of a catastrophic plan are:

- Catastrophic plans are for the individual market, both inside and outside the Exchange.
- Individuals under age 30 or those that meet the financial hardship exemptions are eligible.
- Catastrophic plans are not subject to the prescribed actuarial value levels for the metal plans. They would generally have a lower actuarial value than the bronze. However, since no premium subsidies are available for these plans, the actual premium paid by a subsidy-eligible member could be higher than what a member would pay for the metal plans.
- For 2014, catastrophic plans have a self-only deductible of \$6,350. But, they can have at least three primary care visits covered before reaching the deductible. Insurers may apply copays to the three primary care visits.
- These plans include coverage for essential health benefits like other plans in the individual market.
- Preventive benefits are covered at 100 percent.

6. What is the definition of “tobacco use”?

The definition of tobacco use for rating purposes as included in the Final Rule on Health Insurance Market Rules and Rate Review (45 CFR 147.102) is:

Tobacco use means use of tobacco on average four or more times per week within no longer than the past six months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

7. Can you please clarify how long a dependent can stay on a parent’s plan?

The Affordable Care Act requires insurers that offer dependent coverage to allow dependents to remain on their parent’s insurance plan up to age 26. This requirement is applicable for fully insured plans in all market segments (individual, small group and large group). Grandfathered plans are not required to provide this coverage if the adult child is eligible to enroll in another employer-sponsored health plan. Insurers must make coverage available until the dependent’s 26th birthday. However, insurers are permitted to allow a dependent to remain covered for a longer period, such as until the first renewal date following the dependent’s birthday.

8. If an employee makes a decision to leave a group plan due to cost, is that loss of coverage a qualifying event that would allow the employee a limited open enrollment period to purchase coverage in the individual market?

An individual would be permitted a 60-day limited open enrollment period to purchase coverage in the individual market due to loss of minimum essential coverage. This may be a decision related to cost during an open enrollment period. However, loss of minimum essential coverage does not include coverage which is terminated due to nonpayment of premium or situations allowing for a rescission of coverage (such as intentional misrepresentation or fraud.)

9. Is an employer required to offer dependent coverage?

The federal market rules do not require family coverage to be offered.

However, under the shared responsibility requirement, an employer with 50 or more employees (full-time and full-time equivalents) must offer minimum essential coverage to its full-time employees and their dependent children.

The employer will pay a penalty if:

(a) The employer does not offer health coverage or offers coverage to less than 95 percent of its full-time employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on an Exchange; or

(b) The employer offers health coverage to at least 95 percent of its full-time employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on an Exchange, which may occur because the employer did not offer coverage to that employee or because the coverage the employer offered that employee was either unaffordable to the employee (based on the 9.5 percent rule) or did not provide minimum value (based on the 60 percent rule).

The Department of the Treasury and the Internal Revenue Service issued Notice 2011-73 which includes a safe harbor to address the problem that arises with determining affordability based on a percentage of an employee’s household income. The safe harbor allows affordability of an employer’s coverage to be measured based on an employee’s wages as reported on the W-2

Form. To qualify for this proposed safe harbor, an employer must meet the following requirements:

- The employer must offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, and
- The employee portion of the self-only premium for the employer's lowest cost coverage that provides minimum value must not exceed 9.5 percent of the employee's W-2 wages.

If an employer satisfies both of these requirements for a particular employee, the employer is not subject to penalty with respect to that particular employee, even if that employee receives a premium tax credit or cost-sharing reduction.

10. Can you provide more information on the safe harbors related to the Summary for Benefits and Coverage (SBC) document?

In an effort to work together with employers, issuers, states, providers and other stakeholders to come into compliance with the provisions of the Affordable Care Act, the US Departments of Labor, Treasury and Health & Human Services have taken an approach toward implementation that is based on assisting, rather than penalizing, those working diligently and in good faith to understand and come into compliance with the new law. As such, the departments extended the following safe harbors related to the SBC through 2014:

- Ability to provide SBCs electronically to employees in connection with their online enrollment or online renewal of coverage under the plan or on request;
- Continuation of the good faith compliance standard in determining whether penalties will be assessed for failure to provide the SBC or uniform glossary;
- Continued availability of the coverage examples calculator;
- Permission to issue separate SBCs for carve-out arrangements;
- Non-enforcement of the SBC requirement with respect to expatriate coverage and Medicare Advantage plans;
- Ability to modify the SBC for plan terms and conditions that do not fit within the SBC requirements as long as the SBC is completed as close to the instructions as possible; and
- The ability to contract with another entity to complete, provide information, or deliver an SBC.

11. Can you please clarify the safe harbor for employer groups and how that works with the 8 percent rule?

While the safe harbors (described in part in Question 9 above) relate to penalties for employers under the employer shared responsibility requirements, the 8 percent rule relates to a test for determining an individual's exemption from the individual mandate.

The Affordable Care Act requires individuals to maintain minimum essential coverage. There are exemptions from this requirement including an exemption for individuals who lack access to affordable health coverage. The exemption provides that group health plan coverage is not affordable for an employee if the employee's required contribution for the lowest cost self-only coverage exceeds 8 percent of his or her household income. That employee would be exempt from the individual mandate. He or she could apply for Exchange coverage using the premium assistance tax credit, enroll in the employer's health plan despite the cost, or remain uninsured without paying a penalty.