ACA INFORMATION
The Affordable Care Act (ACA)

Key Provisions *(coverage of preventative services)*

In March 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (ACA aka "health care reform" or "Obamacare"), into law. The ACA is intended to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising health care costs. It provides a number of mechanisms — including mandates, subsidies, and tax credits — to employers and individuals to increase the coverage rate and health insurance affordability.

Individual Shared Responsibility
The Individual Shared Responsibility provision of the law applies to the self-employed and requires that each individual, beginning in January 2014, have basic health insurance coverage (known as minimum essential coverage) for each month, qualify for an exemption, or make a payment when filing a federal income tax return starting in 2015. Individuals will not have to make a payment under these rules if coverage is unaffordable, you spend less than three consecutive months without coverage, or you qualify for an exemption for several other reasons, including hardship and religious beliefs.

Health Insurance Marketplaces
Also known as the health insurance "Marketplace," the Affordable Insurance Exchange is a new transparent, competitive insurance marketplace where individuals and small businesses can purchase affordable and qualified health benefit plans. The Marketplace for small employers, known as the Small Business Health Options Program (SHOP), and the Individual Marketplace for consumers and those who are self-employed, will be open in all states in November 2014.

Essential Health Benefits
The Affordable Care Act ensures that health plans offered in the individual and small group markets, both inside and outside of the health insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include services within at least ten core categories, among them emergency services, maternity and newborn care, prescription drugs, and prevention and wellness services.

Premium Tax Credits for Consumers & Self-employed Individuals
Consumers and self-employed individuals may be eligible for a tax credit that can be used right away to lower the monthly health plan premiums. Individuals who qualify can take the premium tax credit in the form of advance payments to lower their monthly health plan premiums starting in 2014, which can help make insurance more affordable. The value of the tax credit an individual is eligible for depends on how much income they or their family expects to earn.

Tax Credits for Small Businesses
The ACA enacted Section 45R of the Internal Revenue Code, which contains provisions for tax credits available to certain small businesses that offer health insurance coverage to their employees. Effective June 26, 2014, the IRS published final regulations that affect small employers that may be eligible for any taxable year in the credit period. The final regulations define an eligible small employer as an employer with no more than 25 full-time equivalent employees (FTEs), whose employees have average annual wages of no more than $50,000 per FTE, and that has a qualifying arrangement where the employer pays a uniform percentage (not less than 50 percent) of the premium costs offered by the employer to its employees through a SHOP Exchange.

Timeline
The Affordable Care Act contains numerous provisions taking effect at various times between 2010 and 2018. The following timeline are the highlights of provisions that have passed and those to come in the next several months.

2017
- **February 28:** Large employers must report and notify the offer of affordable and adequate coverage to the IRS by February 28 (March 31 if submitted electronically)

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- Health insurance exchanges become available for larger employers (those with 50-100 employees)

2014
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- Coverage for pre-existing conditions
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2013-2010
- **October 1, 2013:** Open enrollment in the Health Insurance Marketplace begins
- **October 1, 2013:** Employers are required to notify employees of the existence and functioning of these Health Insurance Marketplaces
- New preventive services for women
- Plan participants have a right to Summary of Benefits and Coverage in order to make informed decisions about their healthcare options
- Prescription drug discounts for seniors
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HEALTH INSURANCE MARKETPLACE NOTICE

You May Be Eligible to Shop for Coverage at the Marketplace
Beginning January 1, 2014, individuals and employers of small businesses will have access to affordable coverage through a new competitive private health insurance market – the Health Insurance Marketplace.

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Open enrollment for health insurance coverage through the Marketplace begins October 1, 2013. Section 1512 of the Affordable Care Act (ACA) creates a new Fair Labor Standards Act (FLSA) section 18B requiring a notice to employees of coverage options available through the Marketplace.

Background:

Section 18B of the FLSA, as added by section 1512 of the Affordable Care Act, generally provides that, in accordance with regulations promulgated by the Secretary of Labor, an applicable employer must provide each employee at the time of hiring (or with respect to current employees, not later than October 1, 2013), a written notice:

1. Informing the employee of the existence of the Marketplace (referred to in the statute as the Exchange) including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance;
2. If the employee plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code if the employee purchases a qualified health plan through the Marketplace; and
3. If the employee purchases a qualified health plan through the Marketplace, that the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer. All or a portion of such contribution may be excludable from income for Federal income tax purposes.

What is the Marketplace?

The Marketplace is a new way to find health coverage that fits your budget and meets your needs. With one application, you can see all your options and enroll.

When you use the Health Insurance Marketplace, you'll fill out an application and find out if you can get lower costs on your monthly premiums for private insurance plans. You'll find out if you qualify for lower out-of-pocket costs.

The Marketplace will also tell you if you qualify for free or low-cost coverage available through Medicaid or the Children's Health Insurance Program (CHIP).

Open enrollment started October 1, 2013. Coverage begin January 1, 2014.

The Health Insurance Marketplace is sometimes known as the health insurance "exchange."

If your state does not yet operate a Health Insurance Exchange, you can visit HealthCare.gov to seek further information and check eligibility – even apply for insurance.

90-DAY WAITING PERIOD LIMITATION

For plan years beginning on or after January 1, 2014, individuals who are eligible for employer-provided health coverage will not have to wait more than 90 days to begin coverage. On June 25, 2014, the IRS, DOL, and HHS published final regulations which allow an orientation period not exceeding 30 days prior to the start of the 90-day waiting period, effective for plan years beginning on or after January 1, 2015.

Orientation Period Defined
The orientation period is a time period used by the employer and employee to evaluate whether the employment situation is satisfactory for each party. The duration of the orientation period cannot exceed one month, and is measured by adding one calendar month to the employee's start date and then subtracting one calendar day. For example, if an employee's start date is an otherwise eligible position is May 2nd, the last permitted day of the orientation period is June 1st.

Waiting Period Defined
A group health plan and a health insurance issuer offering group coverage may not use a waiting period that exceeds 90 days. A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective. For this purpose, being eligible for coverage means having met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms).

Furthermore, if, under the terms of a plan, an employee may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, the 90-day waiting period limitation is considered satisfied. Accordingly, a plan or issuer will not be considered to have violated this rule merely because employers take additional time to elect coverage.

Employees with Variable Hours Each Week
If a group health plan conditions eligibility on an employee regularly working a specified number of hours per period (or working full time), and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period (or work full time), the plan may take a reasonable period of time to determine whether the employee meets the plan's eligibility condition, which may include a measurement period that is consistent with the time frame permitted for such determinations.

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) EXCLUSION LIMITED

Health FSAs are benefit plans that employers can sponsor to allow their employees to be reimbursed on a tax-favored basis for certain medical expenses that are not covered by the employer's major medical plan. Generally, employees decide before the beginning of the plan year how much money they want to contribute to the FSA. Throughout the year, they can draw from this account for qualified medical expenses that are not covered by their employer's main health plan. This can include copays, deductibles, and various medical services and products – from dental and vision care to eyeglasses and hearing aids.

Under the Affordable Care Act, beginning with calendar year 2013, the maximum amount an employee can exclude from income for contributions to a flexible spending account is limited to $2,500. That limit is per person, so both the employee and their spouse can each set aside $2,500 where applicable. The new limit is based only on the calendar year regardless of the plan year of the plan.

The $2,500 limit applies only to salary reduction contributions under a health care FSA and does not limit the amount allowed for reimbursement under an FSA for dependent care assistance or adoption care assistance. Likewise, it also doesn't apply to salary reduction or any other contributions to a health savings account (HSA) or to amounts made available by an employer under a health reimbursement arrangement (HRA).

WHISTLEBLOWER NOTICE

The Affordable Care Act (ACA) contains various provisions to make health insurance more affordable and accountable to consumers. To further these goals, the Affordable Care Act's section 1558 provides protection to employees against retaliation by an employer for reporting alleged violations of Title I of the Act or for receiving a health insurance tax credit or cost sharing reductions as a result of participating in a Health Insurance Exchange, or Marketplace.

Title I includes a range of insurance company accountability requirements, such as the prohibition of lifetime limits on coverage or restrictions due to pre-existing conditions. Title I also includes requirements for certain employers.

An employer may not discharge or in any manner retaliate against an employee because he or she:
- provided information relating to any violation of Title I of the ACA, or any act that he or she reasonably believed to be a violation of Title I of the ACA to the employer, the federal government or a state attorney general;
- testified, assisted, or participated in a proceeding concerning a violation of Title I of the ACA, or is about to do so; or
- objected to or refused to participate in any activity that he or she reasonably believed to be in violation of Title I of the ACA.

In addition, an employer may not discharge or in any manner retaliate against an employee because he or she received a credit under section 36B of the Internal Revenue Code of 1986 or a cost-sharing reduction under section 1402 of the ACA.

If an employer takes retaliatory action against an employee because he or she engaged in any of these protected activities, the employee can file a complaint with the Occupational Safety and Health Administration (OSHA), the agency charged with whistleblower law enforcement.

Unfavorable Employment Actions
An employer may be found to have violated the ACA if the employee's protected activity was a contributing factor in the employer's decision to take unfavorable employment action against the employee. Such actions may include:
- Firing or laying off
- Blacklisting
- Demoting
- Denying overtime or promotion
- Disciplining
- Denying benefits
- Failure to hire or rehire
- Intimidation
- Making threats
- Reassignment affecting prospects for promotion
- Reducing pay or hours

Deadline for Filing Complaints
Complaints must be filed within 180 days after an alleged violation of the ACA occurs. An employee, or representative of an employee, who believes that he or she has been retaliated against in violation of the ACA should file a complaint with OSHA.

ANTI-DISCRIMINATION PROVISIONS

Several provisions of the Affordable Care Act prohibit discrimination including:

SEC. 2716. Prohibition of Discrimination Based On Salary
The plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.

This does not prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.

SEC. 2704. Prohibition of Preexisting Condition Exclusions or Other Discrimination Based On Health Status
A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

SEC. 2701. Fair Health Insurance Premiums
The premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market may vary with respect to the particular plan or coverage involved only by:
- whether such plan or coverage covers an individual or family;
- geographic area;
- age (limitations apply); and
- tobacco use (limitations apply).

SEC. 2705. Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status
A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status related factors in relation to the individual or a dependent of the individual:
(1) Health status
(2) Medical condition (including both physical and mental illnesses)
(3) Claims experience
(4) Receipt of health care
(5) Medical history
(6) Genetic information
(7) Evidence of insurability (including conditions arising out of acts of domestic violence)
(8) Disability
(9) Any other health status related factor determined appropriate by the Secretary

SEC. 2706. Non-Discrimination in Health Care
A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan and health insurance issuer to contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer.

A group health plan, a health insurance issuer, or the Secretary may establish varying reimbursement rates based on quality or performance measures.

SEC. 1557. Nondiscrimination
In 2016, the Department of Health and Human Services (HHS) issued its "Nondiscrimination in Health Programs and Activities" final rule to clarify and expand discrimination protections under Section 1557 of the ACA. Under this final rule, individuals are now protected in health care against discrimination on the basis of:

- Race
- Age
- Color
- Disability
- National Origin
- Sex and Gender Identity

WELLNESS PROGRAMS

The Affordable Care Act creates new incentives and builds on existing wellness programs policies to promote employer wellness programs and encourage opportunities to support healthier workplaces. The Departments of Health and Human Services, Labor and the Treasury have jointly released regulations on wellness programs to reflect the changes to existing wellness provisions made by the Affordable Care Act and to encourage appropriately designed, consumer protective wellness programs in group health coverage. These regulations are effective for plan years starting on or after January 1, 2014.

The regulations divide wellness programs into three categories:
- "Participatory Programs" are those that either do not provide a reward or do not include any conditions for obtaining a reward that are based on an individual satisfying a standard that is related to a health factor. For example, a program that reimburses employees for all or part of the cost of membership in a fitness center or a program that provides a reward to employees for attending a monthly, no-cost health education seminar.
- "Activity-only" programs are those in which an individual is required to perform or complete an activity related to a health factor in order to obtain a reward. Activity-only wellness programs do not require an individual to attain or maintain a specific health outcome. Examples of activity-only wellness programs include walking, diet, or exercise programs.
- "Outcome-based" programs are those in which an individual must attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward.

Protecting Consumers
In order to protect consumers from unfair practices, the regulations require activity-based and outcome-based wellness programs to follow certain rules, including:
1. Individual employees must have the opportunity to qualify for the reward annually;
2. The reward cannot exceed 30% of the total cost of healthcare coverage (with an additional 20% available for programs designed to reduce tobacco use);
3. The program must be reasonably designed to promote health or prevent disease;
4. The full reward must be uniformly available, requiring reasonable alternatives that provides employees identical benefits as the original program; and
5. The employer must provide adequate notice of the plan, its alternatives and the available benefits.

SUMMARY OF BENEFITS AND COVERAGE AND UNIFORMED GLOSSARY

Under the Affordable Care Act, health insurers and group health plans are required to provide Americans who have private insurance with clear, consistent and comparable information about their health plan benefits and coverage. Specifically, the regulations ensure consumers have access to two forms that will help them understand and evaluate their health insurance choices. The forms include:
- An easy to understand summary of benefits and coverage
- A uniform glossary of terms commonly used in health insurance coverage (such as "deductible" and "copayment"

Under the law, insurance companies and group health plans will provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary of benefits and coverage document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. People will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year, and within seven business days of requesting a copy from their health insurance issuer or group health plan.

Plans and issuers are also required to provide notice of modification in any of the terms of the plan or coverage involved that would affect the content of the SBC that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage.

Coverage Examples
This summary of benefits and coverage will include a standardized health plan comparison tool for consumers called "coverage examples," much like the Nutrition Facts label required for packaged foods. The coverage examples would illustrate how a health insurance policy or plan would cover care for common benefits scenarios, using clear standards and guidelines provided by the Centre for Consumer Information and Insurance Oversight (CCIIO). plans and issuers will simulate claims processing for such scenarios so consumers can see an illustration of the coverage they get for their premium dollar under a plan. The examples will help consumers see how valuable the health plan will be at times when they may need the coverage.

Uniform Glossary of Terms
Under the Affordable Care Act, consumers will also have a new resource to help them understand some of the most common but confusing jargon used in health insurance. Insurance companies and group health plans will be required to make available upon request a uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "copayment." To help ensure the document is easily accessible for consumers, the Departments of Health and Human Services (HHS) and Labor will also post the glossary on the new health care reform website, www.HealthCare.gov and www.dol.gov/ebsa/healthreform.

If recipients don't speak English, they should be entitled to receive the SBC and uniform glossary in their native language upon request.

MARKETPLACES AND 4 WAYS TO APPLY FOR COVERAGE

There are four basic ways to apply for health coverage through the Marketplace:
- **Apply online.** Visit HealthCare.gov to get started.
- **Apply by phone.** Call 1-800-318-2596 to apply for a health insurance plan and enroll over the phone. (TTY: 1-855-889-4325)
- **Apply in person.** Visit a trained counselor in your community to get information and apply in person. Find help in your area at LocalHelp.HealthCare.gov.
- **Apply by mail.** Complete a paper application and mail it in. You can download the paper application form and instructions from HealthCare.gov.

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- geographic area;
- age (limitations apply); and
- tobacco use (limitations apply).

SEC. 2705. Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status

(2) Medical condition (including both physical and mental illnesses)

(3) Claims experience

(4) Receipt of health care

(5) Medical history

(6) Genetic information

(7) Evidence of insurability (including conditions arising out of acts of domestic violence)

(8) Disability

(9) Any other health status-related factor determined appropriate by the Secretary

SEC. 2706. Non-Discrimination in Health Care

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan and health insurance issuer to contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer.

A group health plan, a health insurance issuer, or the Secretary may establish varying reimbursement rates based on quality or performance measures.

SEC. 1557. Nondiscrimination

In 2016, the Department of Health and Human Services (HHS) issued its "Nondiscrimination in Health Programs and Activities" final rule to clarify and expand discrimination protections under Section 1557 of the ACA. Under this final rule, individuals are now protected in health care against discrimination on the basis of:

- Race
- Color
- National Origin
- Age
- Disability
- Sex and Gender Identity

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The Affordable Care Act (ACA)

WHISTLEBLOWER NOTICE

The Affordable Care Act (ACA) contains various provisions to make health insurance more affordable and accountable to consumers. To further these goals, the Affordable Care Act's section 1558 provides protection to employees against retaliation by an employer for reporting alleged violations of Title I of the Act or for receiving a health insurance tax credit or cost sharing reductions as a result of participating in a Health Insurance Exchange, or Marketplace.

Title I includes a range of insurance company accountability requirements, such as the prohibition of lifetime limits on coverage or exclusions due to pre-existing conditions. Title I also includes requirements for certain employers.

An employer may not discharge or in any manner retaliate against an employee because he or she:

- provided information relating to any violation of Title I of the ACA, or any act that he or she reasonably believed to be a violation of Title I of the ACA to the employer, the federal government or a state attorney general;
- testified, assisted, or participated in a proceeding concerning a violation of Title I of the ACA, or is about to do so; or
- objected to or refused to participate in any activity that he or she reasonably believed to be in violation of Title I of the ACA.

In addition, an employer may not discharge or in any manner retaliate against an employee because he or she received a credit under section 36B of the Internal Revenue Code of 1986 or a cost-sharing reduction under section 1402 of the ACA.

If an employer takes retaliatory action against an employee because he or she engaged in any of these protected activities, the employee can file a complaint with the Occupational Safety and Health Administration (OSHA), the agency charged with whistleblower law enforcement.

Unfavorable Employment Actions

An employer may be found to have violated the ACA if the employee's protected activity was a contributing factor in the employer's decision to take unfavorable employment action against the employee. Such actions may include:

- Firing or laying off
- Blacklisting
- Demoting
- Denying overtime or promotion
- Disciplining
- Denying benefits
- Failure to hire or rehire
- Intimidation
- Making threats
- Reassignment affecting prospects for promotion
- Reducing pay or hours

Deadline for Filing Complaints

Complaints must be filed within 180 days after an alleged violation of the ACA occurs. An employee, or representative of an employee, who believes that he or she has been retaliated against in violation of the ACA should file a complaint with OSHA.

MARKETPLACES AND 4 WAYS TO APPLY FOR COVERAGE

There are four basic ways to apply for health coverage through the Marketplace:

- **Apply online.** Visit HealthCare.gov to get started.
- **Apply by phone.** Call 1-800-318-2596 to apply for a health insurance plan and enroll over the phone. (TTY: 1-855-889-4325)
- **Apply in person.** Visit a trained counselor in your community to get information and apply in person. Find help in your area at LocalHelp.HealthCare.gov.
- **Apply by mail.** Complete a paper application and mail it in. You can download the paper application form and instructions from HealthCare.gov

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The Affordable Care Act (ACA)

SUMMARY OF BENEFITS AND COVERAGE AND UNIFORMED GLOSSARY

Under the Affordable Care Act, health insurers and group health plans are required to provide Americans who have private insurance with clear, consistent and comparable information about their health plan benefits and coverage. Specifically, the regulations ensure consumers have access to two forms that will help them understand and evaluate their health insurance choices. The forms include:

- An easy-to-understand summary of benefits and coverage
- A uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "copayment"

Under the law, insurance companies and group health plans will provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary of benefits and coverage document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. People will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year, and within seven business days of requesting a copy from their health insurance issuer or group health plan.

Plans and issuers are also required to provide notice of modification in any of the terms of the plan or coverage involved that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage.

Coverage Examples

This summary of benefits and coverage will include a standardized health plan comparison tool for consumers called "coverage examples," much like the Nutrition Facts label required for packaged foods. The coverage examples would illustrate how a health insurance policy or plan would cover care for common benefits scenarios. Using clear standards and guidelines provided by the Center for Consumer Information and Insurance Oversight (CCIIO), plans and issuers will simulate claims processing for each scenario so consumers can see an illustration of the coverage they get for their premium dollar under a plan. The examples will help consumers see how valuable the health plan will be at times when they may need the coverage.

Uniform Glossary of Terms

Under the Affordable Care Act, consumers will also have a new resource to help them understand some of the most common but confusing jargon used in health insurance. Insurance companies and group health plans will be required to make available upon request a uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "copayment." To help ensure the document is easily accessible for consumers, the Departments of Health and Human Services (HHS) and Labor will also post the glossary on the new health care reform website, www.HealthCare.gov and www.dol.gov/ebsa/healthreform.

If recipients don't speak English, they should be entitled to receive the SBC and uniform glossary in their native language upon request.