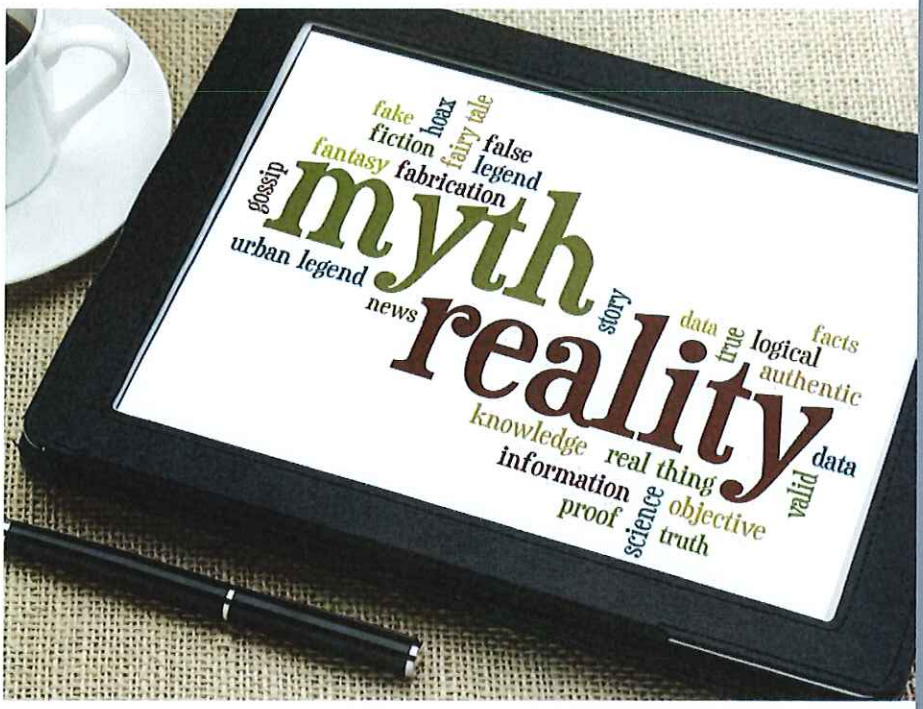
Editor's note: To share this article with your clients, visit www.hiu-digital.com.

THE TOP 10 MISCONCEPTIONS ABOUT PPACA



By Scott M. Stevens, RHU, CDHC
S.M. Stevens and Associates, LLC
Omaha, NE

Over the course of the last three years, I have had both the honor and pleasure of discussing PPACA with a number of organizations, clubs, groups and even a local radio show. Throughout this time, unfortunately, I have encountered a number of misconceptions and misunderstandings relative to several provisions of the law. So I decided to assemble a list of, you guessed it, the top 10 most common PPACA misconceptions that I have come across to date:

1. The public health insurance marketplace/exchange is the only place to purchase individual health insurance in 2014 that is subject to the various PPACA provisions.

False. The new marketplaces are the only places where individual health insurance coverage can be purchased with federal subsidies/tax credits. However, individual health insurance plans purchased off the PPACA marketplace in 2014 contain the same provisions such as guaranteed-issue, no pre-existing condition exclusions, community rating, essential health benefits, limits on out-of-pocket expenses, etc. Coverage purchased off the PPACA marketplace is not subsidy-eligible, though.

THERE IS A SIGNIFICANT DIFFERENCE BETWEEN EMPLOYER SHARED-RESPONSIBILITY EXPOSURE AND ACTUAL PENALTY. IT'S EXTREMELY IMPORTANT FOR AFFECTED EMPLOYERS TO UNDERSTAND, AND PERHAPS EVEN CALCULATE, BOTH.

2. The individual mandate and associated penalty applies to everyone.

False. The individual mandate does not apply to individuals who cannot afford coverage because the cost exceeds eight percent of their household income. It also does not apply to prisoners, Native Americans eligible for care through the Indian Health Service, immigrants who are in the country illegally, people whose religion objects to having insurance coverage, members of a healthcare-sharing ministry and individuals who experience a short coverage gap of less than three consecutive months.

3. All preventive healthcare is covered at 100% per PPACA.

False. PPACA includes a provision that requires (non-grandfathered) health insur-

ance policies to cover certain prescribed preventive healthcare services at 100% (no copay or deductible). Some preventive services ordered by a doctor may not necessarily be included on the list PPACA-prescribed preventive services, thus not covered at 100%. Additionally, insurers are not required to provide 100% coverage for otherwise eligible preventive care that is provided by non-network providers.

4. **All of the PPACA provisions apply/affect all health insurance plans at the same time, regardless of the type of plan, how the plan is insured/funded and when the plan renews.**

False. Certain provisions of PPACA that affect individual and fully insured small-group plans (i.e., fewer than 50 employees) do not affect fully insured large-group plans (i.e., 50 or more employees). Also, group plans that are partially self-funded are not subject to a number of PPACA provisions. (For a blog post on these exceptions, visit http://sstevenshealthcare.blogspot.com/2013/08/aca-compliance-understanding.html.)

So-called grandfathered plans do not have to comply with a number of provisions, provided they continuously maintain grandfathered status. Finally, a health insurance policy's anniversary date determines when certain provisions apply to a plan. Many provisions become effective upon the plan's first anniversary date, "on or after January 1, 2014."

Note: Many small-group plans were offered (and accepted) the option of an "early renewal" effective 12/1/2013. Such plans will not have to comply with a number of PPACA provisions until their plans renew on 12/1/14.

5. **An employer that is subject to the employer shared-responsibility provision (aka, "pay or play" or "the employer mandate") that does not offer affordable coverage at a minimum coverage level is automatically fined/penalized.**

False! False! False! This is perhaps the most misunderstood (and incorrectly explained) provision of the entire law. There are two types of penalties and different amounts associated with each. Both penalties are triggered specifically by at least one employee doing BOTH of the following:

- Verifying and being eligible for a federal subsidy
- Purchasing coverage on the public marketplace/exchange

Unless or until at least one employee takes both of these actions, the employer faces no penalty. There is a significant difference between employer shared-responsibility exposure and actual penalty. It's extremely important for affected employers to understand, and perhaps even calculate, both.

6. **Insurance companies are cancelling certain health insurance policies that are not "PPACA-compliant," leaving customers uninsured.**

True and false. The vast majority of non-grandfathered small-group (fully insured) and individual policies in place prior to 2014 do not meet several PPACA requirements (e.g., community rating, 10 essential health benefits, out-of-pocket maximum, etc.). In order to be compliant with the law, insurance companies sent "cancel and replace" notices to affected customers, and replaced those policies with PPACA-compliant coverage. Customers were offered a plan that is closest to what was in place, along with some alternative plan designs. In many cases, because the PPACA requirements increase the cost of coverage, the replacement/alternative plans include higher out-of-pocket limits and/or higher premiums. So, yes, policies are being cancelled, but customers are being offered replacement coverage in order to prevent them from being uninsured.

Note: Regarding the president's announcement giving states the option of maintaining otherwise non-compliant plans through 2014, it is uncertain whether there is sufficient time or practical ability for insurers to "roll back" their renewal offers to existing clients and modify their plans/rates set to be offered for 2014 effective dates. Each state had to decide whether to pursue the president's offer/allowance. For the latest info as of press time, see www.nahu.org/education/programs/ACACancellationFixDecisionsbyRegion11_22_13.pdf?ibcToken=65143d87-1e63-e311-b7cb-005056a75a90.

7. **An individual who meets the PPACA Federal Poverty Level income requirement is automatically eligible for a subsidy for health insurance coverage purchased off a public marketplace/exchange.**

False. An individual who works 30 hours or week or more for an employer of any size that offers health insurance that meets PPACA's affordability and minimum coverage requirements is NOT eligible for a subsidy, regardless of his income. This does not mean that affected employees are forced to accept their employer's health insurance coverage offering. Such individuals can still purchase alternative coverage (e.g., spouse's plan, individual health insurance coverage purchases on or off the marketplace/exchange, Medicare, Tricare, etc.). They simply are not eligible for a subsidy. In most cases, if an employee opts to decline his employer's health insurance offering, he forfeits the employer's premium contribution.

8. **The employer mandate compels employers with 50 or more full-time (30 hours per week) employees to offer health insurance coverage to an employee and all of their dependents or face penalty exposure.**

False. This provision of PPACA addresses the offering of health insurance to eligible employees and "their dependents under the age of 26." Employers are not required to offer coverage to the spouses of their employees. As a result, some employers

Continued on page 47

MISCONCEPTIONS ABOUT PPACA

Continued from page 45

are considering limiting the offer of health insurance benefits to only their employees and eligible dependents. UPS recently announced that it is no longer extending the offering of coverage to employees' spouses. In addition, some employers are requiring employees who choose to include their spouse on their plan to pay significantly more premium IF their spouse is eligible for coverage through their employer.

9. PPACA will be funded exclusively by a combination of fines/penalties placed on individuals and employers and additional taxes assessed on health insurance companies.

True and false. While it is true that PPACA relies on revenue generated from fines imposed on both individuals and employers, along with a number of new taxes assessed on insurance companies and self-funded employers, there are several other new fees and taxes associated with PPACA funding.

The Chamber of Commerce has published a list of 18 specific PPACA fees, penalties and loss of tax deductions (see www.uschamber.com/sites/default/files/issues/health/LABR_HealthCareTaxChart_FIN.pdf), which, combined with other sources of funding, are projected to provide the necessary funding of PPACA. These include separate taxes for things like artificial tanning and medical devices. The cost of PPACA is projected by the Congressional Budget Office to be $1.7 trillion over a 10-year period. And there is much disagreement over the potential effects of PPACA on the federal budget deficit. Suffice it to say, PPACA will draw from a number of funding sources in order to fulfill its intended purpose and objective.

NOTE: It is estimated that the one-year delay in the imposition of the employer mandate will result in up to $11 billion in lost employer fine revenue.

10. PPACA's minimum loss ratio provision requires insurance companies to issue refunds to each affected policyholder if the claims paid out on their specific policy were less than 80% of the premiums collected (or 85% for large-group customers).

False. While PPACA does include the referenced MLR provision, which requires insurance companies to issue refunds to customers if the claims paid amount is less than the applicable premium collected percentage (80% or 85%), the refunds ARE NOT POLICY-SPECIFIC. Insurance companies are allowed to pool their insured customers together into approved "blocks" of business and, based on the performance of these blocks of business, the insurers are required to calculate claims to premium ratios and, if applicable, issue refunds. So while a particular insured individual or employer group may actually have a claims-to-premium loss ratio that is less than 80% (or 85%), if the block of business they are a part of meets or exceeds the 80% (or 85%) figure, there is no refund payable.

The upshot of all this: There's a tremendous amount of information pertaining to PPACA that must be read, understood, translated and communicated to our clients! HIU