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Provided herein is a summary of some recent developments regarding the implementation of the Affordable Care Act (“ACA”).

Medicaid Expansion
It is still uncertain whether Ohio will join the twenty-three states and the District of Columbia in opting to expand Medicaid enrollment. With no strict deadline looming, Ohio is among five other states — Michigan, Indiana, New Hampshire, Pennsylvania and Tennessee — remaining “undecided” on whether to expand Medicaid eligibility up to 133 percent of the federal poverty guidelines, or approximately $30,000 for a family of four. Approximately 275,000 low-income Ohioans will be eligible for Medicaid coverage, if the expansion is approved.

Gov. Kasich continues to urge the Ohio General Assembly to approve the expansion in order to be ready by January 1, 2014, so that Ohio may receive federal funds under the Affordable Care Act. These funds will pay for 100 percent of the cost of expansion through 2016. In 2017, the funding will begin to decline until it reaches 90 percent by 2020. However, Gov. Kasich is still met with resistance from fellow Republicans, as they see the expansion as costly, ineffective and unnecessary. His opponents are also skeptical of the government’s ability to maintain its share of Medicaid spending.

Recently, Gov. Kasich vetoed a budget provision that would have prevented the Medicaid expansion. He remains adamant that the expansion will be inevitable, and continues to press his colleagues to make a decision by fall, when states are permitted to opt-in on a quarterly basis. Some project a change in politics might occur, after midterm elections, allowing Kasich to push through the expansion at that time.

ACA Exchanges
Although Gov. Kasich may be a proponent for the Medicaid expansion, he remains skeptical of other aspects of the ACA. The Kasich administration continues to take a “hands off” approach to implementing the new online marketplaces, or exchanges. The exchanges will allow those who live at or above the poverty line, who do not receive health insurance coverage through their employers or a public program, to purchase federally subsidized health insurance through online marketplaces in each state. Open enrollment is slated to begin October 1, 2013, and coverage purchased through the exchanges will be effective January 1, 2014.

Many physicians are likely curious as to how to educate their patients on the options to obtain coverage through the exchanges. As of yet, Ohio has no plans to market or advertise the exchanges, leaving some of the burden on physicians to explain to an estimated 1.5 million uninsured Ohioans what options might be available for insurance coverage. The simplest advice you can give your patients is to have them visit: www.healthcare.gov, which is the federal government sponsored website with answers to most questions. Many health insurers are also providing education on the subject.

Also with respect to the health exchanges, Ohio insurance regulators recently released rates for health insurance to be sold through the online market places. Although Ohio rejected a state-run exchange, the Ohio Insurance Department nevertheless reviewed health plans insurers are expecting to sell on the federal exchange. According to a press release submitted by the Ohio Department of Insurance, fourteen insurance companies submitted proposed rates for 214 different plans. The premiums that were submitted ranged from $282.51 to $577.40 per month.

The average premium per month for individuals is expected to be $332.58, compared to the previous state average premium of $236.00. Some argue this rise in cost is evidence of how the ACA will hurt the Ohio economy — and how the ACA does not in fact lower the costs of health care. However, proponents of the ACA highlight that the average premium rate in 2013 is based in part on the inclusion of minimum coverage policies, which would not qualify as being acceptable under the ACA. As such, proponents of the ACA would argue we cannot compare last year premium averages to next year’s averages, wherein the coverage provided next year will meet higher standards.

The averages for next year’s premiums, under the exchange, are also affected by the wide range of plans available. The ACA sets forth different coverage levels: bronze, silver, gold and platinum — all of which are acceptable. It is anticipated that most individuals will purchase bronze and silver plans, because they cost less, creating a lower average premium projection for those plans that are likely to be the most popular.

Penalties and Reporting Requirements
On July 2, 2013, the Obama Administration announced a delay in the penalties and reporting requirements of the Employer Shared Responsibilities provisions of the ACA, until 2015. The decision to delay these requirements was in response to concerns with the complexity of the proposed Shared Responsibility regulations, in light of impending deadlines. The regulations had required businesses with more than fifty “full-time” employees to provide insurance to their workers or pay a penalty — starting in January 2014. That deadline is now delayed by one year.

Importantly, this delay does not change the individual mandate requiring individuals to purchase insurance by January 1, 2014. Accordingly, even though employees may not be covered by their employer plans, those employees still need to find insurance coverage.

Also on the subject of the employer mandate, on August 2, 2013, U.S. Representative Dan Lipinski introduced “The Forty Hours Is Full Time Act of 2013” (H.R. 2988) designed to take away the unintended incentive, created in the ACA, for employers to cut the hours of employees to circumvent reporting requirements. The proposed Bill serves to change the definition of “full-time employment” from thirty to forty hours per week, when applying the employer mandate. The hope is that employees do not lose hours of work and/or opportunities to work — by seeing their weekly hours fall to 29 hours per week — which under current law would help an employer avoid the expense of providing insurance to its employees.

The 80/20 Rule
Under the ACA, health insurance companies are required to disclose how much of the patient’s premium dollar was actually spent on health care, and how much they spent on administration, such as salaries and marketing. Under the ACA, if the insurance company spends less than 80 percent on medical care, it must rebate the excess to consumers. In other words, companies are not permitted to keep more than 20 percent of insurance premiums for business costs /profit.
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The ACA rebates will provide partial premium repayment for an estimated 8.5 to 12.8 million Americans this summer — according to the U.S. Health and Human Services Department. The refund will result in approximately $1.1 billion in funds being returned to consumers. The average American family is expected to receive around $100 in insurance premium dollars returned. Many of your patients have likely already received their rebate.

For further information regarding the ACA and/or issues that may be specific to your practice, please do not hesitate to contact David A. Valent, Esq. or Amanda M. Gatti, Esq., at Reminger Co., L.P.A.: dvalent@reminger.com; agatti@reminger.com.