The Affordable Care Act:

What Employers Need to Know

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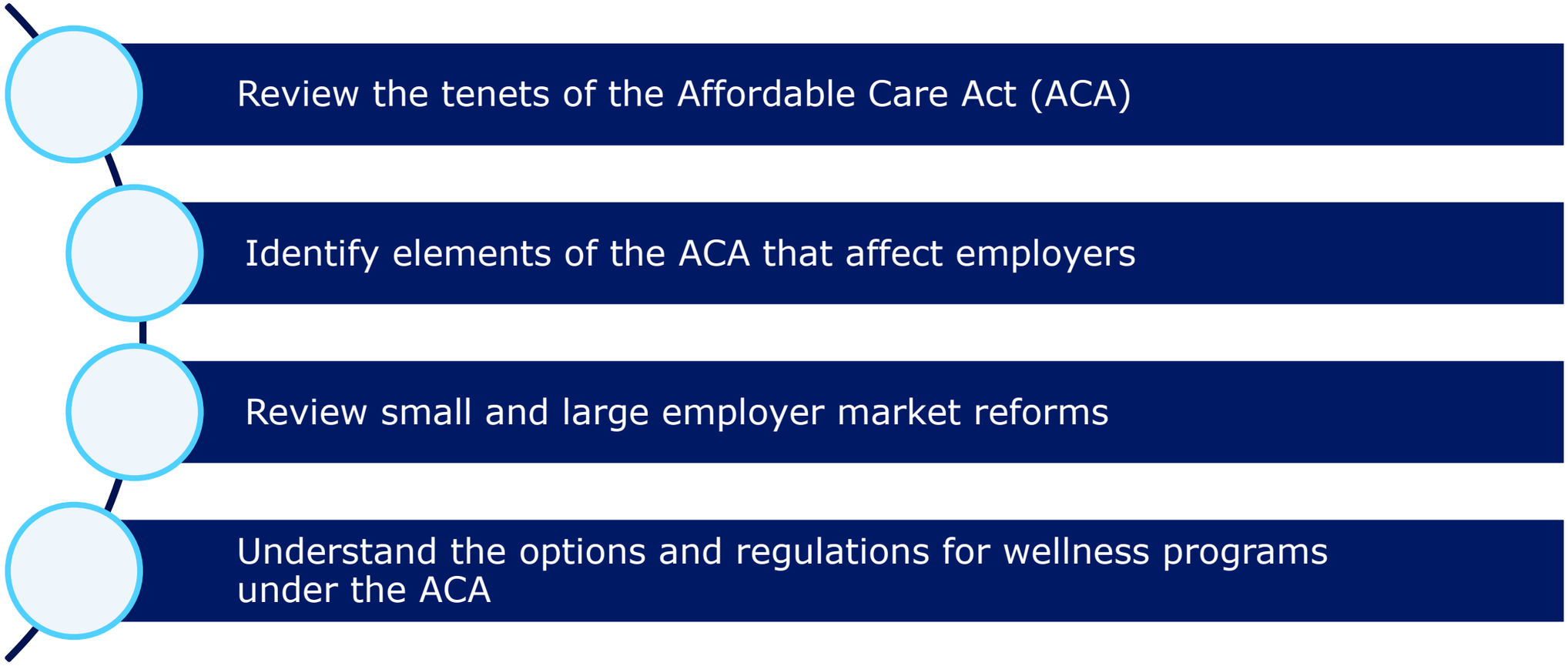
Presenter's Disclosure

This presentation, due to time limitations, is not a complete overview of the ACA and its attendant impact on employers. Moreover, this presentation has been provided for informational purposes only and is not intended and should not be construed to constitute legal advice. Please consult your attorneys with any fact-specific situation under federal, state and/or local laws that may impose obligations on you and your company.

Objectives


Review the tenets of the Affordable Care Act (ACA)
Identify elements of the ACA that affect employers
Review small and large employer market reforms
Understand the options and regulations for wellness programs under the ACA

Basic Tenets of Health Care Reform

- Reform Existing Insurance Laws
  - Mandate standards (eg, essential health benefits, actuarial value, cost-sharing limitations, Grandfather Rules, employer mandate, medical loss ratios, rescission and internal/external reviews)[1]
- Expand Coverage
  - Medicaid expansion (26 states including DC, 6 states open debate, and 19 states not moving forward)[2]
  - Premium subsidies for low to middle income Americans to purchase health insurance vis-à-vis the public exchange (16 states and DC with state-based marketplace, seven states with partnership marketplace, and 27 states with federally facilitated marketplace)[3,4]
  - Individual mandate[3]

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References: **1.** Centers for Medicare and Medicaid Services. 2014. The Center for Consumer Information & Insurance Oversight: Health Insurance Market Reforms. CMS website. http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/. Accessed March 7, 2014. **2.** Kaiser Family Foundation. 2014. Status of State Action on the Medicaid Expansion Decision, 2014. Kaiser Family Foundation website. http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. Accessed March 7, 2014. **3.** Furrow, B et al., *Health Law: Cases, Materials and Problems*, Seventh Edition. St. Paul, MN: West Publishing; 2013. **4.** Kaiser Family Foundation. 2014. State Decisions For Creating Health Insurance Marketplaces, 2014. Kaiser Family Foundation website. http://kff.org/health-reform/state-indicator/health-insurance-exchanges/. Accessed March 7, 2014.

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Selective Aspects of the ACA

No underwriting based on health status[1]

No pre-existing condition exclusions[1]

Dependent children covered up to age 26[2]

No annual lifetime limits[3]

No cost-sharing for certain preventive services[1]

Requirements to provide comprehensive coverage (eg, essential health benefits (fully insured), metal levels and cost-sharing limitations)[1]

90-day maximum waiting period[2]

References: 1. Barry R. Furrow et al., Health Law: Cases, Materials and Problems, Seventh Edition, (West Publishing 2013). 2. Federal Register. Shared Responsibility for Employers Regarding Health Coverage. Vol. 79. No. 29. February. 10, 2014, https://federalregister.gov/a/2014-03082. 3. Centers for Medicare and Medicaid Services. 2014. The Center for Consumer Information & Insurance Oversight: Health Insurance Market Reforms. CMS website. http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/. Accessed March 7, 2014.

New Notice and Disclosure Requirements

- Reporting cost of coverage on Form W-2[1]
  - Effective now and applies to employers that filed more than 250 W-2s in the prior year
- Summary of Benefits and Coverage (SBCs)[2]
  - Effective now
- Exchange notice
  - Employers must have furnished by October 1, 2013[3]
  - Also, must furnish to new employees within 14 days of start date (DOL – no penalty for failure to provide notice) [3,4]
- Reporting health coverage to the IRS[5]
  - Delayed until January 1, 2015

References: **1.** Internal Revenue Service. 2013. Form W-2 Reporting of Employer-Sponsored Health Coverage. IRS website. http://www.irs.gov/uac/Form-W-2-Reporting-of-Employer-Sponsored-Health-Coverage. Accessed March 3, 2014. **2.** Federal Register. Summary of Benefits and Coverage and Uniform Glossary. Vol. 77. No. 30. February 14, 2012. http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=25818. Accessed March 7, 2014. **3.** U.S. Department of Labor. FAQ on Notice of Coverage Options. DOL website. http://www.dol.gov/ebsa/faqs/faq-noticeofcoverageoptions.html. Accessed April 17, 2014. **4.** US Department of Labor, 2013, Technical Release No. 2013-02, DOL website, http://www.dol.gov/ebsa/newsroom/tr13-02.html. Accessed March 3, 2014. **5.** Schreiber, Sally. Simplified employer health coverage reporting announced. Journal of Accounting. http://www.journalofaccountancy.com/News/20149733.htm. Accessed April 17, 2014.

Taxes and Fees

PCORI Excise Tax

Fully and self-insured plans

- $2 per covered life in 2014[1]
- Indexed to CPI annually (tax will end with 2018 plan year)[1]

Insurer Excise Tax

Fully insured plans only

- Estimate based on carrier market share[2]
- Adds an estimated aggregate fee of $3.3 billion in 2016[2]
- Will likely increase 2016 through 2019[2]

Reinsurance Fee

Fully and self-insured plans

- $44 per covered life in 2015[3]

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References: **1.** Federal Register. Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust Fund. Vol. 77. No. 235. December 6, 2012. pdf. http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf. Accessed April 30, 2014. **2**. Federal Register. Health Insurance Providers Fee. Vol. 78. No. 42. March 4, 2013). http://www.gpo.gov/fdsys/pkg/FR-2013-03-04/pdf/2013-04836.pdf. Accessed March 7, 2014. **3.** Federal Register. Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2015. Vol. 79. No 47. March 11, 2014. https://federalregister.gov/a/2014-05052. Accessed March 7, 2014.

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Taxes and Fees (cont'd)[1]

"Cadillac Tax" (2018 and beyond)

Fully and self-insured plans

- 40% excise tax on plan values:
  - $10,200 / single
  - $27,500 / family
- Qualified retirees
- Electrical or telecommunications repair person
- Law enforcement or fire protection workers
- Out-of-hospital emergency medical providers
- Persons engaged in construction, mining, agriculture, forestry, and fishing industries
- Adjusted plan values
  - $11,850 / single
  - $30,950 / family

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Reference: **1.** 26 USC § 4980I - Excise Tax On High Cost Employer-Sponsored Health Coverage

Taxes and Fees (cont'd)

Medicare Surtax

- 0.9% on wages (applies to individual filers with $200,000 or more modified adjusted gross income (MAGI) or joint filers with $250,000 or more MAGI)[1]
- 3.8% on non-wage income[2]

Individual Responsibility Tax

- Once fully phased in by 2016, the greater of $695 for each adult and half that amount for each child in the household, up to $2,085 for a family (updated for inflation)[3]
- Or 2.5% of household income above the filing limit[3]
- For 2014, the penalty is $95 per person (half that amount for a child) or 1% of the family income[3]

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References: **1.** Internal Revenue Service. 2013. Questions and Answers for the Additional Medicare Tax. IRS website. http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Questions-and-Answers-for-the-Additional-Medicare-Tax. Accessed March 3, 2014. **2.** American Institute of CPAs. Estate and Trust Impact of 3.8% net investment income tax. AICPA website. http://www.aicpa.org/interestareas/tax/resources/trustestateandgift/toolsandaids/pages/estateandtrustimpactof38medicaresurtax.aspx. Accessed April 7, 2014. **3**. Federal Register. Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage. Vol.78. No. 169. August 27, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21157.pdf. Accessed March 3, 2014.

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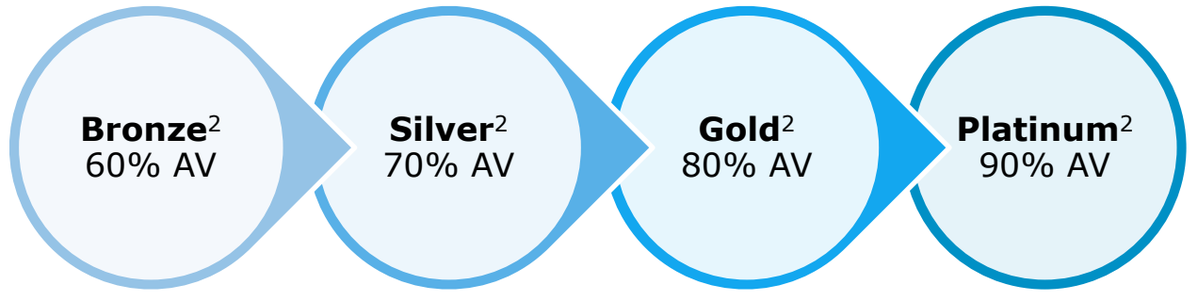
Small Group Market Reforms

- In 2016, small employers will be defined as 1-100 employees[1]
  - Congress allowed states to maintain their current definition of 1 (or 2) to 50 employees until 2016
- All fully insured, small group plans must cover 10 enumerated medical services (essential health benefits)[2]
- Metal levels of coverage that meet an actuarial value (AV) +/- 2%[2]



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References: 1.. Federal Register. Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014. Vol. 78. No. 210. October 13, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-10-30/pdf/2013-25326.pdf. Accessed March 3, 2014. **2.** Federal Register. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Vol. 78. No. 37. February 25, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf. Accessed March 7, 2014.

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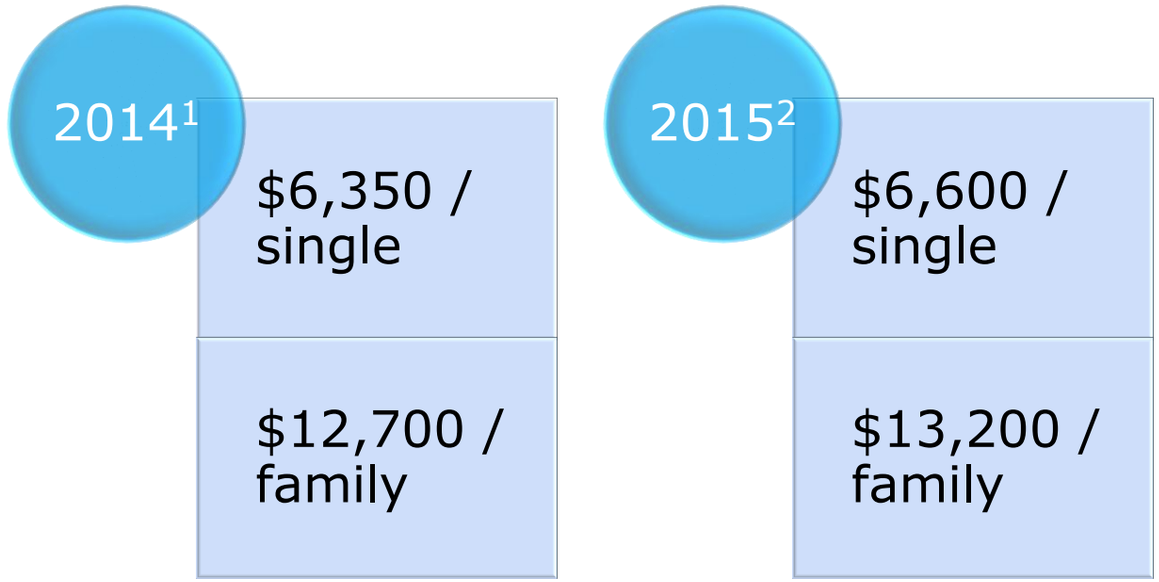
Small Group Market Reforms (cont'd)

Cost-sharing Limitations[1]

The aggregate amount spent on deductibles, co-payments and coinsurance cannot exceed the maximum OOP limits for a high deductible health plan defined under the health savings account (HSA) rule. Cost-sharing does not include premiums, spending for non-covered services or balance billing amounts for non-network providers



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References: **1**. US Department of Labor, January 9, 2014, FAQs Affordable Care Act Implementation(Part XVIII), DOL website, http://www.dol.gov/ebsa/faqs/faq-aca18.html. Accessed March 3, 2014. **2.** Center for Medicare and Medicaid Services. HHS 2015 Health Policy Standards Fact Sheet. CMS website. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-03-05-2.html. Accessed April 29, 2014.

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Small Group Market Reforms (cont'd)

- Small group annual deductible must not be more than $2,000 / single; $4,000 / family[1]
  - HHS guidance permits an insurance company to increase these deductibles if doing so would allow the plan to meet a specified AV[1]
  - Employees can increase the deductible by the amount of their HAS contributions[1]
- Premium Rating Rule
  - Insurance companies prohibited from setting premiums based on health status[2]
- Premium rate may only vary by:[3]
  1. Age (3:1 ratio)
  2. Tobacco use (1.5:1 ratio)
  3. Single or family coverage
  4. Rating area (geography)

References: **1.** Federal Register. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Vol. 78. No. 37. February 25, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf. Accesed March 7, 2014. 2. Public Health Services Act, Title XXVII, Part A, Sec. 2701m as ammened by Patietn Protection and Affordable Care Act, Title 1, Subtitle C, Sec. 1201. **3.** Kaiser Family Foundation. Focus on Health Reform. Health Insurance Market Reforms: Rate Restrictions. KFF website. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8328.pdf. Accessed April 17, 2014/

Small Group Market Reforms (cont'd)

- Risk Pooling
  - All employees of small employers in the small group market are treated as a single risk pool (pooled by the insurance company) regardless of where coverage is obtained(eg, health risks inside and outside of the SHOP Exchange will be pooled)[1]

References: **1.** Patient Protection and Affordable Care Act, Title I, Subtitle D, sec. 1312.

Large Group Market Reforms

- Out-of-pocket Maximum Transition Rule[1]
  - Beginning in 2014, fully insured small and large group plans, along with self-insured plans of any size are subject to an out-of-pocket (OOP) maximum of $6,350 for single and $12,700 for family coverage (same as small groups)[1]
- For 2014 only:
  - The OOP maximum does not have to be an integrated accumulation between pharmacy and medical group plans[1]
    - For group plans without existing Rx MOOP, no Rx MOOP is required for the 2014 plan year[1]
    - Both pharmacy and medical can have independent accumulations up to the limit[1]
    - ACA-affected plans (non-grandfathered) will need a pharmacy-only MOOP set up within their benefit plans[1]

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Reference: 1. US Department of Labor. 2014. FAQs Affordable Care Act Implementation (Part XVIII). DOL website. http://www.dol.gov/ebsa/faqs/faq-aca18.html. Accessed March 3, 2014.

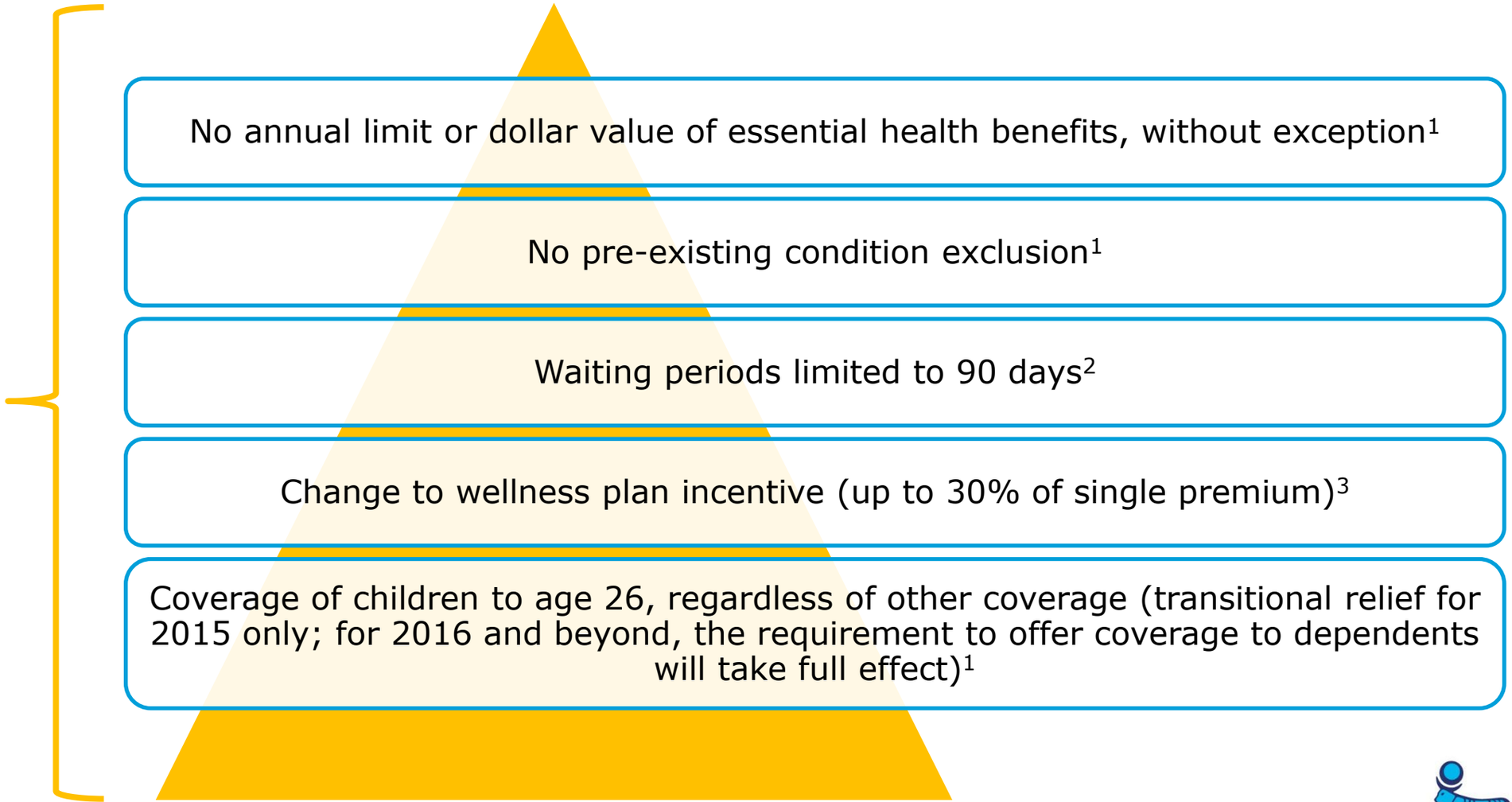
Large Group Market Reforms (cont'd)

- For 2015:
  - In 2015, the out-of-pocket maximum increases to $6,600 for single and $13,200 for family coverage (same as small groups)[1]
  - A safe harbor delays MOOP requirements for most group plans to plan years beginning January 1, 2015 or after[2]
    - Group plans will be required to have an integrated member OOP limit (pharmacy and medical); or
    - Allocate the annual limit on out-of-pocket costs across multiple categories of benefits, rather than reconcile claims across multiple service providers

References: **1.** Federal Register. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, Vol. 79, No. 47. March 11, 2014. https://federalregister.gov/a/2014-05052. Accessed March 3, 2014. **2.** US Department of Labor. 2014. FAQs Affordable Care Act Implementation (Part XVIII). DOL website. http://www.dol.gov/ebsa/faqs/faq-aca18.html. Accessed March 3, 2014.

Mandate for Grandfathered and Non-grandfathered Plans

Generally, plan years beginning on or after January 1, 2014.[1]



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References: **1.** Furrow B et al., *Health Law: Cases, Materials and Problems*. Seventh Edition. St. Paul, MN: West Publishing; 2013. **2.** Federal Register. Incentives for nondiscriminatory wellness programs in group health plans. Vol. 78. No 106. June 3, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-06-03/pdf/2013-12916.pdf. Accessed March 7, 2014. **3.** Patient Protection and Coverage Act, Title I, Subtitle D, Section 2708.

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Additional Mandates for Non-grandfathered Plans Only

- Limits on deductible and out-of-pocket maximums[1]
- Nondiscrimination for insured plans determined under IRC 105(h)[2]
- Internal and external appeals process rules[1]
- Coverage of in-network preventive services without cost sharing[1]
- Special rules on choosing a primary care provider[1]
- No prior authorization for OB-GYN visits[1]
- Coverage of out-of-network emergency services using in-network cost sharing and no prior authorization requirement[1]
- Coverage of treatment for those in clinical trials[1]

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References: **1.** Furrow B et al., *Health Law: Cases, Materials and Problems*. Seventh Edition. St. Paul, MN: West Publishing;2013. **2.** Internal Revenue Service. 2011. Notice 2011-1: Affordable Care Act Nondiscrimination Provisions Applicable to Insured Group Health Plans. IRS website. http://www.irs.gov/pub/irs-drop/n-11-01.pdf. Accessed March 3, 2014.

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Employer Mandate
(Shared Responsibility)[1]

- On February 12, 2014, the IRS issued final regulations
- Mandate applies to "Applicable Large Employers" with 50 or more FTEs (for 2015, employers with 50-99 employees will be given transitional relief). Employers are subject to a tax penalty if:

1	The employer is not offering health coverage to at least 95% of its full-time employees (70% of FTEs for 2015 only) and their dependent children younger than age 26 (D26 rule transitional period until 2016)
2	The employer offers coverage, but the coverage is unaffordable or does not provide "minimum value"
3	The tax penalty is only triggered if an employee purchases health insurance through the exchange and accesses a premium subsidy

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Reference: 1. Federal Register. Shared Responsibility for Employers Regarding Health Coverage. Vol. 79. No. 29. February 10, 2014. https://federalregister.gov/a/2014-03082. Accessed March 3, 2014.

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Employer Mandate
(Shared Responsibility cont'd)

- Footnotes:
  a) If the employer offers multiple health care coverage options, the affordability test applies to the lowest cost option available to the employee that also meets the minimum value requirement[1]
  b) On April 30, 2013, the IRS issued a proposed rule that prohibits employers from using incentives offered through most wellness programs for purposes of calculating the "affordability" or "minimum value"[2]
    - Exception for tobacco cessation programs[2]
    - Transitional rule until 2015[2]

References: **1.** Federal Register. Shared Responsibility for Employers Regarding Health Coverage. Vol. 79. No. 29. February 10, 2014. https://federalregister.gov/a/2014-03082. Accessed March 3, 2014. . **2.** Federal Register. Minimum Value of Eligible Employer Sponsored Pans and Other Rules Regarding the Health Insurance Premium Tax Credit. Vol. 78. No. 29. proposed April 30, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-05-03/pdf/2013-10463.pdf. Accessed March7, 2014.

Penalty for Failure to Offer Coverage[1]

$2,000 x number of actual FTEs minus 30 x 1/12 for each month health coverage was not offered

Assessed only if FTE receives a premium subsidy to purchase coverage through the exchange or "marketplace"

If employee was offered coverage, but declined, his or her waiver will not trigger a penalty even if he or she enrolls in a plan on the exchange

Transitional Relief

- For 2015 and any calendar-year months that fall within the employer's 2015 plan year, if an employer with 100 or more FTEs is subject to a 4980(a) penalty, then the penalty calculation will be made after subtracting the employer's allocable share of 80 full-time employees instead of 30

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Reference: 1. Federal Register. Shared Responsibility for Employers Regarding Health Coverage. Vol. 79. No. 29. February 10, 2014. https://federalregister.gov/a/2014-03082. Accessed March 3, 2014.

Penalty for Unaffordable or Less than Minimum Value Coverage[1]

- $3,000 x actual number of FTEs who received a federal premium subsidy x 1/12 for each month health coverage is not affordable
- The penalty for any calendar month is capped at the penalty the employer would have paid had it not offered coverage
- To calculate minimum value, an MV calculator is available at http://cciio.cms.gov/resources/regulations/index/html/#pm

Reference: 1. Federal Register. Shared Responsibility for Employers Regarding Health Coverage. Vol. 79. No. 29. February 10, 2014. https://federalregister.gov/a/2014-03082. Accessed March 3, 2014.

Penalties Imposed on Employers with 100 or More Employees[1]

- Determining "Applicable Large Employers" Status
  - A full-time employee who works 30 or more hours per week during a calendar month; or at least 130 hours per month
  - Part-time employees are aggregated together on a pro rata basis to equal full-time equivalent employees (eg, if people work less than 30 hours per week, add up all the hours worked and divide by 120)
  - Add these numbers together
  - Include hours actually worked plus hours for which the employee is entitled to pay because of sick leave, holiday, vacation, military duty, etc.
- Effective January 1, 2015
- Penalties are not tax deductible

Note: a "seasonal worker," as defined under DOL regulations and works 120 or fewer calendar days, may be excluded from this calculation

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Reference: **1.** Federal Register. Shared Responsibility for Employers Regarding Health Coverage. Vol. 79. No. 29. February 10, 2014. https://federalregister.gov/a/2014-03082. Accessed March 3, 2014.

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What about "Variable Hour" Employees?

- If an employer cannot reasonably determine that someone will work 30 or more hours per week, the employer can treat him or her as a "VH" employee. The final regulations allow employers to use a look-back measurement method to determine full-time status[1]
- The duration of the "stability period" must be at least the greater of 6 consecutive calendar months or the length of the "standard measurement" period[1]
- Transition Relief: For "stability periods" that begin in 2015, even those that are 12 months, employers may use a transition "measurement period" that is 6 months[1]

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Reference: 1. Federal Register. Shared Responsibility for Employers Regarding Health Coverage. Vol. 79. No. 29. February 10, 2014. https://federalregister.gov/a/2014-03082. Accessed March 3, 2014.

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General Rule Regarding Subsidies[1]

- An individual is not eligible for subsidies offered through the Exchange if he or she is "eligible" for employer-sponsored coverage
- Exception: The employer-sponsored coverage is either unaffordable or does not provide minimum value. Under the exception, the employee may opt out of employer coverage, go to the Exchange for coverage, and depending on his or her income, access the subsidies[1]

Reference: **1.** Furrow B et al., *Health Law: Cases, Materials and Problems* Seventh Edition. St. Paul, MN: West Publishing;2013.

An Individual is Eligible for Premium Subsidies if:[1]

- Household income is between 133% and 400% of the federal poverty level
- The individual is not enrolled in the employee's group health plan
- The individual's required premium contribution for his or her employer group health plan exceeds 9.5% of the individual's household income or the employer plan's share of covered health expenses is less than 60%

Reference: **1.** Furrow B et al. *Health Law: Cases, Materials and Problems* Seventh Edition. St. Paul, MN: West Publishing;2013

Automatic Enrollment[1]
(Estimated release date of regulation is undetermined)

- ACA requires employers with more than 200 FTEs that offer health coverage to automatically enroll new FTEs in a coverage option
- Existing elections for current FTEs must also automatically continue on a yearly basis
- Employers are not required to comply with this provision until regulations are issued

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Reference: 1. US Department of Labor. Technical Release No. 2012-01, Frequently asked questions from employers regarding automatic enrollment, employer shared responsibility, and waiting periods. February 2012. US DOL website. http://www.dol.gov/ebsa/newsroom/tr12-01.html. Accessed March 3, 2014.

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Wellness Programs Under ACA

Five requirements for wellness programs that provide rewards:[1]

1. The reward may not exceed 30% of the cost of individual coverage
2. The program must be designed to promote health or prevent disease
3. The program must give eligible individuals the opportunity to qualify for the reward at least once per year
4. The reward must be available to all similarly situated individuals and must provide a reasonable alternative standard to obtain the reward for individuals who cannot meet the standard due to a medical condition
5. The program must disclose the availability of the alternative standard

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Reference: 1. Federal Register. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, Vol. 78 No. 106. June 3, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-06-03/pdf/2013-12916.pdf. Accessed March 7, 2014.

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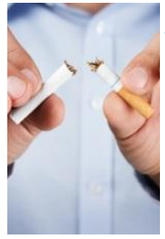
Wellness Programs Under ACA

Wellness program activities recognized under the ACA include:[1]

Wellness and prevention efforts



Smoking cessation

Weight management

Diabetes prevention

Physical fitness

Health Coaching

Heart disease prevention

Health Education Seminars

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Reference: 1. Federal Register. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, Vol. 79. No. 1=6. June 3, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-06-03/pdf/2013-12916.pdf. Accessed March 7, 2014.

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Hypothetical Example

Problem: Designing a Corporate Wellness Program

Susan Ross, the corporate benefits manager at Acme Incorporated, would like to give employees a substantial discount on their premium contribution to health insurance if they participate in the program. In particular, Susan has proposed to the VP of Human Resources giving each employee who participates a 10% discount on that employee's health insurance premium for each one of the following "wellness opportunities" that employees undertake during the initial pilot year.

Hypothetical Corporate Wellness Program Details

1. A smoking cessation program, with the discount available to anyone who does not smoke or who successfully completes the program
2. A “maintaining appropriate body weight” program, with the discount available to anyone who maintains a proper body weight or who makes substantial progress toward maintaining a proper body weight during the program
3. An immunization program, with the discount available to any employee who has received every medically recommended immunization
4. A basic care program, with the discount available to anyone who visits a primary care provider at least once during the year
5. A basic safety program, with the discount available to anyone who agrees not to own or ride on a motorcycle, bicycle, skidoo or seadoo, or engage in any dangerous sport (eg, skiing and diving)
6. Another 5% discount on the premium to an employee if for 6 months neither the employee nor a family member uses medical care covered by the health plan

Hypothetical Corporate Wellness Program Issue

- The proposed program was leaked to employees before the VP of Human Resources and the General Counsel had a chance to review and approve or disapprove all or part of the proposal.
- Several employees have complained about the contours of the proposed program:
    1. An overweight employee has a letter from a website from which he purchased a genetic test. The test says his obesity is at least in part, due to genetic factors
    2. A few employees object to the immunization program because they have decided to forgo immunizations (for themselves and their children) for religious, medical, or philosophical reasons
    3. A Christian Scientist objects to the requirement that he see a primary care provider regularly to partake in the discount
    4. An employee who just bought a time share in a ski resort argues that it would be unfair to create the basic safety program
    5. A pregnant employee argues that she will be excluded from some potential reward activities because of her pregnancy

Hypothetical Corporate Wellness Program Resolution

Questions:

1. Can Susan Ross institute these wellness programs and give premium discounts (assuming she has authorization from the VP of Human Resources and Legal)?
2. How would you structure these programs to make them consistent with the limitations of the ACA?

QUESTIONS, ANSWERS, & CLOSING COMMENTS

THANK YOU!

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