PREPARING FOR HEALTH CARE REFORM IN 2013 AND 2014

The Affordable Care Act (ACA) brings significant and sweeping changes to how Americans access and pay for health care. Our goal is to help you understand what health reform means to you and your employees.

As regulations, mandates and laws become effective over the next months and years, it's important to know where to begin and what to focus on.

Focusing on Key Changes:

Expanded Benefits

The health reform law defines certain categories of benefits as Essential Health Benefits (EHB) as outlined below. Small groups are required to include these benefits in their plan designs. Large and self-funded groups are not required to offer EHB, however, if they do include them, annual and lifetime dollar limits must be removed.

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavorial health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

• A couple significant changes are the introduction of pediatric dental and vision and habilitative coverage. Habilitative coverage is a health services that allows a patient to acquire a functional skill that should be present but is absent due to sickness or injury.

• Preventive services with no cost were expanded to include women's preventive services, such as contraceptives, prenatal and expanded screenings.

• Employers will be required to provide coverage for essential health benefits that has a minimum actuarial value of 60 percent.

• The actuarial value thresholds are tied to benchmark plans selected by each state. Note that state definitions of EHB will vary and may require product adjustments.

Coverage Changes

There are new out-of-pocket maximum (OOPM) accumulation rules and deductible ceilings.

1. OOPM ceiling at Health Savings Account (HSA) level: likely $6,400 single/$12,800 family In 2014 (2013 levels are $6,250 single/$12,500 family indexed to inflation).

    - All cost-sharing (for EHB) must accumulate to OOPM

2. Small group deductible ceiling: $2,000 single/$4,000 family

    - These limits will be indexed to inflation
    - The deductible ceiling does not apply in the individual market

Coverage Level Requirements

Plan coverage requirements are limited to the "metallic" coverage levels for individual, small group and Exchanges. Exchanges are required to offer at least one Silver and one Gold plan. Plans must be plus or minus two percent of the target.

Plan Type	**0% of the actuarial value of the covered benefits**
BRONZE	**60%**
SILVER	**70%**
GOLD	**80%**
PLANTINUM	**90%**

Rating Changes

The ACA calls for a move to adjusted community rating, which means the use of actual or expected health status or claims experience to set group premiums is prohibited. Beginning with plan years on or after January 1, 2014, other rating factors such as age, geographic area and tobacco use may be used to vary premiums, within certain limits. These rules are still proposed and subject to change before becoming final law. In addition, there is:

- Prohibition of excluding pre-existing conditions for all ages
- Guaranteed availability of coverage
- Guaranteed renewability of coverage
- No medical underwriting
- Single risk pool
- Index rate
- Plan level adjustments to index rate
- Rate increase review and notifications
- Catastrophic plans for specific populations

The Role of Health Benefit Exchanges

Health Benefit Exchanges, also called Health Insurance Exchanges, are marketplaces unique to each state where individuals and small groups can shop for health plans at competitive rates. States can also form regional Exchanges.

Although Exchanges are not in place until 2014, members must provide all current employees and, going forward, new employees at the time of hire to inform them of the Exchanges and the circumstances under which an employee may be eligible for a premium tax credit or a cost-sharing subsidy.

Employer Mandate, Requirements and Penalties

Beginning in 2014, employers with 50-plus full-time employees may be subject to a penalty if an employee receives a premium credit or cost-sharing subsidy. The penalty is calculated as follows:

- **Employers Not Offering Coverage:** If an employer does not offer minimum essential coverage (MEC) and one or more full-time employees receive a premium credit or cost-sharing subsidy through the Exchange, the penalty is $2,000 per year per full-time worker. When calculating the penalty, the first 30 full-time workers are subtracted from the payment calculation.

- **Employers Offering Coverage:** If an employer offers MEC and one or more full-time employees receive a premium credit or cost-sharing subsidy through the Exchange, the penalty is $3,000 per employee who receives a premium credit or cost-sharing subsidy.

Fast Forward to Modernized Care

As a broker and consultant to a number of state and national associations, our focus is on providing more accountability, more health improvement and more engagement… essentially, more of what matters.

We're working to solve the big problems by focusing on these three areas – accountability, health and engagement to the members of our association clients.

For more information on the Affordable Care Act, contact our health insurance affinity partner, Mass Marketing Insurance Consultants, Inc. toll-free at 1-800-349-1039 or by e-mail at mmic@mmicinsurance.com.