Bernie Lowe & Associates, Inc.
"Beyond the Product"

Health Care Reform Update

IMPORTANT NOTICE REGARDING HEALTHCARE REFORM

Update #29 **January, 2014**

How the Affordable Care Act Affects Small Businesses and Individuals

Small Businesses

No Financial Requirements for Small Businesses:
The ACA imposes no financial requirements for small businesses to contribute to their employees' health insurance. However, beginning in 2014, larger employers with more than 50 full-time employees ("FTEs") who do not offer coverage face a penalty of $2,000 per FTE (excluding the first 30 FTEs) if at least one FTE receives a government subsidy to buy coverage on the exchange.

Small Business Health Care Tax Credit:
This tax credit helps small businesses and small tax-exempt organizations afford the cost of covering their employees. It encourages small businesses to offer health coverage for the first time or maintain their current coverage.

To qualify, an employer must:

1. Cover at least 50% of the cost of health insurance for employees;
2. Not have more than 25 full-time equivalent employees; and
3. Have annual wages of less than $50,000.

Credits became available in 2010, covering up to 35% of the employer's contribution to health insurance coverage; on January 1, 2014, this will increase to 50%. Also beginning January 1, 2014, employers filing for the Health Care Tax Credit must purchase coverage from the SHOP exchange to be eligible. This tax credit expires December 31, 2015.

Requirement for All Small Employers Providing Coverage:
Small employers must:

1. Limit waiting periods to no more than 90 days.
2. Eliminate lifetime and annual benefit limits.
3. Offer dependent coverage to workers' adult children up to age 26.
4. Eliminate all pre-existing condition exclusion periods.
5. For non-grandfathered plans, offer a deductible not greater than $2,000 for self only coverage, or $4,000 for coverage other than self only.
6. For non-grandfathered plans, offer annual out-of-pocket maximums on essential health benefits that are no more than the out-of-pocket maximum thresholds that apply to HSA compatible high-deductible health plans. For 2014 these amounts will be $6,350 for self only and $12,700 for coverage other than self only. Also, out-of-pocket will include deductibles, coinsurance, and copayments for in-network providers.
7. For non-grandfathered plans, coverage for participation in an approved clinical trial for an individual who is approved to participate in the trial.

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Essential Health Benefits Requirement for Non-Grandfathered Small Group Plans:
These plans must meet the essential health benefit requirements ("EHBs"). The ACA defines essential health benefits to "include at least the following general categories and the items and services covered within the categories:

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services, including behavioral health treatment;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive and wellness services and chronic disease management;
10. pediatric services, including oral and vision care."

Adjusted Community Rating:
Single Risk Pool: Health insurance issuers in the small group market must consider all enrollees in all non-grandfathered health plans issued in a particular state to be members of a single risk pool when developing rates and premiums for plan years (in the individual market, policy years) effective on or after Jan. 1, 2014.

Guaranteed Availability of Coverage: Health insurance issuers are to offer coverage to and accept every employer or individual who applies for coverage in the group, subject to certain exceptions.

Exceptions allow issuers to restrict enrollment in coverage to:

- Open and special enrollment periods;
- Employers with eligible individuals who live, work, or reside in the service area of a network plan; and
- For situations involving limited network capacity and limited financial capacity.

Fair Health Insurance Premiums: Health insurance issuers may vary the premium rate charged to a specific non-grandfathered small group from the rate established for that particular plan only based on the following factors:

- Family size (individual or family);
- Geography (rating area);
- Age (within a ratio of 3:1 for adults); and
- Tobacco use (within a ratio of 1.5:1).

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Grandfathered Plans:
Small employers already offering health coverage can continue to provide such coverage to their workers, with current policies being "grandfathered," or exempt from most of the law's regulatory reforms and the essential benefits requirements. However, if an employer ends a grandfathered policy, new coverage bought on small group markets is subject to the regulatory reforms and benefit minimums.

Small Business Health Options Program ("SHOP") Exchanges:
Beginning in 2014, small businesses can use state-based SHOP exchanges to purchase coverage. SHOP exchanges utilize a premium rate review process and sets standards for how much insurance companies can spend on administrative costs (i.e. the medical loss ratio).

Individuals

Individual Mandate:
In 2014, all individuals must have health insurance (with exceptions). Those without coverage must pay a yearly financial penalty. The penalty in 2014 is the greater of calculated one of 2 ways. You'll pay whichever of these amounts is higher:

- 1% of your yearly household income, with the maximum penalty being the national average yearly premium for a bronze plan, or
- $95 per person for the year ($47.50 per child under 18). The maximum penalty per family using this method is $285.

The fee increases every year. In 2015 it's 2% of income or $325 per person. In 2016 and later years it's 2.5% of income or $695 per person. After that it is adjusted for inflation.

If you're uninsured for just part of the year, 1/12 of the yearly penalty applies to each month you're uninsured. If you're uninsured for less than 3 months, you don't have a make a payment.

Exceptions: religious exceptions;

- American Indians;
- those uninsured for under 3 months;
- those for whom the lowest cost health plan exceeds 8% of income;
- individuals with income below the tax filing threshold ($9,350 for individuals, $18,700 for married couples in 2009).

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Health Insurance Exchanges:
individuals without access to affordable employer coverage will be able to purchase qualified health plans ("QHP") through a health insurance exchange.
Exchanges, at minimum, will:

1. Certify Qualified Health Plans (QHPs);
2. Require certain public disclosures (e.g. claims payment policies; periodic financial disclosures; data on enrollment, denied claims, rating practices; information on cost sharing and payments for out-of-network coverage; enrollee rights);
3. Require QHPs make available timely information about the cost sharing for specific items or services;
4. Assign ratings to each plan based on the relative quality and price of their benefits:
    - Bronze - Pays 60% of costs,
    - Silver - Pays 70% of costs,
    - Gold - Pays 80% of plan costs; and
    - Platinum - Pays 90% of plan costs.

Qualified Health Plans that are certified:

- Provide Essential Health Benefits;
- Are licensed health insurers who are in good standing;
- Must offer at least one QHP in the silver and gold levels,
- Must agree to charge the same premium rate for each QHP whether or not the plan is purchased on the exchange or through an agent;
- Make all plan renewable; and
- Must adhere to the rating limitations.

Subsidies for premiums will be offered as refundable and advanced tax credits starting 2014 for individuals and families with incomes from 133% to 400% of the federal poverty level.

Catastrophic Plan:
Low cost plans are available to those up to age 30; those exempt from mandate or any person who lost their existing health coverage due to not meeting the ACA plan requirements.

No Pre-Existing Coverage Exclusions:
Health plans may not exclude coverage of pre-existing conditions for children. This will apply to adults in 2014.

No Lifetime/Annual Limits:
Insurers can no longer set lifetime or annual limits on health plans.

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Medicaid Expansion:
Medicaid will be expanded to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) for all individuals under age 65.

Pre-Existing Condition Insurance Plan ("PCIP") or High Risk Pools:
Those who cannot get insurance due to pre-existing conditions (e.g. cancer, diabetes) may join the PCIP; PCIP ends in 2014, when government-regulated exchanges start operating. States may run their own PCIPs with federal funding or have their residents use a federal PCIP run by the federal government.