

Patient Protection and Affordable Care Act (ACA)

ACA Guide for Group Employers

July 15, 2013

Florida Blue 
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Health Benefit Changes

Market-Wide Reforms Individual, Small Group, Large Group

- Guarantee issue, guarantee renewability
- No preexisting condition limitations
- No dollar lifetime maximums or annual dollar limits*
- Out of pocket maximums limited to \$6,350 / \$12,700
- \$2500 limit on FSA contributions*
- Other - clinical trials, mental health parity

Individual and Small Group Only

- “Metal” level plans (Platinum, Gold, Silver, Bronze)
- Essential Health Benefits (EHBs)
- Qualified Health Plans

Small Group Only

- \$2,000 / \$4,000 maximum deductible (flexibility for bronze plans)

Small Group and Large Group Only

- Maximum 90 day waiting period*

Individual Only

- Child-only enrollment on marketplace
- Maternity (Part of EHB)

NOTE: issuers/carriers who do not integrate these new benefits into their plans face a penalty of \$1,000 per member per day.

* Applies to grandfathered plans too



This information is for illustrative purposes only and is being provided to help increase understanding of the impacts of some of the provisions of the Affordable Care Act (ACA). This document does not attempt to cover all of the law's provisions and should not be used as legal advice for implementation activities. We encourage clients to seek professional advice including legal counsel, regarding how the new requirements may affect their specific plan.

Updated 6/21/13

Essential Health Benefits Individual and Small Group Coverage

Essential Health Benefits = Benefits in Florida's Most Popular Small Group Plan
supplemented by
Additional Habilitative, Pediatric Oral, and Pediatric Vision benefits

1. Ambulatory patient services*
2. Emergency services
3. Hospitalization
4. Maternity, newborn care
5. Mental health/substance abuse
6. Prescription drugs
7. Rehabilitative, Habilitative services, devices
8. Laboratory services
9. Preventive, wellness services
10. Pediatric services, oral and vision care

The benchmark plan is BlueOptions 5462

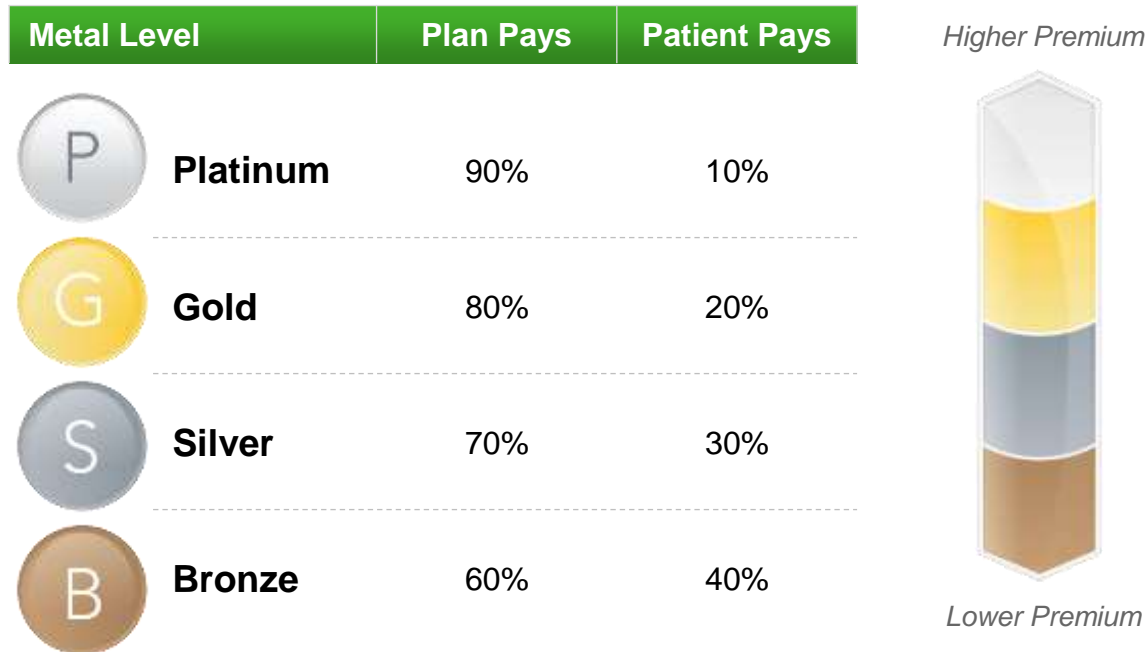
Non-grandfathered individual and small group health plans must cover these benefits.

All state Medicaid plans must cover these services, but can use a different benchmark plan.

**Includes Primary Care visit to treat injury/illness, Specialist Visit, other practitioner office visit (Nurse, Physician Assistant), Outpatient Surgery Physician/Surgical Services, Outpatient Facility Fee (e.g., Ambulatory Surgery Center), Home Health Care Services, Skilled Nursing Facility, Hospice Services*

“Metal” Benefit Plans, Coverage Levels

Metal Level is a measure of plan’s relative value



- Metal Level is NOT a measure of what a plan will actually pay for a single individual.
- **Theory:** Metal Level uses “Actuarial Value” (AV) as applied to a Standard Population.

E.g., if 100,000 random people all bought the same Silver Plan, the insurer would pay about 70% of the total cost of the claims.

- **Practice:** Issuers use an “Actuarial Value Calculator” to determine plan Metal Level.

How is rating and underwriting changing for small group and individual markets?

- No medical history or gender used in rating
- Single risk pool for individual market
- Single risk pool for small group market
- Rating factors used to determine premiums limited to:
 - **Ages** of each individual applying for coverage
 - **Geography** (where the subscriber lives [for individual] and where group is located)
 - **Tobacco use** (rates may be higher for tobacco users)
- **Family Composition.** Rates for families will be the sum of the rate for each person to be covered.
 - The number of rated children (ages 0-20 and not including spouse) is capped at 3.
- Employee contribution options
 - Member level
 - Average rate (broken)

90 Waiting Period

- For plan years starting in 2014, **all** group employers cannot have a waiting period that exceeds 90 days (coverage must be effective no later than 91st day)
- 90 day maximum waiting period applies to:
 - Large and Small Group Employers
 - Insured and Self-Insured
 - Grandfathered and Non-Grandfathered
 - All employees eligible for coverage
- 90 day count down starts on date employee is eligible for coverage, typically date of hire

Method	Effective/Add	Available Waiting Period
Counts Actual Days	Date of Event	0-90
Counts Actual Days	Billing Cycle	0-60
Counts Months (30-day)	Date of Event	0, 30, 60
Counts Months (30-day)	Billing Cycle	0, 30, 60

Health Insurance Marketplace (Exchange) Overview



Marketplace
(Individuals)



FF-SHOP
(Small Groups)

Four categories of plans are to be offered through the Exchanges, and in the individual and small group markets:

Bronze	Silver	Gold	Platinum
60%*	70%*	80%*	90%*

*Plans on the exchange provide essential health benefits and, on average, pay this percentage of the costs for covered benefits.

- Open Enrollment effective dates are 10/1/13 - 12/15/13 (for 1/1/14 effective dates)
- Open Enrollment continues 12/16/13 – 3/31/14 (for effective dates after 1/1/14)



NOTE: Applications received prior to 15th of month effective following month.

Who is eligible for Subsidies (Premium Tax Credits)?

- Household's expected income for the coverage year is between 100% and 400% of the Federal Poverty Level (FPL)

2013 FPL	100%	200%	300%	400%
Single	\$11,490	\$22,980	\$34,470	\$45,960
Family of 4	\$23,550	\$47,100	\$70,650	\$94,200

- Individual enrolls in coverage through the Marketplace
- Applicant cannot enroll in another form of Minimum Essential Coverage besides the individual market
- Minimum Essential Coverage includes Medicaid, Medicare, Tricare, Employer coverage
- If married, must file joint tax return

The Family Glitch

- Affordability test for Employees is based on Self-Only coverage
- If coverage is Affordable to the Employee and is offered to Dependents, then Employee and Dependents cannot get subsidy on the Exchange, even if Employer doesn't contribute anything to Dependent coverage

Eligibility for Employer –Sponsored Coverage	Eligible for Subsidies?
Not eligible for coverage	Yes
Eligible but coverage for employee is not affordable	Yes
Eligible but coverage does not meet 60% minimum value requirement	Yes
Employee eligible (coverage affordable) but no dependent coverage offered	Employee not eligible, but dependents are eligible
Employee eligible (coverage affordable) but only the dependent coverage is unaffordable	Employee and dependents are not eligible (based on current reading of the law)*
Eligible for COBRA or other continuation coverage	Yes, as long as not currently enrolled