

HEALTH INSURANCE MARKETPLACE

What to expect in 2014



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Overview

The Affordable Care Act (ACA) includes several provisions geared to extend greater access to health insurance benefits to more people. Beginning in 2014, most Americans must purchase a minimum amount of health insurance or be taxed by the government.

While there is a lot to be done before the ACA is fully implemented, this useful guide provides important information to help you understand the implementation of the ACA in Arizona.

This guide will review:

The ways purchasing health insurance in Arizona is expanding

Changes to health plan benefits

- Essential health benefits
- Actuarial value
- Rating

What individual consumers need to know

- Health insurance options for individuals and families
- Cost sharing reductions and premium tax credits
- Income requirements for federal tax credits and cost-sharing reductions
- Penalties for uninsured individuals

What businesses need to know

- Health insurance options for small group employers
- Health insurance options for large group employers
- Taxes and fees for businesses
- Blue Cross Blue Shield of Arizona (BCBSAZ) and the new era of healthcare

The ways purchasing health insurance in Arizona is expanding

The ACA requires each state to operate a health insurance marketplace, also known as an exchange, where people can purchase coverage. The health insurance marketplace is an online site where consumers can compare plans of participating insurers and purchase health insurance. The U.S. Department of Health and Human Services (HHS) runs the marketplace in states that choose not to create one, such as the case in Arizona.

Those who wish to can still buy health insurance privately—however, people who don't have a health insurance plan offered at work, or who can't afford it, may be able to get it through the federal health insurance exchange starting in October 2013 at open enrollment. These plans will become effective on January 1, 2014.

Individuals and businesses now have more ways to purchase health insurance.

INDIVIDUALS

1. Direct purchase through a broker or insurance provider
2. Those who are eligible and wish to obtain a federal subsidy or premium tax credit may purchase health insurance on the marketplace
3. Those that do not qualify for a federal subsidy or premium tax credit still have the option to purchase health insurance on the marketplace

BUSINESSES

1. Direct purchase through a broker or insurance provider
2. Employers may use a broker to access the Small Business Health Options Program (SHOP) to purchase a health plan online, or shop direct for plans
3. Direct purchase through a private marketplace option

The marketplace will not replace private health insurance. It is simply a new place for qualified individuals and employers to shop for and buy it.

Brokers and navigators will work with individuals and small group employers looking for coverage on the marketplace. They may allow brokers and navigators to help people enroll in QHPs or help them with their applications for premium tax credits and cost sharing reductions. As more guidance is shared about these roles, more information will be provided.



Changes to health plan benefits

In order to sell on the marketplace, BCBSAZ must offer Qualified Health Plans (QHPs) in the individual and small group markets. This means our plans must be certified by the exchange marketplace and meet a number of coverage and other requirements, including a specific set of services and items called Essential Health Benefits (EHB).

Additionally, the ACA requires QHPs offered off the exchange marketplace to offer standardized benefits packages in the individual and small group markets.

These packages represent four levels of value, which makes it easier to compare options.

ACA requirements for QHPs on the exchange marketplace

Beginning in 2014, the small group and individual insurance market will offer QHPs. Under the ACA, all non-grandfathered plans must follow new coverage and benefit rules, with requirements based on:

- If the plan is offered in or outside the marketplace
- If the plan is fully insured or self-insured
- Group size

Not only does the ACA mandate that nearly all Americans must purchase health care, the law also requires health insurance to be “guaranteed issue.” That means a person (or family) can’t be denied coverage or charged more because of a pre-existing health condition.

Rather than establish premiums based on health status, rates for these individual and small group plans will be based on variables that include:

- Family tier
- Age
- Geographic area
- Tobacco use

In addition, the federal healthcare law requires QHPs to use 3-to-1 age-rating bands. As a result, the highest premium cannot be more than three times the lowest premium for the same plan. All of these requirements may have an impact on rates, although the specific effects are difficult to define at this time as QHPs continue to be developed.

“Essential health benefits” will become essential components of coverage

Whatever the level of coverage, each of the benefit plans has to include what are called “essential health benefits.” According to the ACA, an essential health benefits package must include services and items in these 10 *broad* categories of care:

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

* Healthcare.gov: Essential health benefits (accessed October 2012).

Standard benefits package

Sometimes referred to as “metal plans,” the different tiers are defined by the percentage each plan will pay toward healthcare expenses for an average person (known as the actuarial value). Here’s how the metal levels break down:

Bronze	plans provide 60% coverage
Silver	plans provide 70% coverage
Gold	plans provide 80% coverage
Platinum	plans provide 90% coverage

As an example, a Bronze plan will generally have the lowest monthly premium and pay 60 percent of healthcare services; enrollees are responsible to pay 40 percent for healthcare services through some combination of cost shares. Although cost shares will be just 10 percent for Platinum plans, this tier will also have the highest monthly premium.

Mixing the metals

Health insurers offering QHPs must offer at least one plan at the Silver level and one plan at the Gold level on or off the exchange marketplace. Although not a requirement, they also have the option to offer a choice of Bronze or Platinum plans. Under each metal level there can be several plans available, which will vary according to the deductibles, coinsurance and copays offered.

At-a-Glance Coverage & Essential Health Benefits

	Inside marketplace	Outside marketplace – fully insured small group and individual	Outside marketplace – fully insured large group and self-insured
Include essential health benefits	●	●	
Provide 60% actuarial value minimum	●	●	*
Adhere to deductible** and out-of-pocket maximum limits	●	●	
Comply with “metal levels” (actuarial values – (60, 70, 80 and 90 percent)	●	●	
Be certified by the marketplace through which the plan is offered (certification requirement to be determined)	●		
Out-of-pocket maximum requirements			●

* The healthcare reform law does not require carriers to offer plans with at least a 60 percent actuarial value, nor does it require employers to provide health coverage. However, it imposes penalties on employers with 50+ FTEs that do not provide minimum coverage if an employee purchases coverage on the exchange and receives a premium tax credit or cost sharing reduction.

** Deductible limits apply to small group health plans only

What individual consumers need to know

Health insurance options for individuals and families

Consumers purchasing insurance in the individual market will be guaranteed coverage for pre-existing conditions, and their premiums cannot vary based on their gender or medical history. Here are some options, benefits and criteria for individuals and families purchasing health insurance in 2014.

1
Keep their grandfathered plan

2
Buy a plan through either:

- The individual marketplace
- Direct through broker or an insurer

3
Go uninsured and pay a penalty, unless exempt

This online marketplace will allow consumers to:

- Shop for and compare a variety of private health plans
- Get answers to questions about health coverage options
- Find out if they're eligible for health programs like Medicaid and the Children's Health Insurance Program, premium tax credits or cost sharing reductions
- Enroll in a health plan that meets their needs

People who purchase coverage in the marketplace are eligible for a tax credit as long as their household income is **up to 400 percent** of federal poverty guidelines. Figures based on January 2013 federal poverty guidelines:

- For an individual, that equals \$11,490 to \$45,960 per year
- For a family of four, that equals \$23,550 to \$94,200 per year

The assistance amount that a person can receive varies with income. The tax credit may be applied to any plan level (Bronze, Silver, Gold or Platinum).

Cost sharing reductions and premium tax credits for individuals

To address the needs of those who fall in certain income levels and cannot afford minimum essential health benefits, the law includes provisions for federal subsidies to reduce the cost of premiums.

Income requirements for cost-sharing reductions

Those who earn up to **250 percent** of federal poverty guidelines and enroll *at the Silver level only* may also be eligible for reduced cost sharing. Again, the subsidy amount will vary according to income. Examples of cost sharing that may be reduced include deductibles, co-insurance, co-payments or similar charges and do not include balance billing for non-network providers or spending on non-covered services.

Penalties for uninsured individuals

In 2014, legal U.S. citizens who do not carry a minimum amount of health coverage will receive a penalty of \$95 or one percent of their taxable income, whichever is greater. Penalties will increase each year through 2016. In future years, the penalties will adjust annually.

Penalty timeline

2014	2015	2016	2017
Greater of \$95 or 1% of taxable income	Greater of \$325 or 2% of taxable income	Greater of \$695 or 2.5% of taxable income	and beyond Annual adjustments



What businesses need to know

Small businesses also can use the marketplace to find insurance for their employees. These are called Small Business Health Options Programs, or SHOPs, for short. Individual insurance and SHOP programs may be available separately or combined in a single online marketplace.

Employers can opt to:

1
Offer a fully insured plan through either:

- A SHOP marketplace
- The traditional market

2
Stop offering coverage and let employees buy an individual plan in or outside the marketplace**

Private marketplace for businesses

Businesses have a new way to shop for insurance and control costs with the BCBSAZ health plan marketplace and defined contribution plans. These plans let the employer determine how much to contribute to their employees' benefits. Employees then apply the contribution and shop for 10 different BCBSAZ plans right from the convenience of BCBSAZ's private online marketplace.

Key benefits:

- Monthly contribution helps keep expenses predictable
- Streamline benefits administration saves time and money
- Retain the value health insurance brings to employee recruitment and retention

Subsidies for small employers

In 2014, tax credits will increase for employers with 25 or fewer employees (with an average wage of less than \$50,000 a year) who offer coverage through the marketplace.

- The credit will cover up to 50 percent of the employer's cost (35 percent for small nonprofit organizations)
- Employers will be eligible for credits in the first two years they offer coverage through the marketplace
- Credits will decrease on a sliding scale as group size and employee wages increase

* Small employer is defined differently for different purposes.

** Penalty risk may apply to employers with 50+ FTEs.

Large group employers

Health insurance options for large group employers

1
Offer health insurance (either fully insured or an administrative services only [ASO] plan) that meets the minimum coverage definition and is affordable

2
Offer some level of coverage that does not meet minimum requirements and risk the employer penalty

3
Stop offering coverage, let employees buy insurance through the individual marketplace, and risk the employer penalty

Penalties for large group employers

- If minimum coverage is not offered to full-time employees, and at least one employee does not meet minimum value requirements gets subsidized coverage through the exchange marketplace, then a \$2,000 penalty is assessed for each employee (after the first 30)
- If minimum coverage is offered to full-time employees, but is not affordable for an employee or does not meet minimum value requirements, and that employee gets subsidized coverage through the marketplace, then a \$3,000 penalty is assessed for each employee who receives subsidized coverage



Other taxes and fees

Individuals and employers may be responsible for other taxes and fees related to the healthcare reform law. The chart below highlights some of them.

Tax/Fee	Effective Date	Responsible Party	Annual Tax/Fee Amount
Comparative effectiveness research fee – this fee funds research on the effectiveness, risks and benefits of medical treatments through the Patient-Centered Outcomes Research Institute	Plan/policy years that end after September 30, 2012, and beginning before October 1, 2019	Issuers of fully insured plans Self-insured plan	For plan years that end during October 1, 2012, through September 30, 2013, this fee is \$1 per participant per year. For plan years that end during October 1, 2013, through September 30, 2014, the fee increases to \$2 per participant per year. After that, the rate increases each year by the medical inflation rate.
Tax on high earners and unearned income – an annual tax on wages or unearned income of more than \$200,000 for singles and \$250,000 for married couples	Tax years beginning January 1, 2013, and later	Individual taxpayers	0.9% Medicare surtax on wages in excess of \$200,000 single/\$250,000 married couples. 3.8% tax on unearned income for taxpayers with modified adjusted gross income in excess of \$200,000 single/\$250,000 married couples.
ACA insurer fee – an annual excise tax on health insurance to fund premium subsidies and Medicaid expansion	Tax years beginning January 1, 2014 and later	Issuers of fully insured plans	Based on the insurer's market share of net premiums written based on the previous year. For example, the 2014 fee will be based on 2013 premiums. Total fee amount to be collected across all insurers starts at \$8 billion in 2014 and increases to \$14.3 billion in 2018. After 2018 the fee increases annually based on premium growth.
ACA reinsurance fee – this will support the transitional reinsurance program that aims to stabilize premiums for coverage in the individual market and lower the effects of adverse selection	Plan/policy years beginning in the 3-year period starting January 1, 2014	Issuers of fully insured plans Self-insured plans	Funds will be used to make reinsurance payments to health insurance issuers that cover high-cost individuals in non-grandfathered individual market plans.
High-cost insurance tax – an annual excise tax on high-cost health plans	Tax years beginning January 1, 2018 and later	Issuers of fully insured plans Sponsors/administrators of self-insured plans	Tax of 40% on health plan costs that exceed "Cadillac" plan thresholds of \$10,200 for single coverage or \$27,500 for family coverage.

BCBSAZ and the new era of healthcare

BCBSAZ has been hard at work for more than two years to implement the provisions resulting from the Affordable Care Act. We are working to develop qualified health plans that comply with the new 2014 benefit requirements the law sets forth.

Ensuring the value of our products has always been a core focus of our business, and BCBSAZ will continue to work constructively with state and federal officials to provide quality healthcare solutions.



Our commitment to Arizonans remains unchanged

Despite the maze of changes brought about by the federal healthcare law, at the end of the day your healthcare needs haven't wavered.

As we have for more than 73 years, we stand prepared to provide our employers expert guidance and support, while continuing to deliver quality products, competitive pricing and an unmatched level of service to our members. We're in this time of transition together—and backed by our long history of value, innovation and customer satisfaction—we will continue to earn Arizona's confidence in BCBSAZ.



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Last revised March 2013. The information provided may change due to newly government issued regulations.