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# Benefits 101: Health Care Reform



# What is Health Care Reform?

- Biggest overhaul of the United States' health care system since Medicare and Medicaid in 1965
- Requires most individuals to obtain health care coverage
- Requires insurance companies and employers to provide consumer protections related to health coverage, like covering pre-existing conditions and not charging more for coverage based on gender

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# Key Elements of Health Care Reform

- Free preventive care
  - Most health plans are required to cover certain preventive care services at no cost to you
- The individual mandate
  - People who can afford health insurance but don't have coverage in 2014 may have to pay a fee, and will have to pay for all of their health care
- The Health Insurance Marketplace
  - A new way to find quality health coverage
  - Can help if you don't have coverage now or if you have it but want to look at other options
- The Affordable Care Act's Patients' Bill of Rights
  - The ACA offers new rights and protections that make coverage fairer and easier to understand

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# Preventive Care

- Preventive care refers to measures taken to prevent individuals from contracting diseases.
- Under the ACA, most private health plans must provide coverage for a range of preventive services and may not charge any copayments, deductibles or coinsurance to patients receiving preventive care.
- Preventive care includes:
  - Medical tests, immunizations, screening tests, preventive medications and any other services that would prevent disease



# Preventive Care Services

- Adults
  - Physical examinations, immunizations, blood pressure screenings, colon cancer screenings, HIV and STI screenings
  - Counseling and treatment for alcohol, tobacco, drugs and obesity
- Women
  - Well-woman visits, Breast Cancer Genetic Test Counseling (BRCA) test, mammograms, cervical cancer screenings, osteoporosis, certain pregnancy and post-birth services, contraceptives
- Children
  - Newborn care, many age-specific medical, behavioral and developmental assessments for children up to 18 years old
- Medicare recipients also have some no-cost preventive services available

# Grandfathered Plans

- Grandfathered plans are those that were in existence on March 23, 2010, and have stayed basically the same
- Grandfathered plans do not have to cover preventive care for free
- Check with your insurance company or benefits administrator to find out whether your plan is grandfathered

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# The Individual Mandate

- Requires most people to have “minimum essential coverage” health insurance
- Beginning in 2014, most individuals must either have health insurance that meets minimum standards of coverage or pay a penalty when filing tax returns
- Minimum essential coverage is defined as:
  - Any Marketplace plan, or any individual insurance plan you already have
  - Any employer plan (including COBRA), with or without “grandfathered” status, including retiree plans
  - Medicaid
  - Medicare
  - The Children’s Health Insurance Program (CHIP)
  - TRICARE and other veterans health care programs
  - Peace Corps Volunteer plans

# How much is the tax penalty?

- The annual tax penalty for not having minimum essential coverage depends on the age and number of dependents in your household.
- The penalty will be the greater of a flat dollar amount per individual or a percentage of the individual's taxable income, and increases over the next three years.

2014

- \$95 per adult and \$47.50 for each child (up to \$285 for families), or 1 percent of income, whichever is greater

2015

- \$325 per adult and \$162.50 for each child (up to \$975 for families), or 2 percent of income, whichever is greater

2016 and  
Beyond

- \$695 per adult and \$347.50 for each child (up to \$2,085 for families), or 2.5 percent of income, whichever is greater

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# The Health Insurance Marketplace

- Health Insurance Marketplaces (Exchanges) create alternative markets for buying health insurance.
- They will:
  - Offer a choice of different health plans
  - Certify plans that participate
  - Provide information to help consumers understand their coverage options
- Individuals can purchase insurance through a Marketplace if they are:
  - Not currently incarcerated
  - A lawful U.S. citizen or resident
  - Living in the service area of the Marketplace

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# What types of plans will be available?

There are four categories of Marketplace insurance plans available to everyone and one specialized plan available to select individuals:

- Bronze
- Silver
- Gold
- Platinum
- Catastrophic plans available to people under 30 and those with very low incomes

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# What will the plans cover?

All plans will cover a comprehensive package of items and services known as essential health benefits:

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

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# Marketplace Subsidies

- Some people can save money in the Marketplaces in three ways:
  - Subsidized coverage, available to some individuals and families with incomes up to 400 percent of the federal poverty level
  - Reduced out-of-pocket costs (like deductibles, coinsurance and copayments), available to some individuals and families with incomes up to 250 percent of the poverty level
  - Expanded Medicaid eligibility, available to some individuals and families with incomes up to 133 percent of the federal poverty level



# Enrolling in the Marketplace

- Open enrollment starts Oct. 1, 2013, and ends March 31, 2014
- Medical coverage begins as early as Jan. 1, 2014
- Three ways to apply for Marketplace coverage:
  - Online at [healthcare.gov](http://healthcare.gov)
  - By mail
  - In person
- You can enroll with the help of a Navigator or other qualified helper

# Employer Coverage vs. Exchange Coverage

- The coverage offered through is likely more affordable than coverage purchased through the Exchange
- Exchange coverage is a good option if you are ineligible for coverage through

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# The Affordable Care Act's Patients' Bill of Rights

- The Patients' Bill of Rights is designed to summarize health coverage protections embedded within the ACA. Protections include:
  - No pre-existing condition exclusions
  - No arbitrary rescissions of insurance coverage
  - No lifetime dollar limits on coverage
  - Restricting annual dollar limits on coverage
  - Allowing participant choice of a health care provider
  - Granting access to emergency services

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# No Pre-Existing Condition Exclusions

- Health plans cannot deny coverage based on pre-existing conditions beginning in 2014.
  - Includes benefit limitations (refusing to pay for chemotherapy because a person developed cancer before getting insurance)
  - Includes outright coverage denials (refusing to offer a policy to an individual because of his or her pre-existing medical conditions)
- These protections apply to all health plans except grandfathered individual policies.



# No Rescissions of Insurance Coverage

- Health plans and insurance companies can no longer cancel your policy retroactively if:
  - You become sick
  - You (or your employer) make a paperwork mistake
- Coverage can only be rescinded if there is fraud or intentional misrepresentation of facts
- Insurers seeking to rescind coverage must give you at least 30 days' notice to provide time for an appeal
- Coverage can be canceled if premiums are not paid

# Annual and Lifetime Limits

- Insurance companies can't set a dollar limit on what they spend on essential health benefits for your care during the entire time you're enrolled in that plan.
- Beginning in 2014, most health plans cannot place an annual dollar limit on essential health benefits.
  - The ban on annual limits applies to all health plans except for grandfathered individual market plans.

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# Choosing a Health Care Provider

- Choice of primary care provider
  - You can choose any available primary care provider in your insurance plan's network
  - Parents can choose any available network pediatrician as their child's primary care doctor
- No referrals needed for OB-GYN services
  - Most health plans cannot require women to get a referral from a primary care provider before receiving obstetrical or gynecological care from a specialist
- These policies apply to all health plans that are not grandfathered plans

# Access to Emergency Services

- Most health plans cannot:
  - Charge higher copayments or coinsurance if you get emergency care from an out-of-network hospital
  - Require prior approval to receive emergency care
- This policy applies to all health plans except grandfathered plans

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