HEALTH CARE REFORM

10.01.2013 **ANSWERS & ADVICE**

OBAMACARE INSURANCE BASICS

MORRIS & REYNOLDS HAS CERTIFIED OBAMACRE EXPERTS AVAILABLE TO HELP YOU

QUALIFIED HEALTH PLANS
"METAL" LEVEL PLANS

Beginning in 2014, the Affordable Care Act (ACA) requires health plans offered through a Marketplace Exchange to be what are called qualified health plans (QHPs) and that those plans meet certain *levels* of what the law refers to as "actuarial value".

To simplify consumer's ability to review various plans **ACA's required actuarial value levels are referred to as "Metal Levels"—Bronze (lowest premium and, in the event of claims, highest cost out of pocket), Silver, Gold and Platinum (highest cost but least cost out of pocket)**.

ACA's Metal Plans are intended to allow consumers to compare health plans with similar levels of coverage in order to make informed decisions about what plan is right for them. The four metal plans are distinguished from one another by their "actuarial value." Actuarial value refers to the average dollar amount of expenses that would be paid b the insurance company. The *higher* the value of a plan, the lower the out-of-pocket costs you would pay in the event of a claim.

With respect to the plan names, the more expensive the metal, the higher the actuarial value (and the more it pays when you have a claim and the more, typically, it costs in terms of the premium the insurer will charge). Since coverage will be similar (but not necessarily exact) for all plans in a given metal tier (for example, all silver plans), consumers can focus on other plan factors, such as the premium and network of providers, when selecting a health plan.

The metal levels are as follows;

- **PLATINUM PLAN**
- **GOLD PLAN**
- **SILVER PLAN**
- **BRONZE PLAN**

Qualified Health Plans (insurers) must offer at least one plan in the silver level and one in the gold level through the Marketplace Exchanges. Outside of the Exchanges insurers must offer coverage that matches the metal level plans to the individual and small group (business) market.

ESSENTIAL HEALTH BENEFITS

The Affordable Care Act ("ACA") also requires health plans to cover certain categories of benefits. These categories are described as "**essential health benefits**." Beginning in 2014 individual and small group plans must include these essential health benefits unless the plan qualifies as grandfathered. The ACA law requires health plans to provide coverage for at least the following categories:

- Ambulatory patient services: These include outpatient services such as doctor visits.
- Emergency Services: These include care received in an Emergency Room
- Hospitalization: These include medically -necessary surgeries and other inpatient procedures
- Maternity and newborn care
- Mental health services
- Substance use disorder services
  Including behavioral health treatment
- Prescription drug coverage
- Rehabilitative and habilitative services and devices: Rehabilitation covers services such as referring to walk after a stroke. Habilitative services involve learning a new skill such as a speaking without a speech impediment.
- Laboratory tests and services
- Preventive and wellness services, as well as the management of chronic diseases
- Pediatric services (including both oral care and vision care)

Health plans are allowed to impose cost sharing obligations on plan members for most essential benefits, but those that qualify under a category of preventative health services will be made available at no charge to plan members. The ACA gives states authority to specify details surrounding the essential benefits.

The states must each choose a **Benchmark Plan** that serve as a detailed definition of benefits within each of the ten Essential Health Benefit categories. In Florida the benchmark plan shall be Blue Cross Blue Shield's (Florida Blue) "BlueOptions HMO 5462″ .

"ACTUARIAL" VALUE

Actuarial value is calculated as the percentage of total average costs for what are called essential health benefits that a plan will cover. Essential health benefits are the core items and services that the plan must cover, such as prescription drugs, maternity and newborn care, preventive and wellness services and many additional benefits.

A health plan's actuarial value tells consumers how generous the plan's coverage is based on its cost-sharing provisions such as deductibles, copayments and coinsurance. Plans with higher actuarial values provide coverage that is more generous and also cost more than those with a lower value.

For example, if a plan has an actuarial value of 70%, a consumer would be responsible for 30% of the costs of covered benefits. If a plan has an actuarial value of 80%, on average, a consumer would be responsible for 20% of the cost of covered benefits.

Each Metal Plan is based on a specified share of the actuarial value of the plan's essential health benefits.

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HOW METAL PLANS WORK

The Details

METAL PLAN	ACTUARIAL VALUE
BRONZE	60%
SILVER	70%
GOLD	80%
PLATNIUM	90%

Bronze plans have the least generous coverage in the form of highest out of pocket cost for consumers when you have a claim, while platinum plans have the most generous coverage in the form of lowest out of pocket costs when you have a claim.

The Department of Health and Human Services (HHS) allows for small variations (plus or minus two percentage points) in the actuarial value used to determine levels of coverage. For example, under HHS's guidance, a silver plan could have an actuarial value between 68% and 72%.

Insurers will charge progressively higher premiums among the plans with Bronze Plans having the lowest premiums and Platinum having the highest premiums. However, this considers plans only within a single insurance company. It is possible that one company's Silver Plan could be cheaper than another company's Bronze Plan. Under the law, all plans, whether Bronze, Silver, Gold or Platinum, will have a shared maximum out-of-pocket amount that an enrolled individual can pay in a calendar year.

All the plans must offer essential health benefits. These are the basic insurance benefits that all qualified health plans must provide enrollees. States have the discretion to require additional benefits beyond the Essential Health Benefits. However, these are minimum benefits and plans can choose to offer additional benefits so long as the essential benefits are properly covered.

It is important to know that since plans differ by the amount of costs they cover, the plans may all cover the essential health benefits, but they can cost the member different amounts due to the differences in insurance expenses paid for by the plans.

Individual insurance companies are not required to offer all four plans. At a minimum, they must offer the Silver plan and the Gold plan. There is also a catastrophic plan for individuals who can demonstrate problems affording a Bronze Plan. This plan is only available through an exchange and tax subsidies cannot be used to reduce its premiums.

THE PLATINUM PLAN / 90%

A Platinum Plan is designed to offer the **lowest out-of-pocket expenses for enrollees**. Platinum enrollees pay approximately 10% of the out-of-pocket costs of healthcare services with the plan paying the remainder. In comparison, the Bronze Plan requires enrollees to pay 40% of covered medical expenses.

Since the Platinum Plan has the most generous cost-sharing for enrollees, it is expected that these plans will typically have the highest premiums when compared to the Bronze, Silver, and Gold plans.

However, this is a generalization. It will be important to compare premiums among different insurance companies offering Platinum Plans. Deductibles and copayments will also differ among Platinum Plans. This is perfectly acceptable as long as the Platinum Plan covers **90%** of healthcare expenses for a standard population.

The chart that follows is a hypothetical example revealing how cost-sharing could differ among Platinum Plans.

	PLATNIUM EXAMPLE A	PLATNIUM EXAMPLE B
OUT OF POCKET COSTS	10% OF COSTS	10% OF COSTS
DEDUCTIBLE	$ 250	$ 2,000
COINSURANCE	10 %	5 %

Insurers are not obligated to offer a Platinum Plan. To participate in an Exchange the insurer must only offer a Silver Plan and a Gold Plan. While Platinum Plans share the same essential benefits as offered in Bronze, Silver, and Gold Plans, an insurer has the option to add extra benefits. Additionally, states may require plans to offer other benefits in order to participate in a state exchange.

THE GOLD PLAN / 80%

The Gold Plan offers the **second lowest out-of-pocket costs of the new plan types**. Only the Platinum Plan offers lower out of pocket costs. The Gold Plan provides the same essential benefits, the minimum services covered by ACA, as the other plan types. However, individual plans do have the option of enhancing their benefits beyond the basic benefits required by the ACA.

Based on an average person's expected use of healthcare services, Gold Plans are designed to have the insurer pay 80% of covered healthcare expenses. The remaining 20% of expenses are paid by the consumer out of pocket. These out-of-pocket expenses include deductibles, copayments, and coinsurance. However, the plan's monthly premium is not included as one of these out-of-pocket costs.

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While the specifics of deductibles, copayments, and other out-of-pocket costs will vary by Gold Plan, we do know that for a standard population the Gold Plan should be expected to cover 80% of healthcare expenses. To illustrate how costs could differ among Gold Plans, we've created a table of two hypothetical Gold Plans.

	GOLD EXAMPLE A	GOLD EXAMPLE B
OUT OF POCKET COSTS	20% OF COSTS	20% OF COSTS
DEDUCTIBLE	$ 250	$ 2,000
COINSURANCE	20 %	10 %

The federal government intends to monitor is whether Gold and Platinum plans attract more sickly enrollees and drive up premiums.

The ACA provides some tools to address this issue (e.g. reinsurance, risk adjustment, and risk pooling), but it is impossible to tell whether these tools will be sufficient if these plans do attract a disproportionate representation of high-cost enrollees.

THE SILVER PLAN) / 70%

Silver Plans have **lower out-of-pocket costs than the Bronze Plan but than either the Gold and Platinum Plans.** All Silver Plans share the same minimum health benefits but the way they charge out-of-pocket costs can differ significantly.

Based on an average person's expected use of healthcare services, Silver Plans have the insurance company pay **70%** of covered healthcare expenses. The remaining 30% of expenses are paid by plan out-of-pocket.

These out-of-pocket expenses include deductibles, copayments, and coinsurance. However, the plan's monthly premium is not included as one of these out-of-pocket costs. The table below illustrates how out-of-pocket costs can differ among three insurance companies that offer a Silver Plan.

	SILVER EXAMPLE A	SILVER EXAMPLE B
OUT OF POCKET COSTS	30% OF COSTS	30% OF COSTS
DEDUCTIBLE	$ 250	$ 2,000
COINSURANCE	30 %	15 %

As you can see in the examples above, deductibles and coinsurance can vary significantly among Silver Plans. Even though both Silver Plan examples cover 70% of medical costs, this coverage applies to the entire enrolled population.

Some individual may receive more cost sharing and some less depending on the medical services used. The out-of-pocket costs also assume enrollees are using doctors and facilities approve by the plan.

All of these plans will offer the same minimum of benefits. These minimum benefits are determined by the federal and state government and must be included in a plan regardless of any additional benefits the plan decides to include.

If you use a healthcare provider who is not approved, you could pay considerably higher costs and those costs might not apply towards the maximum out-of-pocket expenses you can pay in a calendar year.

There are also special versions of Silver Plans with lower out-of-pocket costs for people whose income qualifies them for enrollment. These Silver Plans are known as **"Cost-Sharing Reduction" Plans** or CSR plans. CSR eligible health plans can only be Silver Plans and enrollees must meet income eligibility criteria.

TAX CREDIT SUBSIDIES FOR INDIVIDUALS & FAMILIES

The Affordable Care Act provides federal tax credits to people with middle incomes and low incomes whether they are buying individual or family insurance plans. **The tax credit is based on the Silver Plan's costs.**

If you are wondering what the tax credit is and how to determine if you are eligible then visit our Affordable Care Act Tax Credit page at morrisandreynolds.com or contact one of our fine professional agent's or underwriters.

SILVER PLAN AS A "BENCHMARK"

A state insurance exchange uses the premium amount from a selected Silver Plan within the state to serve as the basis for subsidy calculations. The Silver Plan selected is the Silver Plan in the exchange with the second lowest premium. Even if a subsidy-eligible person chooses a Bronze, Gold, or Platinum plan, his or her subsidy amount is calculated based on the benchmark Silver Plan.

A) BENEFIT COMPARISON

Silver Plans have the same benefit requirements as Bronze Plans. These benefit requirements are known as the Essential Health Benefits. An insurance company can choose to add benefits to a Silver Plan, as well as any of the other new reform health plans.

However, adding benefits are not required and does not distinguish a Silver Plan from a Bronze Plan, Gold Plan, or Platinum Plan.

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B) COST COMPARISON

On average, Silver Plans should have higher premiums than Bronze Plans since Silver Plans pay a higher percentage of medical costs. However, prices vary among insurers and prices vary among regions so it is theoretically possible that there can be a specific Silver Plan that is less expensive than a specific Bronze Plan but this is expected to be an exception rather than the rule.

THE BRONZE PLAN / 60%

The **Bronze Plan** is **intended to have the lowest premium of the four categories but charge the highest out-of-pocket costs for healthcare services** (claims).

For people without group insurance from an employer or other group, the Bronze plan is the minimum health insurance plan in which they can enroll that will satisfy the Affordable Care Act's mandate for people to purchase health insurance.

Bronze Plans are designed so that insurers will pay **60%** of covered healthcare expenses with the remaining 40% to be paid by consumers. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium. Out-of-pocket expenses for individuals is expected to be capped at **$6,350** annually starting in 2014.

The 40/60 percentages are based on projected use of healthcare services. The actual out-of-pocket expenses of any single beneficiary may work out to be more or less than this ratio, but should remain within the range.

Those people whose out-of-pocket limits reach the annual maximum could see their share of healthcare costs fall until a new calendar year begins and the annual limit reset. Out-of-pocket expenses include fees like deductibles, copayments, or coinsurance.

Different plans will approach the 40/60 split in various ways (see the table below) so it is important to research the financial details of a specific plan before deciding which one to purchase. For example, a person who has frequent medical expenses may want a Bronze Plan with a lower deductible (depending on premium) while a healthy person may want the opposite. Below is an illustration of how costs could differ among Bronze plans for an individual enrollee.

	BRONZE EXAMPLE A	BRONZE EXAMPLE B
OUT OF POCKET COSTS	40% OF COSTS	40% OF COSTS
DEDUCTIBLE	$ 250	$ 2,000
COINSURANCE	40 %	20 %

For some plans, your share of expenses may come in the form of large deductibles (e.g. above $5,000) with low out-of-pocket costs for services received after the deductible is satisfied. For other plans, the deductible might be low but you would be responsible for 40% of the cost of every covered medical service he or she receives.

The examples above show significant differences between deductibles and coinsurance even though the plans offer the same essential benefits and cap the maximum out-of-pocket expenses at $6,350 in 2014.

It's also important to know that coverage depends on using the plan's approved network providers. Using a doctor or hospital outside of that network will result in significantly higher costs. It's estimated that the Bronze Plan requires higher cost-sharing for you than a typical employer-based plan.

Moreover, people who are insuring family members. along with themselves, will have higher out-of-pocket limits, as well as higher premiums. However, with respect to families, the income limits for government subsidies are also higher.

BRONZE PLAN PREMIUMS

As noted, bronze plans are expected to have the lowest premium rates for the four new types of plans since they charge the highest out-of-pocket costs. There may be instances where the Silver Plan for one insurance company may charge a lower premium than the Bronze Plan of another insurance company.

Comparison shopping will be essential for anyone who wants to minimize their healthcare expenses. This is especially true when you consider that premium subsidiaries are only approved for the first three years that coverage is offered, as well as the fact that based on some estimates suggest a Bronze Plan premium in 2016 to be $4,500 to $5,800 annually for individuals and $12,000 to $20,000 for families of four or five.

Morris & Reynolds's agents and underwriters are available to assist you with quotes for plans from both the Marketplace Exchange and directly from insurers.

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