Health care reform is upon us. While many of the provisions of the Affordable Care Act, or ACA, have already been implemented, the big ones are just around the corner. If you’re feeling a little overwhelmed by all the information and changes coming at you, we completely understand – and we’re here to help. We’ve been researching, absorbing, digesting, questioning, clarifying, processing and preparing for these changes for quite a while now. Today, we stand ready to guide you through them.

In this guide, you’ll find information about the most important changes coming from the ACA, including key changes to benefits, changes in the ways that employers and employees may shop for plans, and employer requirements for offering plans.

It’s important to note that small-group employers – defined in Oregon as businesses with between one and 50 employees – are not required to provide group health coverage for their employees. Those who do choose to provide coverage, however, must offer it to all of their eligible employees.

The essentials

The ACA changes are coming up fast. Here are some key dates and changes to be aware of:

- All health plans taking effect on or after Jan. 1, 2014, must conform to ACA rules.
- When your company’s health plan is up for renewal for 2014, your current plan will be discontinued and you will be able to select a new, ACA-compliant plan to replace it.
- Employers may purchase coverage for 2014 and beyond through carriers and producers, as in the past, or they may go through Cover Oregon, the new state health insurance exchange.
- A tax credit is available to help cover up to 50 percent of premium costs for qualifying small businesses (up to 35 percent for tax-exempt organizations).
- If you renew any time before Jan. 1, 2014, you will keep that plan until your renewal date in 2014.

Read on for additional details to help you make sense of the changes to come. And remember, you don’t have to go it alone on the road to reform. We’re here to help, every step of the way.
Six key changes to benefits and requirements

The ACA will bring with it an overwhelming number of changes in health plan benefits and requirements. Rather than list them all here, we’ll make it easier on you. Here are the top six changes that we think small-group employers need to know about when making health coverage decisions for 2014.

1. **Essential health benefits will be required.**
   All health plans will be required to cover a comprehensive package of “essential health benefits.” These essential benefits include services such as outpatient care, emergency services, mental health and substance abuse care, rehabilitation services and devices, and preventive care, to name a few.

2. **Health plans will pay for a larger percentage of health care costs.**
   Under the ACA, all health plans – with the exception of catastrophic plans – must cover a minimum of 60 percent of average health care costs. This percentage of the total average cost of covered benefits is called the actuarial value. In a plan with an actuarial value of 70 percent, for example, plan members are responsible for paying 30 percent of the total average costs of their covered benefits through deductibles, copays and coinsurance.

3. **Qualified health plans will be categorized in “metal levels” according to their actuarial values.**
   Under the ACA, small-group plans will be categorized as bronze, silver, gold or platinum plans based on their actuarial values, as follows:
   - Platinum: 90 percent AV
   - Gold: 80 percent AV
   - Silver: 70 percent AV
   - Bronze: 60 percent AV

4. **Out-of-pocket expenses will be capped.**
   Out-of-pocket expenses, including deductibles, copays and coinsurance, will be capped starting in 2014. With some exceptions, deductibles for small-group plans will be limited to $2,000 for individual coverage and $4,000 for family coverage. Out-of-pocket maximums – which include the plan deductible, copays and coinsurance for covered services and prescription medications – will not be more than $6,350 for self-only and $12,700 for family coverage. To meet actuarial value limits, a plan may have a higher deductible. An employer can help offset the deductible for employees by making a contribution to an HRA or HSA.

5. **Probationary waiting periods will be limited.**
   Eligibility waiting periods for group health insurance will be limited to a maximum of 90 days.

6. **Covered services may not exclude certain provider types.**
   If a service is covered, it must be covered regardless of the type of provider performing the service, as long as the service is within the scope of the provider’s license. For example, if office visits are covered for MDs, they also must be covered for naturopaths who are licensed to do office visits; if acupuncture is covered for acupuncturists, it also must be covered for MDs who are licensed to perform acupuncture. If a service is not covered – such as massage therapy – then it must be excluded for all provider types. As before, coverage for alternative care will vary by carrier and plan, and carriers will not be required to cover in-plan services provided by non-contracted providers.

This guide provides an overview of the changes you need to know about if your business plans to provide group health coverage. It covers some broad ground, so if you have questions, feel free to connect with us. We’re here to provide you with all the information you need to make the best choices for your company.
Health Insurance Exchanges

Health insurance exchanges are a key part of federal health care reform under the ACA. Exchanges are the marketplaces where individuals and small-group employers will be able to shop online for insurance coverage.

These new health insurance exchanges are intended to offer three advantages:

- To help people better understand their health insurance options
- To provide a more standardized market of health plan choices
- To provide financial assistance for those who qualify

Private marketplaces will allow small businesses to shop online directly with one carrier, or with multiple insurance companies represented by a producer. All plans offered on these private exchanges must meet the ACA requirements. Providence Health Plan will offer a wide variety of plans that meet all ACA requirements (with the exception of pediatric dental services, which will require separate coverage) on our own private marketplace. Employers will enjoy the same ease of doing business with us as they have in the past.

Private marketplaces will include the broadest range of choices, carriers, plans and networks, as well as multiple defined-contribution options from individual carriers. Small-group employers will be able to maintain their current carrier relationships, if they choose. The main change is that all plans, regardless of carrier, will include the same baseline of Essential Health Benefits mandated by the ACA.

Oregon’s public health insurance exchange, called Cover Oregon, will offer multiple plans from multiple carriers, including Providence plans. It also will offer financial assistance for qualifying small businesses and individuals. Employers are not required to participate in Cover Oregon – you may continue to purchase coverage in the private market through a producer.

The Cover Oregon SHOP opens for business in October

Small-group employers who wish to participate in the Cover Oregon Small Business Health Options Program, or SHOP, must meet these eligibility requirements:

- At least 51 percent of employees must work in Oregon.
- At least 75 percent of employees must be enrolled in the health plan (50 percent for dental coverage).
- The company must contribute at least 50 percent of the employee-only premium.
- Employees must be enrolled by the 22nd day of the month prior to the coverage effective date.

Small-business tax credits

A tax credit is available through the IRS to help small businesses cover the cost of premiums. To qualify, an employer must:

- Provide health insurance to employees and cover at least 50 percent of the premium.
- Employ fewer than 25 full-time workers (employers with fewer than 50 part-time workers also may be eligible).
- Pay average annual wages of less than $50,000.

Starting in 2014, the credit will cover up to 50 percent of premium costs for taxable organizations and up to 35 percent for tax-exempt organizations and it will be available only for plans purchased through SHOP. You can still deduct from your taxes the rest of your premium costs not covered by the tax credit.

You can find out if your company is eligible by visiting www.coveroregon.com/shop_calculator.php.

For more information on how to qualify, contact a CPA or a tax professional, or consult the IRS at www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers.
A few important points about individual coverage

It’s important to understand some aspects of the ACA rules that apply to individual coverage, since they may apply to your employees:

- Most U.S. citizens are required to have health insurance by Jan. 1, 2014.
- Depending on income and family size, individuals may receive financial assistance when they shop in Cover Oregon.
- If an employer’s plan is unaffordable for an employee (e.g., exceeds 9.5 percent of income), the employee can shop in Cover Oregon to seek alternative plans and to determine whether he or she qualifies for financial assistance.

Resources for more information

Your producer is an excellent source for more information regarding the ACA.

If you have any questions about health care reform in general, about how the ACA will affect your company, or about the plans that will be offered by Providence, we encourage you to connect with your producer or with the sales team at Providence Health Plan at 503-574-6300 or 877-245-4077. We’ve been living and breathing health care reform and we stand ready to help guide you through it.

In addition, these resources may be very helpful:

www.ProvidenceHealthPlan.com/reform
www.coveroregon.com
www.healthcare.gov

This information is provided by Providence Health Plan in partnership with your producer. Providence offers this information on some of the laws applicable to health care reform so that employers can understand the general legal landscape and seek their own counsel. Where possible, we provide tips for how to find additional information from regulators. This guide is offered for general educational purposes only and should not be taken as legal advice. Employers should consult with their benefit advisors about the specific legal considerations of their benefit programs.
Employer Requirements

Under the ACA, employers will be required to do the following:

**Provide a Summary of Benefits and Coverage to all plan participants**

The Summary of Benefits and Coverage, or SBC, provides basic health plan coverage information in a standardized format. It is designed to help people comparison shop for health insurance, and does not replace the plan benefit summary. Employers must provide the SBC to all participants at the time of enrollment and each subsequent year during open enrollment, as well as any time an employee requests it.

**Notify all employees about Cover Oregon and eligibility for tax credits**

Employers will be required to notify employees about Cover Oregon and eligibility for premium tax credits. The notice must be sent by October 1. After the initial notice, all new employees must be notified on their date of hire.

**Set employee eligibility requirements for group health insurance**

Small-group employers can continue to set the minimum number of hours that employees must work each week to be eligible for group health insurance between 17.5 and 40 hours.

**Follow nondiscrimination rules**

Employers will not be allowed to provide highly compensated employees with enhanced eligibility, health benefits or employer contributions. Differences based on years of service, age or compensation level are not permissible. The probationary period can be waived for all employees at the initial group enrollment, but cannot be waived for selected employees after that point. Enforcement of this requirement is on hold pending the issue of federal rules.

**Fees and Taxes**

The ACA includes fees that will be collected from health insurance carriers. Providence Health Plan has incorporated the following into its small-group plan premiums:

- A Cover Oregon Fee, which helps fund federal and state exchanges, as well as subsidies for low-income purchasers. The impact on premiums is approximately 2.3 percent of the premium in the first year.
- A Transitional Reinsurance Fee, which collects funds that will be distributed to insurers who disproportionately attract individuals at risk for high medical costs. The estimated cost is $5 to $6 per member per month.
- A Risk Adjustment Fee, which helps with the cost of the Risk Adjustment Program, and costs about $1 per member per year.
- A Patient-Centered Outcomes Research Institute (PCORI) Fee, which is a temporary fee that began in 2012 and will continue through 2019. The estimated cost is $2 per member per year.
Our Mission
As people of Providence, we reveal God’s love for all, especially the poor and vulnerable, through our compassionate service.

Our Core Values
Respect, Compassion, Justice, Excellence, Stewardship

Portland metro area
503-574-6300

All other areas
877-245-4077

www.ProvidenceHealthPlan.com