The Affordable Care Act (ACA) brings significant changes to how Americans access and pay for health care. We want to help you understand health reform and how it will affect you and your patients. Here are some of the provisions and health plan changes that have the greatest impact to health care providers:

**Health Insurance Marketplaces**

The Health Insurance Marketplaces (also called Exchanges) are intended to help individuals and small groups to research, compare and enroll in quality health plans from health insurers. The ACA requires Health Insurance Marketplaces to be established in each state by Jan. 1, 2014. If a state does not establish a Marketplace, the federal government will step in and operate the Marketplace on behalf of the state. From 2014 to 2016, only individuals and employers in the small group market are eligible to participate in a Marketplace. Small groups are defined as groups with 50 to 100 employees depending on the state. In 2017, states may permit employers in the large group market to participate. In most states the initial open enrollment period for plans offered through the Individual Marketplace starts Oct. 1, 2013 and ends March 31, 2014.

Marketplaces will exist in each state and be operated by the state, the federal government or as a federal/state partnership. The minimum responsibilities of the Marketplaces include:

- Operate a web portal and toll-free number
- Determine eligibility, enrollment, and exceptions and connect with Medicaid
- Certify health plans
- Determine eligibility for financial subsidy assistance and maintain electronic cost calculator
- Determine financial integrity/manage risk adjustment and reinsurance
- Review patterns of rate increases
- Implement health plan rating system and enrollee satisfaction system
- Establish a Navigator program to facilitate enrollment

**Individual Mandate**

Beginning in 2014, the ACA requires most Americans to have health insurance or pay a penalty. Coverage may be obtained through an employer or individual insurance plan, Medicaid, Medicare, other government program, or a Health Insurance Marketplace. In 2014, individuals who do not elect coverage offered by their employer and do not have other coverage will be assessed a tax penalty based on the individual’s income. This penalty will grow from $95 per uninsured person or one percent of household income over the tax filing threshold (whichever is greater) in 2014 to $695 per uninsured person or 2.5 percent of household income over the tax filing threshold by 2016, subject to certain limits and indexed to inflation in future years (whichever is greater).

**Federal Subsidy Assistance**

Under the ACA, many individuals and families may qualify for federal subsidies. Subsidies can be used to lower a monthly premium and for some qualifying individuals, to lower their out-of-pocket costs. Subsidies are only available through the Individual Marketplace. An employee with access to employer-based coverage is only eligible for a subsidy through the Individual Marketplace if the coverage offered through his or her employer is “unaffordable” (i.e., the required share of the employee’s premium for self-only coverage exceeds 9.5 percent of his or her household income) or if the coverage does not satisfy a “minimum value or minimum essential coverage” requirement (i.e., the plan must pay at least 60 percent or more of the plan’s total allowed benefit costs anticipated for a standard population).

**Three-Month Grace Period**

Under the ACA, health insurance plans are required to provide a three-month grace period before terminating coverage for certain individuals enrolled in a health plan purchased through the Individual Health Insurance Marketplaces. The grace period applies to those who receive federal subsidy assistance in the form of an advanced premium tax credit and have paid at least one full month’s premium within the benefit year.

**Removal of Pre-Existing Condition Exclusions**

For plan/policy years beginning on or after Jan. 1, 2014, the ACA will remove any restrictions on pre-existing conditions for individuals of all ages. Therefore, coverage may not be denied for pre-existing conditions, nor will individuals with pre-existing conditions be charged more because of their pre-existing condition. This is an update to the provision from 2010 that did not allow plan exclusions for children under age 19 with a pre-existing condition. This applies to non-grandfathered and grandfathered plans (with the exception of grandfathered individual health plans).
Guaranteed Availability of Coverage
(Appplies to Non-grandfathered Plans)
Health insurers are to offer coverage to and accept every employer or individual who applies for coverage in the Group and Individual Marketplaces, subject to certain exceptions. Exceptions allow issuers to restrict enrollment in coverage to:

1. Open and special enrollment periods,
2. Employers with eligible employees who live, work or reside in the service area of a network plan, and
3. In situations involving limited network capacity and limited financial capacity.

Essential Health Benefits
Beginning in 2014 for non-grandfathered plans, all health insurance plans in the fully insured small group and individual markets (offered in or outside the Marketplace) must include all Essential Health Benefits (EHB) specified in the EHB benchmark plan in their state. All annual and lifetime dollar limits will be removed from EHB. These benefits include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services (including behavioral health treatment)
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services (including dental and vision care)

For plan years beginning on or after Sept. 23, 2010, non-grandfathered health plans are required to cover emergency room services as in-network without prior authorization. If services are provided out-of-network, the cost-sharing requirement is the same as if services were provided in-network.

For plan years beginning on or after Jan. 1, 2014, non-grandfathered health plans are also required to cover routine patient costs incurred in approved clinical trials.

Out-of-Pocket Maximum Changes
Beginning in 2014, all cost-sharing toward services that are defined as Essential Health Benefits must accumulate toward the plan’s out of pocket maximum (OOPM).

Key Considerations for Providers
- The widespread coverage expansion may cause an increase in wait times for primary care access.
- Newly-insured patients with limited familiarity of the health care system may require more education by health care providers.
- There will be more emphasis on preventive care for individuals with no prior source of health care.
- There is greater alliance on verifying patient eligibility at the point of service due to the potential changes in coverage plans and federal subsidies within a single enrollment year. Health plans will provide members with emergency services in and out of the service area.
- A percentage of Americans will still be uninsured after the individual mandate goes into effect January 1, 2014.

Refer to the www.uhc.com/reform website for updates and more detailed information.

1 Disproportionate Share Hospitals (DSH) and DSH-eligible Hospitals, Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, and Critical Access Hospitals.