Navigating the Health Insurance Maze, ACA, and What it Means to the Traveling Healthcare Professional

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Course Objectives

What You Will Learn Today

• Understanding of how health plans are written and meaning of key terms
• Definition and Overview of the primary elements of the Patient Protection and Affordable Care Act (ACA)
• Outline of the new individual and employer mandates required by the ACA legislation and when they take effect
• How ACA will impact employees, including travelers
• Evaluating health insurance plans & estimating costs for 2014
• Sources, qualifications & cost comparison of health insurance plans
Evaluating Your Benefit Options

It is about more than your premium cost
Understand all costs associated with your health plan options to make an informed decision

• **Waiting Period** – how long you must work for a new employer before you are eligible to join their health plan. Travel staffing firm waiting periods range from “none”, meaning coverage as of day one to the 1\textsuperscript{st} day of the next calendar month, to the 1\textsuperscript{st} day of the calendar month following 30 to 60 days of employment.

• **Qualifying event** – a change in an individuals or spouse’s employment or personal status that impacts their eligibility for benefits (allows enrollment or drop of benefits outside open enrollment). This includes, but not limited to, loss or gain of employment, marriage, death, birth or adoption of child, loss of other benefits due to employment change of spouse.
Additional Definitions

- **Wellness/Preventative care** – primary care services, wellness visits, annual physicals, immunizations, and preventive diagnostic procedures (ie: mammogram)

- **In-Network** – Providers and services that have negotiated services and reimbursements with the health plan

- **Out of Network** – Providers that do not have a service agreement with the health plan. In most cases care/services from out-of-network providers are reimbursed at a much lower percentage or not covered at all.

- **Premium** – the total monthly cost of the health plan you choose. In some cases, your employer will “subsidize” that cost to you. Your portion of the premium is often referred to as “employee deduction” and is typically taken out “pre-tax”

- **Co-Pay** – the cost you pay for the specific services. For example a PCP visit may be assessed a co-pay of $25 (the portion of the visit you pay, the rest is covered by the health plan)
• **Deductible** – the amount of money you pay for health services BEFORE your health plan starts paying benefits. In some plans, the deductible will not apply to primary care services.

• **Co-Insurance** – a cost sharing agreement within the health plan whereby the health plan and insured share a percentage of the cost of certain services.

• **Maximum Out of Pocket** – the maximum amount that the insured would be required to pay out of pocket for health care services even if other limits are exceeded.

• **Maximum Limit** – the maximum financial limit a plan will pay for services. Usually defined as either an annual or lifetime amount.
## Sample Health Plan

<table>
<thead>
<tr>
<th></th>
<th>HMO Plan</th>
<th>PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employee Only</td>
<td>Employee +1</td>
</tr>
<tr>
<td>Weekly Deduction</td>
<td>$50.00</td>
<td>$98.00</td>
</tr>
<tr>
<td>Co-Pay PCP</td>
<td>$25.00</td>
<td></td>
</tr>
<tr>
<td>Co-Pay Specialist</td>
<td>$40.00</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$150.00</td>
<td></td>
</tr>
<tr>
<td>Vision Exam</td>
<td>$25.00</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$10.00 – Generic</td>
<td>$10.00 – Generic</td>
</tr>
<tr>
<td></td>
<td>$35.00 – Preferred</td>
<td>$35.00 – Preferred</td>
</tr>
<tr>
<td></td>
<td>$50.00 - Non-formulary</td>
<td>$50.00 - Non-formulary</td>
</tr>
<tr>
<td>Deductible</td>
<td>$2000 (does not apply to preventative services)</td>
<td>$3,000 (does not apply to preventative services)</td>
</tr>
<tr>
<td>Co-Insurance</td>
<td>70% / 30% employee</td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>Deductible &amp; Co-Insurance</td>
<td>Deductible &amp; Co-Insurance</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>Deductible &amp; Co-Insurance</td>
<td>Deductible &amp; Co-Insurance</td>
</tr>
</tbody>
</table>
Why the Affordable Care Act?

Designed to primarily decrease the number of uninsured Americans.

Unreimbursed health care has contributed to the rising costs of health care in this Country. In excess of 32 million Americans are either uninsured or under insured.
Primary Elements of ACA

• Individual mandate
• Health Care Exchanges and access to premium tax credits
• Shared responsibility for large employers (>50 Employees) working full time
• Health plan design and premium requirements
• IRS reporting requirements
Factors Affecting Health Care Costs

• State run health insurance exchanges open for individuals and small businesses

• Individuals under 400% of the Federal Poverty Level entitled to premium tax credits/federal subsidies if their only option is to obtain coverage through an exchange*

• Health insurance mandates:
  – No pre-existing condition provisions
  – Restrictions on health and age rating premiums
  – Guaranteed availability of coverage
## Determining Eligibility for Tax Credits

<table>
<thead>
<tr>
<th>Family Members</th>
<th>100%</th>
<th>138%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,490</td>
<td>$15,852</td>
<td>$45,960 ($22.09/hr)</td>
</tr>
<tr>
<td>2</td>
<td>15,510</td>
<td>21,404</td>
<td>62,040</td>
</tr>
<tr>
<td>3</td>
<td>19,530</td>
<td>26,951</td>
<td>78,120</td>
</tr>
<tr>
<td>4</td>
<td>23,550</td>
<td>32,499</td>
<td>94,200</td>
</tr>
<tr>
<td>5</td>
<td>27,570</td>
<td>38,047</td>
<td>110,280</td>
</tr>
<tr>
<td>6</td>
<td>31,590</td>
<td>43,594</td>
<td>126,360</td>
</tr>
<tr>
<td>7</td>
<td>35,610</td>
<td>49,142</td>
<td>142,440</td>
</tr>
<tr>
<td>8</td>
<td>39,630</td>
<td>54,689</td>
<td>158,520</td>
</tr>
</tbody>
</table>

Individuals will **not** be eligible for tax credits if they are offered health insurance through their employer that meets both the affordability and minimum essential coverage tests.
Determining Your Cost Using The Affordability Test

Sample scenario in determining if health care coverage meets the affordability requirement of ACA (based upon a single individual household)

Taxable hourly rate $25 x 36 hours/week = $46,800 annual salary

9.5% of $46,800 annual salary = $4,446 (max employee costs)

Monthly insurance premium cannot cost more than $370.50 or approximately $93 per week to be considered “affordable” per the ACA
Individual Mandate Effective 1/1/14

- All Americans are required to secure health insurance that meets MEC to avoid tax penalties in 2014.
- Health insurance coverage must begin meeting some of the ACA guidelines of “minimal essential coverage” (e.g. no policies with lifetime limits).
- Paying the tax penalty does not mean that you have health coverage. You would still be responsible for any healthcare costs you incur.
Individual Mandate Effective 1/1/2014, Cont.

- Tax penalty in 2014 is $95 per adult and $47.50 per child, or 1 percent of household income over the filing threshold ($10,000), whichever is greater. ($50,000 salary = $400 tax penalty). Family Penalty capped at 300% of the individual penalty or $285.
- Tax penalty in 2016 increases to $695 per person or 2.5% of taxable income; whichever is greater.
What Kind Of Plans Do Not Qualify As Coverage?

• Worker’s compensation
• Coverage for only dental or vision
• Disease or condition specific coverage
• Plans that only offer discounts on products and services
• Plans that impose a financial cap/limits on total annual spend/health care costs
Defining Minimum Essential Coverage (MEC)

• Big change in travel world! No more “mini-medical” plans as of Jan 1, 2014
• This requirement will have the highest impact on the costs to traveling healthcare professionals
• Health insurance plans that limit or cap the total annual health care costs are no longer allowed under the new ACA regulations
• Health coverage plans must also offer preventive care, wellness visits, immunizations, & medical screenings at no cost to the covered individuals (no insurance co-pays or deductibles) as of Jan 1, 2015
• As of Jan 1, 2015, Health plans must offer a “minimum value”, defined as covering at least 60% of the health care costs as determined by actuaries
Sources For Health Insurance

- Employer sponsored plans
- Medicare/Medicaid (if you meet eligibility)
- State/federal exchanges, also called marketplace
  - Health insurance marketplace found on [www.healthcare.gov](http://www.healthcare.gov). Regardless of which state you live in, the marketplace will allow you to search for health plan options, compare plans, and enroll.
  - Plans on the marketplace offered by private insurance companies but managed/overseen by either the state or federal government
- Cannot be denied due to age or pre-existing conditions
Evaluating Your Options For Health Insurance In 2014

• The process for buying individual health insurance will be much easier

• Individuals will be able to apply for advance premium tax credits in exchanges either online, via call center, or paper application

• Plan choices will be arrayed online based on where you live. A standard, short summary of coverage will be provided for all plans. This will explain covered benefits and cost sharing and provide illustrations of how coverage would work. When looking online, consumers are expected to be able to sort and compare plans based on the standard coverage elements they care most about.
Evaluating Your Options For Health Insurance In 2014

• All insurers will be required to cover mostly the same benefits, including some services that are often excluded or limited today for people buying their own insurance (e.g., maternity care, mental health, and prescription drugs).

• Coverage will be standardized into tiers (from bronze to platinum). Deductibles and copays will typically vary from plan to plan, but all plans in a given tier will provide the same overall level of protection to consumers.

• Health insurance plans can only be purchased from the state exchange/marketplace during open enrollment or in the even of a “qualifying event”. Open enrollment for the first year is 6 months (October 2013 – March 2014)
Estimating Your Costs In 2014

• Health Plan information will publicized in the state exchanges/marketplace as of October 1st, 2013, the start of open enrollment

• In addition, the Kaiser Foundation Plan has developed a calculator to help consumers estimate their potential purchase price for individual health plans.
  • With this calculator, you can enter different income levels, ages, and family sizes to get an estimate of your eligibility for subsidies and how much you could spend on health insurance. As premiums and eligibility requirements may vary, contact your state’s Medicaid office or exchange with enrollment questions.  
    http://kff.org/interactive/subsidy-calculator/
  • Calculator estimates that an individual plan coverage premium for a single non-smoking person will be $3,018 ($251.50 per month) through the exchange/marketplace (prior to any eligible tax credits being applied)

• OTHER CONSIDERATIONS: Health plan options purchased through the state exchanges/marketplace are not pre-tax, while in comparison, most employer sponsored plans offer pre-tax premiums.
Employer Mandates Effective 1/1/2015

- Employers* (including travel staffing firms) must offer “affordable” health care coverage to all full time employees to avoid tax penalties.
- Must offer health insurance meeting the ACA guidelines of “minimum essential coverage”
- Full-time employee is defined as working a minimum of 30 hours per week.
- “Affordability” is defined as the employee’s cost for self-only coverage no exceeding 9.5% of the employee’s household income.
- Employers can impose up to a 90 day waiting period before an employee is deemed eligible for employer sponsored health insurance.

*Employers with less than 50 employees (temporary or permanent) are not bound by these requirements.
ACA Review - What Happens In 2014?

Employers do not yet have to offer health insurance, but if they do, certain conditions apply:

• Beginning in 2014, a ban on annual and lifetime coverage limits on essential health benefits, such as physician, hospital, and pharmacy benefits.

• If a plan includes coverage for children, a parent must be allowed to cover a child through age 26.

• Certain preventive services must be provided with no cost-sharing for those services.

• Expanded nondiscrimination rules preclude more favorable benefits to higher paid employees.

Individual mandate goes into effect (you must obtain health insurance or pay a penalty)
ACA Review - What Does Not Happen Until 2015?

- Employers must offer health insurance to FTE’s (min. 30 hrs per week) if they employ over 50 people or they face taxes/penalties
- Employers must offer MEC (minimum essential coverage) on all plans
- Employers must file complex reports on health care coverage, health care plan provisions and other information on full time employees.
Resources For More Information

- All employers are required to provide more detailed information about their health plan coverage and the state exchanges to all employees by October 1, 2013.

- www.healthcare.gov
  - Includes information about state exchanges
  - Open marketplace for individual health coverage plans
  - Online forms and tools to find out if you are eligible for tax credits/federal subsidized health coverage and estimate your 2014 health insurance costs