ANSWERING THE QUESTION: WHY SHOULD I RENEW MY MEMBERSHIP?

HEALTH CARE REFORM: D-DAY IS NEAR

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Jan. 1, 2014, marks the beginning of a new era for health insurance in the United States. That’s when the final and most significant provisions of the Patient Protection and Affordable Care Act (PPACA, or ACA) take effect.

The U.S. Supreme Court decision and President Barack Obama’s re-election in 2012 signaled that the PPACA would be implemented. The federal health reform law is fundamentally changing the structure of health insurance in Michigan and the rest of the United States, and this will have an impact on you.

President Obama’s re-election sent insurance carriers scrambling to develop and obtain approval for ACA-compliant plans. Work went into overdrive to get the state- and federally run online insurance marketplaces (formerly called “exchanges”) ready to begin enrolling participants on Oct. 1. Behind the scenes, federal agencies, including Health and Human Services, the Internal Revenue Service, the Treasury Department and the Department of Labor, are writing and releasing regulations almost every week to implement various aspects of the health care reform law. As this is written, the House of Representatives continues its attempts to repeal or defund “Obamacare.”

Despite the sometimes heated discussions in the mass media about the merits and drawbacks of PPACA, many people remain unaware of how the law will affect them individually or in their role as employers. This article will explain the employer mandate, the individual mandate and premium subsidies that are available, how the marketplace works, what ACA-compliant plans are, how the exclusive MDA-endorsed health plan will be affected, and how others who purchase their health insurance from MDA Insurance will be affected.

We’ll also provide a little detail about what health care reform has already implemented (see the box on Page 26). In a separate article in this issue, the MDA Insurance department explores the many new taxes that take effect next year:

- All health insurance coverage is guaranteed issue, meaning you cannot be denied coverage due to health conditions.
- All coverage is guaranteed renewable, so you cannot be canceled from your selected health insurance policy.
- Effective in 2014

There are five major ACA-related changes coming to health insurance that take effect Jan. 1, 2014.

1. The individual mandate requires all American citizens to have health insurance or pay a penalty tax.
2. Premium subsidies will be available to some individuals.
3. The online insurance marketplace, which was scheduled to open Oct. 1, becomes a purchasing mechanism for consumers who are eligible for subsidies.
4. Community rating and risk aggregation are implemented.
5. Medicaid is being expanded to include those up to 133 percent of federal poverty level, effective April 1 in Michigan.

In addition, the following ACA-related health insurance provisions take effect next year:

- All health insurance coverage is guaranteed issue, meaning you cannot be denied coverage due to health conditions.
- All coverage is guaranteed renewable, so you cannot be canceled from your selected health insurance policy.
- Effective in 2014
### Affordable Care Act
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plan, except for non-payment of premium.

- All insured health plans in the individual market and small groups of less than 50 employees must include coverage for 10 essential health benefits (EHB). All annual limits on EHB are abolished (see the box on Page 27).
- Pre-existing condition coverage exclusions are eliminated. Health care services for current and/or chronic conditions are eligible for benefit payment when your policy is effective.
- Waiting periods of greater than 90 days are prohibited. If you offer insurance to your employees, you cannot require them to wait more than 90 days to participate in your plan.
- Actuarial value scoring of health plans in bronze, silver, gold and platinum “metal tiers” (see the box on Page 27 for more information).
- Postponed until 2015 is the employer mandate, which requires employers of 50 or more full-time equivalent employees (FTE) to provide affordable health insurance to their employees or pay a tax penalty.

Let’s take a closer look at some of the biggest changes.

#### The individual mandate

With few exceptions (see the box on Page 28) the individual mandate requires all American citizens to have health insurance. Citizens can choose to comply with the law and obtain health insurance, or they can choose non-compliance and pay a tax penalty. The tax penalty for failing to have health insurance graduates over time. For 2014, it is the greater of $95 per adult and $47.50 per child up to $285 for a family, or 1 percent of household income. By 2016, the tax goes up to the greater of $695 per adult and $347.50 per child or 2.5 percent of household income. Gaps in coverage of three months or less are exempt from penalty.

Some people are exempt from the broad individual mandate (see the box on Page 28) and many will continue to obtain health insurance from their employers. Those who do not, or who cannot afford the premium cost-sharing required by their employer’s plan, may shop for health insurance coverage using an insurance agent or the online marketplace.

Because children must also have insurance, 2014 brings the availability of child-only policies, which would be appropriate if the parents obtained insurance through their employers, for example, but that coverage was for the employee only.

Another aspect of the health care reform law that has received little attention relates to how rates are developed in the insured market. Prior to the ACA, rates were set based on the age of the primary policy holder and determined by whether they offered health insurance. New employees must receive the notice within 14 days of employment.

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### Reforms Already in Place

#### 2010
- $0 cost-sharing for preventive in-network services
- Young adult coverage extended to age 26 on parent’s policy
- Pre-existing condition exclusions end for those under 19 years of age
- Lifetime dollar limits eliminated
- Restricted yearly dollar limits permitted for certain benefits
- Coverage recessions/cancellations disallowed
- Enhanced appeals process

#### 2011
- 50 percent discount on brand-name drugs for Medicare subscribers in “donut hole”
- Medical loss ratio rules: Insurers must expend 80 percent of premium at minimum for health care services in small groups/individual plans, 85 percent minimum for large groups, or rebate premium to insureds
- Rate increases equal to or greater than 10 percent must be submitted for review and approval
- Employers issuing 250 or more W-2 forms must report the cost of health insurance premiums on statement; postponed for employers issuing fewer than 250 W-2s
- Voluntary long-term care insurance program was to be effective, but was rescinded due to economic non-viability

#### 2012
- Women’s wellness benefits effective: free services include well-woman visits, generic contraceptives, counseling, screenings, breast-feeding supplies and support
- Uniform Summary of Benefits and Coverage requirements for employers providing health insurance
- New annual fees on pharmaceutical manufacturing sector

#### 2013
- New 2.9 percent tax on medical device manufacturers
- Increase Medicare Part A tax rate by 0.9 percent on those earning $200,000 or $250,000 filing jointly
- Itemized deduction threshold for unreimbursed medical expense increased from 7.5 percent to 10 percent of adjusted gross income
- $2,500 limit on Flexible Spending Account contributions
- Notice of the availability of the Health Insurance Marketplace was to be issued by Oct. 1 by all employers to current employees regardless of whether they offer health insurance. New employees must receive the notice within 14 days of employment.
family. Beginning next year, member-level rating takes effect. This means that the policyholder will receive one rate, based on his or her age, the spouse another rate based on his or her age, and children ages 0 to 21 will have their rate. A maximum of three children up to age 21 will be rated per policy. Children 21 through 26 on their parental policy have their own rates, based upon their ages. Member-level rating likely means it will cost more to insure a family.

Subsidies available

Premium subsidies will be available to individuals earning up to 400 percent of the federal poverty level (see the chart on Page 28) and who do not receive health insurance from their employer or who must pay more than 9.5 percent of their income for single-person coverage for employer-provided plans. We do not expect many dentists will be subsidy-eligible. However, some of their employees, especially part-timers or single parents, may be. Varying levels of subsidy will be available with which to purchase marketplace insurance plans. MDA Insurance agents can provide assistance in determining subsidy eligibility. In order to take advantage of an available subsidy, a marketplace plan must be purchased. MDA Insurance agents are available to help with that process, too.

Being eligible for a subsidy does not mean that the premium will be paid in full by the government. Indeed, there is a sliding scale for subsidies based upon income and family size. The Congressional Budget Office estimates the subsidy will represent 77 percent of the premium for a single person earning $20,600 per year, 45 percent for those earning about $32,400 and 13 percent for those earning about $44,200. More than 5 million people earn too much to qualify for marketplace subsidies.

Subsidies will be paid monthly by the federal government to the insurer to lower the monthly premium the individual must remit. The payments are reconciled on the taxpayer’s tax return. Insurance carriers will provide documentation that insureds must include with their federal income tax return to demonstrate they have health insurance.

About the online marketplace

The online marketplace, formerly known as an exchange, is supposed to be a website where people can learn about and buy health insurance. Marketplace plans available from various carriers will be described by the bronze, silver, gold and platinum metal-tier labels (see the box with metal tier explanations) to make them easier to compare. Thirteen carriers will have plans on Michigan’s online marketplace, but there are a limited number of plans from all carriers.

A person who is not eligible for a subsidy and wishes to buy health insurance will have little reason to use the online marketplace due to the restricted plan offerings. You will receive better service and a better customer experience working directly with an agent at MDA Insurance. We will have access to all plan designs and the same premiums available on and off the marketplace.

The federal government is running the Michigan health insurance online marketplace. For those who think they may be subsidy-eligible, MDA Insurance has agents licensed to assist people with the online marketplace. It costs nothing extra to work with an MDA Insurance agent to purchase from the online marketplace, and MDA members and their employees are encouraged to call us at 877-906-9924 for personal assistance. We’re sure this experience will be more pleasant and efficient than working with a random marketplace employee who may be difficult to contact with follow-up questions or concerns. Let MDA Insurance be your guide through this new outlet for purchasing health insurance.

### 10 Essential Health Benefits

The following 10 items are deemed “essential health benefits” for every health insurance plan under the ACA. Plans must include all these benefits at minimum.

1. Ambulatory services
2. Emergency services
3. Hospitalization
4. Maternity & Newborn care
5. Mental health and substance abuse services
6. Prescription drugs
7. Lab services
8. Preventive and wellness services and chronic disease management
9. Rehabilitative and habilitative services and devices
10. Pediatric oral and vision care

### ACA-Compliant Metal Tier Plans

The Affordable Care Act establishes uniform “metal tiers” that describe health insurance plans with the goal of making it easier to compare plans and understand benefit levels. Every plan must include the 10 Essential Health Benefits. Each metal tier must meet certain actuarial values, varying no more than 2 percent above or below the standard established for the metal tier.

- **Bronze plans:** Cover 60 percent of costs; enrollee pays 40 percent of the cost through copays, deductibles and coinsurance. Actuarial value is 58-62 percent.
- **Silver plans:** Cover 70 percent of costs; enrollee pays 30 percent of the cost through copays, deductibles and coinsurance. Actuarial value is 68-72 percent.
- **Gold plans:** Cover 80 percent of costs; enrollee pays 20 percent of the cost through copays, deductibles and coinsurance. Actuarial value is 78-82 percent.
- **Platinum plans:** Cover 90 percent of costs; enrollee pays 10 percent of the cost through copays, deductibles and coinsurance. Actuarial value is 88-92 percent.

*Bronze Plans are deemed the minimum essential coverage level.*
Open enrollment on the marketplace began Oct. 1 and continues until March 31. Coverage is effective Jan. 1 for plans selected by Dec. 15. In 2015 and thereafter open enrollment on the marketplace will run from Oct. 15 to Dec. 7, except for those eligible for Medicaid and the Children Health Insurance Plan (CHIP).

Community rating and risk aggregation
Prior to the ACA, health insurance carriers could create special rating pools for groups of individuals with similar characteristics. Many groups had their own rating pools, including the exclusive MDA-endorsed, quarterly billed, health plan that is restricted to only MDA members, their families and staff. Since our risk pool consists of health care professionals who generally are attentive to remaining healthy and are in low-risk occupations, our health care claims have been reasonable and predictable. Moving forward, all individuals from every walk of life will be put into one large risk pool. Special pools like ours will be disallowed in commercially available health plans, which will have an effect on the MDA-endorsed plan (see Page 29 for details) as well as plans offered by chambers of commerce and other organizations that relied on special rating pools.

We expect that the new aggregated risk pool, including people who were previously uninsured or uninsurable because of pre-existing conditions, as well as individuals from all employment sectors and lifestyles, will result in higher utilization of medical services. What will happen to premiums? Some analysts say premiums in the insured market will rise from 10 percent to 40 percent due to the combined impact of ACA changes and the medical inflation trend. Consumers will also bear the cost of increased taxes and fees associated with being insured. (See the graphic on Page 54.)

Employer mandate
Most dental practices do not employ 50 or more full-time workers and therefore are exempt from the employer mandate to provide affordable health insurance. However, dentists who own multiple practices or who also own a business or businesses outside of dentistry may bump up against the 50 FTE threshold. That’s because the law stipulates that employees are counted not by the individual businesses, but by all businesses under common ownership. So, if you own several practices that operate under various names or if you own other businesses, you must count all your employees to determine whether the employer mandate applies to you.

For health care reform, an employee who works 30 hours per week is considered full-time. Here’s how you count FTEs per location:
- 35 people averaging 30 or more hours/week = 35 FTE
- 15 people averaging 10 hours/week = 5.41 FTE. This is calculated by multiplying 15 people times 10 hours a week, which equals 150 hours a week. There are 4.33 weeks in a month, which equals 649 hours per month. Divide 649 by 120 (which represents the number of full-time hours in a month as defined by the ACA) to equal 5.41 FTE. Thus, this group has 40.41 FTEs and is exempt from the employer mandate.

In July, the so-called “play or pay” component of the employer mandate was delayed until 2015 to allow parties the necessary time to develop reporting mechanisms to track compliance with the mandate. Accordingly, dentists who may be affected by the employer mandate have another year to comply with the requirement. When it does kick in, employers have two opportunities to be taxed for non-compliance:
- If the employer fails to offer any health plan or offers a plan without “minimum essential coverage,” meaning the plan pays less on average than 60 percent of the cost of essential health benefits, a penalty applies. The tax penalty for those

### Federal Poverty Level

<table>
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<th>Household Size</th>
<th>100%</th>
<th>133%</th>
<th>150%</th>
<th>200%</th>
<th>300%</th>
<th>400%</th>
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<tr>
<td>1 Person</td>
<td>$11,490</td>
<td>$15,282</td>
<td>$17,235</td>
<td>$22,980</td>
<td>$34,470</td>
<td>$45,960</td>
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<tr>
<td>2 People</td>
<td>$15,510</td>
<td>$20,628</td>
<td>$23,265</td>
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<td>$46,530</td>
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<tr>
<td>3 People</td>
<td>$19,530</td>
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<td>$39,060</td>
<td>$58,590</td>
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<tr>
<td>4 People</td>
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<td>$31,322</td>
<td>$35,325</td>
<td>$47,100</td>
<td>$70,650</td>
<td>$94,200</td>
</tr>
</tbody>
</table>

Insurance subsidies will be available to individuals earning up to 400 percent of federal poverty level.
scenarios is $2,000 per employee, per year, assessed on all employees, with the first 30 employees being exempt from the penalty.

If the employer offers health insurance that is not “affordable,” there is also a penalty. A plan is deemed not to be affordable if the employee’s contribution to the premium for single-person coverage exceeds 9.5 percent of his or her income. If the insurance plan costs the employee more, he or she may opt out of the employer’s plan and purchase coverage on the online marketplace. If this happens, the employer becomes subject to a tax penalty for each month at least one employee purchases coverage from the marketplace. If this happens, the employer becomes subject to a tax penalty for each month at least one employee purchases coverage from the marketplace. If this happens, the employer becomes subject to a tax penalty for each month at least one employee purchases coverage from the marketplace. If this happens, the employer becomes subject to a tax penalty for each month at least one employee purchases coverage from the marketplace.

First, every employer must provide each employee with a notice that the online insurance marketplace is available, regardless of whether health insurance is offered as a benefit. Make this a part of your new employee orientation. Model notices are available in the Health Care Reform section of the MDA Insurance website at www.mdadprograms.com. Employers were required to issue the notice to all employees by Oct. 1. All new employees must receive the notice within 14 days of employment. Despite persistent rumors, the government recently announced there will be no fines or penalties associated with non-compliance of this ACA rule.

Second, since 2012 employers have been required to distribute a Summary of Benefits and Coverage form that shows the plan’s benefits and the subscriber’s share of the costs in-network and out-of-network. This requirement continues. Expect to distribute new SBCs in 2014, since carriers are rolling out new plans to comply with the metal tier structure and actuarial value rules.

What’s happening to my insurance?

MDA Insurance insures MDA members in several different product lines right now. Each will be impacted differently by the ACA. We’ll break this down into six segments to help you understand how you will be affected. Most segments apply to those who purchase their health insurance from MDA Insurance, or who may be interested in doing so now or in the future.

Exclusive MDA-endorsed, quarterly billed plan. If you subscribe to the exclusive MDA-endorsed, quarterly billed Blue 4 Ever Life health plan there is great news. We were able to secure an early renewal of this

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plan, allowing us to extend your current coverage throughout 2014. This plan will renew Dec. 31 rather than
Jan. 1 and will be in effect throughout next year, temporarily shielding you from some of the more onerous effects of health care reform discussed previously. This also applies to people age 65 and over who are in our exclusive quarterly billed Complementary to Medicare plan.

There are, however, some things you must be aware of and act upon, if you wish to enter the plan or make plan changes for 2014. After Dec. 1:

- You cannot change between plan designs, so be sure you select the plan you wish to be enrolled in by the end of November. For example, you cannot change from a Comprehensive Major Medical 1500 plan to a Flexible Blue 3 plan after Dec. 1, 2013.

- You may only add a spouse and child/children to your current health insurance plan.

- You may not change the policyholder from one spouse to another.

- No new enrollments will be allowed. Therefore, member dentists will no longer be able to offer the Blue 4 Ever Life individual health insurance plan to new employees. MDA Insurance has other health insurance solutions available to dental office employees and we can help them on the online marketplace as well. Call us for help.

Due to the ACA’s aggregation of risk pools and community rating, at the end of 2014 the MDA’s exclusive Blue 4 Ever Life health plan is expected to transition to a new self-insured group health plan, called a Multiple Employer Welfare Arrangement (MEWA). Self-insured plans are exempt from many ACA insurance market provisions (see the box on Page 29 for more information on the prospective MEWA). The plan we are developing will allow MDA members to have access to a proprietary health insurance program for themselves, their families and their staff members. It will be available only from MDA Insurance. We hope to migrate most of our quarterly billed subscribers and some fully insured group plans to the MEWA for coverage effective Jan. 1, 2015. More information about this new plan will be published in the Journal and other MDA publications throughout 2014. For now, rest happy that you can keep your existing plan for one more year.

Small group plans of less than 50 people. All existing Blue Cross Blue Shield of Michigan (BCBSM) small group health insurance plans are being discontinued at their renewal date in 2014. Groups are being mapped to new ACA-compliant Blue plans that most closely mirror existing plans. It is important to recognize that new plans are not identical to old plans. In October, we began delivering the new plan designs to MDA members whose small group plans renew in January to provide dentists with the option of selecting a different plan if they wish. The new portfolio of small group plans are metal-tier compliant, contain all EHB, and are fixed, meaning plan modifications are not permitted.

For example, pharmacy benefits are included in all plans and prescription drug co-pays cannot deviate from those established by the plan. Small group plans are now rated at the member level, so there is an age-based rate for every participant in the plan.

Looking ahead to late 2014 and beyond, small groups may wish to migrate to the forthcoming MDA exclusive, self-insured MEWA plan referenced above. We expect to be able to begin enrolling groups next fall. Call us at 877-906-9924 for assistance with your small group insurance needs.

Individual BCBSM subscribers. Important note: Individual BCBSM subscribers pay a monthly bill in their own name directly to BCBSM. If you are paying a quarterly bill to MDA Insurance, this information does not apply to you. See the Exclusive, MDA-endorsed, quarterly billed section above. With one plan exception, everyone in a BCBSM individual plan will be mapped to a new ACA-compliant plan effective Jan. 1. Those enrolled in the Keep Fit individual BCBSM plan will be able to retain their plan throughout 2014.

Individuals being mapped to a new plan should have received a letter from BCBSM in September explaining the process. Essentially, people will be transferred to a new ACA-compliant plan and invoiced in December. Payment of the invoice indicates acceptance of the mapped plan. For those who would like to look at an option other than the mapped plan, MDA Insurance can help them find the plan that best meets their needs. Contact us at 877-906-9924 for assistance.

Some people who purchase an individual health insurance plan may be
eligible for premium subsidies through the online marketplace. It may behoove people earning up to 400 percent of federal poverty level to investigate the possibility of receiving premium subsidies.

**Groups with more than 50 employees.** Large group plans are relatively unaffected by health care reform. Plan choices will remain the same for 2014. As noted above, the employer mandate has been delayed until Jan. 1, 2015, but now is the time to plan for the future, even though enforcement of the employer mandate has been postponed. We encourage you to contact MDA Insurance to set a meeting to discuss your needs, and learn more about the exclusive MDA MEWA that will become available just in time to meet your mandated insurance obligations.

**People age 65 or older in the MDA-Exclusive, Quarterly Billed Complement to Medicare Plan.** As noted above, the early renewal of the MDA-exclusive health plan means you can keep your current plan for another year. This plan will renew Dec. 31 rather than Jan. 1 and will be in effect throughout next year. There are, however, some things you must be aware of and act upon, if you wish to enter the plan or make plan changes for 2014. After Dec. 1:

- You cannot change between plan designs, so be sure you select the plan you wish to be enrolled in by the end of November.
- You may not change the policyholder from one spouse to another. This is particularly important if the Blue 4 Ever Life policyholder will attain age 65 this year and become eligible for Medicare. In order to ensure the younger party and any other currently covered family members will be able to continue coverage in your current plan the policy needs to be issued in the name of the younger spouse.

In October, MDA Insurance sent a letter with a Membership Record Change Form to people we identified as being affected by this provision. The Membership Record Change Form must be returned to us by Dec. 1 to facilitate this change effective Dec. 30, 2013. Please contact us if you have not received the change form and have a spouse turning 65 in 2014.

Beginning in 2015, our exclusive Complement to Medicare plan will be forced to close because of the risk aggregation and community rating rules previously discussed. MDA Insurance is now working on a proprietary offering and will also have access to Medigap and Medicare Advantage plans available on the open market. During the Medicare Open Enrollment period from mid-October to early December next year you will need to move to a new Medigap or Medicare supplement plan. MDA Insurance can help you with that process.

**Other people age 65 or older.** If you are not currently in the exclusive, MDA quarterly billed plan, your Medicare and Medigap/Medicare supplement plans are not directly affected by the ACA. Your coverage should not be affected by any ACA-related rules or changes. Any plan changes you wish to make need to occur during the Medicare Open Enrollment period between Oct. 15 and Dec. 7. MDA Insurance can assist you with transitioning to Medicare and purchasing supplemental plans.

**Rely on MDA Insurance**

Few realized the sweeping changes that PPACA would have on the health insurance landscape nationwide, and many people who now have insurance do not recognize that the law will impact them personally. As the reality of health care reform sets in next year, you can rely on MDA Insurance to provide you with any assistance you may need. We can help with subsidy eligibility, finding affordable health insurance for your employees, understanding our new self-insured MEWA plans, finding a plan that fits your practice’s needs, getting your adult offspring coverage, understanding your benefits, and much more.

Access to the expertise of MDA Insurance agents is a value-added benefit of your MDA membership and adds no additional cost to your health plan selection. Please let us help you by calling us at 877-906-9924.