Healthcare Reform for FY 2013-14

Federal healthcare reform (The Patient Protection and Accountable Care Act – "PPACA" or "ACA") is still in the news. As a result of ACA, you will see the following changes to the State's medical plan for FY 2013-14:

As of July 1, 2013, the following services are added to our plan under the Affordable Care Act.

- **Women's Preventive Health Care** – such as mammograms, screenings for cervical cancer and other services – are covered with no cost sharing for health plans. However, the law recognizes and HHS understands the need to take into account the unique health needs of women throughout their lifespan. Here is a list of newly added preventative services for women.
  1. Well-woman visits.
  2. Screening for gestational diabetes.
  3. Human papillomavirus testing.
  4. Counseling for sexually transmitted infections.
  5. Counseling and screening for human-immune deficiency virus.
  6. Contraceptive methods and counseling.
  7. Breastfeeding support, supplies and counseling.
  8. Screening and counseling for interpersonal and domestic violence.

- Employees will no longer be provided the 11-page UnitedHealthcare benefit summaries or the 7-page Kaiser benefit summaries used during the last few plan years. Instead, employees will be provided an 8-page Summary of Benefits and Coverage as required by ACA for all plan years beginning after September 2012.

It is also worthwhile to mention some of the key changes required by ACA that were put into place for the State plan in recent years beginning in FY 2010 that will continue into the FY 2013-14 plan year.

Preventive Care

Recommended preventive services, as defined by and in compliance with ACA, are covered at no charge to the member – no co-pay, co deductible, no co-insurance – so long as services are provided by in-network providers and follow the frequency guidelines.

So what are considered preventive services under healthcare reform? It's a long list, but it includes annual physicals, age-appropriate screenings, and age-appropriate immunizations.

More information can be found at the following websites.

- HealthCare.gov list of preventive service covered under ACA
- U.S. Preventive Services Task Force's list of recommended covered services – ACA requires coverage of services rated as "A" or "B."
- Immunization schedules from the Centers for Disease Control and Prevention

Coverage for Dependent Children

Employees can cover dependent children up to their 26th birthday for medical, dental and dependent child life insurance. This means that during open enrollment, employees can add, or maintain, coverage for their 25-year-old dependent children. A dependent child's coverage ends at the end of the month in which the dependent child turns age 26. In addition, healthcare expenses for most of these dependents can be reimbursed from an employee's *healthcare* flexible spending account (FSA). Expenses for same-gender domestic partners (SGDP) and their children *cannot* be reimbursed from an FSA.

Cancelling Coverage Outside of Open Enrollment

Employees should be aware that healthcare reform created different factors for the eligibility of adult-aged dependent children (19 – 25) for medical or dental coverage. Age and relationship to the employee are the only factors to determine eligibility. If the child moves out of the employee's house, stops receiving financial support from the employee, graduates from college, or gets married, an employee ***cannot*** terminate the child's medical and dental coverage with the State outside of open enrollment, as the child's eligibility has not been impacted. There are very few circumstances under which an employee can remove a child aged 19-25 from coverage in the middle of the year.

Enrolling Outside of Open Enrollment

If an employee does not enroll a 19 – 25-year-old child during open enrollment, the employee ***will not be able*** to enroll the child later, after the plan year begins on July 1, even if the child moves back home, becomes financially dependent upon the employee, or gets divorced. There is one exception. If an employee chooses to not cover a 19 – 25-year-old because he or she is covered under his or her own employer's plan, but the child later loses that coverage when he or she leaves the job, the employee may enroll the child within 31 days of the conclusion of that coverage. Documentation of the loss of that coverage will be required to make such a change.

New External Appeals Process

This process permits employees to request their appeal be reviewed by an external party to determine if the decision is warranted after two internal appeal attempts have failed.

Coverage of Essential Services

There can no longer be annual limits on benefits termed “essential services”. All annual limits have been removed from essential services in the State’s plan.

W-2 Reporting Requirements

The 2012 Form W-2 was the first to show the aggregate cost of health care coverage provided to employees on a calendar year basis. ACA requires employers to provide this information in box 12 of Form W-2 coded as DD. Providing employees this information allows them the opportunity to compare the cost of their healthcare coverage to other carriers.

Limited Contributions to Healthcare Flexible Spending Accounts

ACA limited the salary reduction contributions to a healthcare FSA to $2,500 per employee per plan year.

Healthcare Reform’s Future

Should there be any changes due to the Supreme Court’s decision on healthcare reform, the State will evaluate the best way of implementing those changes and will communicate to employees and department’s human resources personnel.

For detailed, consumer-oriented information regardi federal healthcare reform, visit www.healthcare.gov.

“Health Reform Hits Main Street” - A short, animated movie that explains the current healthcare system, the changes that have been implemented by reform, and the big changes that will come in 2014.