A special look at health care reform.
This is a special edition of Blue magazine that features all of the previously published health care reform articles for our members.

HEALTH CARE REFORM

3 Changes ahead
How the Affordable Care Act’s individual mandate could impact you and your family.

6 How health care reform will impact rates
The new mandate serves up changes that will affect your premium.

10 Five ways health care reform may affect you
Beginning in 2014, your health care experience may change in a number of ways.

12 Key provisions
Invest time now to be prepared for upcoming changes.

Scan this code or visit Wellmark.com/WhatMatters to learn more about how health care reform affects you.

IN THE SUMMER OF 2012, THE SUPREME COURT UPHELD THE INDIVIDUAL MANDATE COMPONENT OF THE AFFORDABLE CARE ACT (ACA). THIS WAS A HISTORIC DECISION, AND MANY AMERICANS ARE STILL TRYING TO FIGURE OUT WHAT IT MEANS.

Under the mandate, virtually every legal U.S. resident will be required to have health coverage—or what’s referred to as minimum essential coverage in the law—beginning in 2014, or pay a tax penalty.

What qualifies as minimum essential coverage?
› Insurance purchased through an employer
› Insurance you’ve purchased and pay for on your own
› Enrollment in a government-sponsored program (for example, Medicare or Medicaid)

AS A WELLMARK MEMBER, THE GOOD NEWS IS THAT YOU ALREADY MEET THE INDIVIDUAL MANDATE REQUIREMENT. Your health plan may change in order to meet other requirements of the ACA, but you won’t be affected by the individual mandate requirement as long as you keep your coverage. For those who don’t have coverage in 2014, the news may not be as bright.

Benefit information presented is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in your benefits certificate or coverage manual and enrollment regulations in force when the certificate or manual becomes effective. Certain exclusions and limitations may apply.

© Wellmark, Inc. 2013. Used with permission.
THE PENALTY FOR NOT HAVING MINIMUM ESSENTIAL COVERAGE will be the greater of a flat dollar amount or a percentage of income, and WILL BE PHASED IN OVER THREE YEARS:

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FLAT $ amount OR % of income</strong></td>
<td><strong>Flat $ amount OR % of income</strong></td>
<td><strong>Flat $ amount OR % of income</strong></td>
<td></td>
</tr>
<tr>
<td><strong>(whichever is greater)</strong></td>
<td><strong>(whichever is greater)</strong></td>
<td><strong>(whichever is greater)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>IN 2014</strong>, individuals and families with income under approximately $28,500 will pay a flat dollar penalty amount if they fail to obtain minimum essential coverage. Individuals and families with income over $28,500 will pay a penalty equal to 1 percent of their income.</td>
<td><strong>IN 2015</strong>, individuals and families with income under approximately $48,750 will pay a flat dollar penalty amount if they fail to obtain minimum essential coverage. Individuals and families with income over $48,750 will pay a penalty equal to 2 percent of their income.</td>
<td><strong>IN 2016</strong>, individuals and families with income under approximately $83,400 will pay a flat dollar penalty amount if they fail to obtain minimum essential coverage. Individuals and families with income over $83,400 will pay a penalty equal to 2.5 percent of their income.</td>
<td></td>
</tr>
</tbody>
</table>

**EXAMPLE**

**FAMILY OF 3**

<table>
<thead>
<tr>
<th>INCOME</th>
<th>$50,000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FLAT $ AMOUNT</strong></td>
<td><strong>ADULT 1: $95</strong></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$237.50</strong> (UP TO $285)</td>
</tr>
<tr>
<td><strong>OR WHICHEVER IS THE HIGHER AMOUNT</strong></td>
<td><strong>$500</strong></td>
</tr>
<tr>
<td><strong>% OF INCOME</strong></td>
<td><strong>$500</strong></td>
</tr>
</tbody>
</table>

After 2016, the tax penalty will be increased annually by the federal cost-of-living adjustment.

The Congressional Budget Office estimates that in 2016, 6 million Americans will pay a penalty because they are uninsured. For some people, going without coverage will be a matter of choice, but for others it will be simply a matter of economics — they won’t be able to afford it.

In either case, the potential for financially crippling medical bills and other health care costs may make the option of going without health coverage a risk not worth taking. Remember, one of the goals of the ACA is to make coverage more affordable for Americans. One way to realize this goal is to provide premium tax credits and cost-sharing subsidies to individuals who meet certain income and coverage criteria as long as the coverage is purchased through the newly created Marketplace (formerly known as the public exchange).

The Marketplace, which will be available Oct. 1, 2013, will allow individuals to shop and compare health plans — similar to websites that allow you to book a flight or find a hotel room.

**Income requirements**

States have the option to expand Medicaid to include individuals under age 65 with income below 133 percent of the federal poverty level (FPL). However, those with household incomes between 100 percent and 400 percent of the FPL may be able to get help paying for coverage with premium tax credits and cost-sharing subsidies.

The premium assistance subsidy reduces the amount that an individual or family pays for health insurance coverage by providing a tax credit. These subsidies are only available through the Marketplace. Cost-sharing subsidies provide an out-of-pocket spending cap, including a cap on deductibles, copayments and coinsurance, to those who buy coverage through the Marketplace.

**Federal poverty guidelines for 2013** are as follows:

<table>
<thead>
<tr>
<th>INDIVIDUALS:</th>
<th>FAMILY OF FOUR:</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% FPL = $11,490</td>
<td>100% of FPL = $23,550</td>
</tr>
<tr>
<td>400% FPL = $45,960</td>
<td>400% of FPL = $94,200</td>
</tr>
</tbody>
</table>

**Coverage requirements**

In addition to the previously mentioned income criteria, individuals can qualify for premium tax credits and cost-sharing subsidies if they:

1. Do not have access to employer-sponsored coverage
2. Are not eligible for government programs like Medicaid
3. Individuals who have employer-sponsored coverage can qualify for premium tax credits and cost-sharing subsidies if their employer plan does not cover at least 60 percent of covered benefits or if the employee’s share of the premium exceeds 9.5 percent of their annual household income.

Again, it’s important to point out that the premium tax credits and cost-sharing subsidies only apply to coverage purchased through the Marketplace.

Learn More

For more information about health care reform, visit Wellmark.com/WhatMatters.

---

3. The IRS has proposed three affordability safe harbors that would measure affordability based on an employee’s W2 wages, an employee’s rate of pay, or the federal poverty line. Source: “Assessable Payments, Proposed Rule.” Federal Register 78 Jan 2, 2013: 252-252.

The information provided is accurate as of the date of publication. Items are subject to change based on additional government guidance.
Buying health insurance on your own? Find out how rates will be impacted.

SETTING THE TABLE FOR HEALTH CARE REFORM

The new mandate serves up changes that will affect your premium

IF YOU HAVE AN APPETITE FOR UNDERSTANDING HOW PREMIUMS ARE DETERMINED, LET US SERVE UP THE INFORMATION.

The rising cost of health care is a concern. It’s frustrating when premiums increase. Understanding some basic concepts about premium rates may make it easier to understand why health insurance has become so expensive, even for people who are healthy.

Health insurance premiums are meant to cover the amount it costs to pay for the health care services the insured population receives in a year. They’re developed by projecting the population’s past claims expenses into the future. Think of it like a household budget — we look at expenses from the previous year, and estimate how much is needed next year.

Because health care costs are projected to rise, premium rate adjustments must be made to meet these future increases in costs.

MANY FACTORS INFLUENCE THE COST OF HEALTH INSURANCE COVERAGE, INCLUDING:

› People, as a population, are using more health care services.
› The cost of many medical services increases over time, like most other products and services.
› Individual choices can cost more, such as choosing an emergency room over a doctor’s office, having an MRI instead of an X-ray, and taking brand name drugs rather than generics.

A new way to split the bill

HOW HEALTH CARE REFORM WILL IMPACT RATES

Health care reform will require health insurance carriers to look differently at how premiums are calculated for individuals.
Health insurance premiums are regulated by law. Today, health insurers rate people by age. The average cost of medical care for an older person is significantly higher than the amount needed to cover the costs of a younger person. Health insurers can vary premiums to reflect these cost differences. Currently, the premiums for an older person can be five times the amount of a younger person. Beginning in 2014, premiums for an older person can be only three times the amount of a younger person. To accomplish this, premiums for older individuals will be reduced, while premiums for younger people will increase.

Also beginning in 2014, health status and gender can no longer be a factor in calculating premiums. This will cause dramatic changes in premiums from 2013 to 2014. Let’s look at an example of how this works.

Let’s say a group of people meet at a restaurant for an exclusive dinner party. Orders are placed and hours later the bill comes.

Today

At a restaurant, each person would pay his or her share based on what he or she typically ordered.

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pasta</td>
<td>$15</td>
</tr>
<tr>
<td>Salad</td>
<td>$30</td>
</tr>
<tr>
<td>Soup</td>
<td>$12</td>
</tr>
<tr>
<td>Steak</td>
<td>$25</td>
</tr>
<tr>
<td>Pie</td>
<td>$4</td>
</tr>
<tr>
<td>Dessert</td>
<td>$10</td>
</tr>
</tbody>
</table>

Based on how initial rating works today, the dinner party is exclusive, only certain people can come to the table. Insurance is intended to pay for conditions and events that may occur in the future, but do not exist today. For this reason, insurers do not have to cover everyone or can limit the amount of coverage offered. In this analogy, it would be similar to offering a menu with limited choices. Each person would pay his or her share based on what he or she typically orders. The amount each person pays is based on past eating habits, etc. For the most part, those who ordered more food will pay a larger share of the bill and those who ordered less will pay a lower share.

However, in 2014, this will work differently. First, due to the guaranteed issue requirement, the dinner party is no longer exclusive. Anyone can come regardless of health status. Second, everyone can see the full menu of covered benefits because there are no pre-existing condition exclusions. Third, because of the new premium rating requirements, the bill will be split more evenly among all people at the table. Those who paid a lower share of the bill before will be asked to pay more, even though they don’t plan to change their orders. Those who paid a larger portion of the bill before, now would pay less.

This may upset some of those who used to pay a lower portion of the bill. They may not want to come to the table. However, if individuals do not purchase coverage, they will be subject to a penalty.

The Affordable Care Act also requires coverage of certain benefits known as essential health benefits. When applying this to the dinner scenario, it means that everyone will now get a side dish whether they ordered one or not AND the side dish will be reflected in the amount each person will pay for their meal.

2014

This will work differently. That same bill would be split more evenly among all people at the table, no matter what each person ordered.

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pasta</td>
<td>$17</td>
</tr>
<tr>
<td>Salad</td>
<td>$15</td>
</tr>
<tr>
<td>Soup</td>
<td>$16</td>
</tr>
<tr>
<td>Steak</td>
<td>$17</td>
</tr>
<tr>
<td>Pie</td>
<td>$16</td>
</tr>
<tr>
<td>Dessert</td>
<td>$17</td>
</tr>
</tbody>
</table>

It’s important to look ahead

Health care reform means big changes. It’s more important now than ever to understand your health plan. Log in to myWellmark.com and select My Benefits to access your health benefits. You can find much more about the health care reform law on Wellmark.com/WhatMatters.
Consider these five ways that health care reform is transforming your health care experience:

1. **LIVE A HEALTHIER LIFE BY IMPROVING YOUR HEALTH**
   - Exercise, eating right, and regular checkups are important to living a longer, healthier life. Health care reform helps make it more affordable to do all three.
   - With ACA, many preventive services you once paid for are now available without cost-sharing when delivered by a network provider (this applies to non-grandfathered health plans only). Coinsurance, copayments and deductibles no longer apply to preventive services such as cancer screenings, nutrition and weight-loss counseling, routine vaccinations, and more.

2. **ACCESS TO STANDARDIZED BENEFITS AND SERVICES**
   - Beginning in 2014, the ACA requires that all non-grandfathered health plans, meaning those plans that were purchased or obtained after March 23, 2010, cover certain categories of benefits, known as essential health benefits. This applies to coverage you purchase on your own (individual or family coverage), as well as coverage through your employer (small groups covering 1 to 50 employees). Essential health benefits must include health care services within several categories, including:
     - 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 and chronic disease management
     - Pediatric services, including oral and vision care

3. **RECEIVE THE CARE YOU NEED, WITHOUT POLICY LIMITS**
   - Under the new law, beginning in 2010, lifetime dollar limits for essential health benefits were prohibited for plan years on or after Sept. 23, 2010, while annual limits were significantly limited. However, beginning in 2014, neither annual nor lifetime dollar limits on essential health benefits will be allowed. The new law applies to most covered benefits and to every health plan, whether you buy the coverage for yourself, your family or you receive your coverage from an employer.

4. **KEEP YOUR POLICY REGARDLESS OF YOUR HEALTH**
   - Today, if you have a pre-existing condition, you may have some difficulty finding a policy or a policy free from exclusions. You may even pay a higher premium for coverage. Starting Jan. 1, 2014, pre-existing condition exclusions will be prohibited under the ACA.

5. **COVERAGE FOR ADULT CHILDREN**
   - The ACA allows you to add or keep your children on your health insurance policy until they turn 26. The impact of this provision has been significant. According to a recent Commonwealth Fund report, an estimated 6.6 million young adults who weren’t eligible to stay on or join their parents’ health plans prior to the ACA, did so in 2011.1

The Affordable Care Act (ACA), commonly referred to as health care reform, continues to transform the health care landscape. You may be wondering what it has in store for you. Throughout 2014, the government, along with insurance companies, will implement many changes. **Most changes will be in place beginning January 2014.**

Health care reform is creating many changes to the health insurance landscape. Wellmark Blue Cross and Blue Shield will be here to inform, lead, assist and support you through the changes.

Want to know if your plan is non-grandfathered? Ask your agent or employer.

---

1. The Commonwealth Fund (2012)
UNLOCKING THE AFFORDABLE CARE ACT

BEGINNING JAN. 1, 2014, MANY PROVISIONS THAT ARE THE CENTERPIECE OF THE AFFORDABLE CARE ACT (ACA) WILL GO INTO EFFECT, INCLUDING:

- CHANGES TO HEALTH PLAN BENEFITS
- HOW COVERAGE MUST BE OFFERED AND ADMINISTERED
- AS WELL AS OFFERING A NEW WAY FOR COVERAGE TO BE PURCHASED

Some of these provisions, whether you receive health coverage through your employer or purchase it on your own, may not affect you directly, or immediately. For example, some Wellmark members have received notification that they may elect to remain on their current plan through 2014 or they may choose a new ACA-compliant plan when open enrollment begins in October.

Investing a little time now to review key ACA provisions will make it easier for you to understand changes in the coverage you may be offered by your employer. Or, if you are purchasing coverage on your own, familiarizing yourself with ACA basics can go a long way in helping select the best plan for you and your family. As always, you can count on Wellmark to help inform and guide you through changes.
Important Changes for 2014

You may have already experienced the following benefit changes that were implemented over the past couple of years; however, come Jan. 1, 2014, they will be expanded. Here’s how:

- **Pre-existing conditions exclusions** were eliminated for children under age 19. Beginning in 2014, pre-existing condition exclusions will be removed for everyone — regardless of age, gender or health status.

- **Expanded coverage for young adults** allows for dependents to stay on their parents’ plans until they turn 26. New in 2014, the coverage is expanded to dependents up to age 26 even if they are eligible for employer-sponsored coverage.

- **Your cost-sharing and out-of-pocket maximum spending** will now have new requirements. As a general rule, beginning in 2014, health plans must limit the amount consumers pay out of pocket for in-network essential health benefits. Generally, these amounts cannot exceed $6,350 for an individual, and $12,700 for a family.

Individual Shared Responsibility

The Supreme Court upheld the Individual Mandate requirement as part of the ACA. This means that beginning Jan. 1, 2014, virtually every legal U.S. resident will be required to have health insurance coverage (referred to as minimum essential coverage), or pay a tax penalty, known as Individual Shared Responsibility.

**What qualifies as minimum essential coverage?**

- Insurance obtained through an employer.
- Individual health insurance you’ve purchased.
- Enrollment in a government-sponsored program (for example, Medicare, Medicaid, or the Children’s Health Insurance Program).

**If you have coverage through an employer**

Here are some key points for you to know:

- Your employer must offer its full-time employees and their dependents the opportunity to elect health care coverage at least once a year, or potentially face a penalty*.

- Not all changes will be implemented on Jan. 1, 2014. Ask your health benefits administrator when changes will apply to you.

**If you purchase coverage on your own**

Most Wellmark plans already meet the minimum essential coverage requirement. Your health plan may change in order to meet other requirements, but you will not face a tax penalty as a result of the individual shared responsibility as long as you keep your coverage.

**Essential Health Benefits**

As part of health care reform, a set of 10 categories of benefits will be put into place called essential health benefits. While a majority of Wellmark plans already cover most of these benefits, beginning in 2014, many of the plans will be required to cover the following categories:

- 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
- Pediatric services, including oral and vision care
- Preventive and wellness services and chronic disease management

**Note:** Only non-grandfathered plans that are purchased on your own or obtained through a small group employer with 1 to 50 employees will be required to cover essential health benefits.

**What you’ll need to know when buying coverage**

Starting in 2014, new individual and small group ACA plans will have four basic coverage levels:

- **Bronze**
- **Silver**
- **Gold**
- **Platinum**

These are known as Metallic Tiers. Each tier is defined by the portion of the claims paid by the insurer. This is known as the “actuarial value” of the plan.

For instance, for the Bronze tier, the plan typically pays 60 percent of the cost and you are responsible for the remaining 40 percent through out-of-pocket costs such as copayments, coinsurance and deductibles.

The graph below shows the actuarial value of the metallic tiers:

All the traditional places you purchase Wellmark coverage today will not change — even if you choose to purchase a new ACA-compliant plan during the open enrollment period, which begins Oct. 1, 2013, for plan effective dates of Jan. 1, 2014.

For instance, you can still purchase health insurance directly from Wellmark or through a broker or independent agent.

**Note:** Only non-grandfathered plans that are purchased on your own or obtained through a small group employer with 1 to 50 employees will be required to meet metallic tier levels.

For more information about grandfathered and non-grandfathered plans, visit Wellmark.com/WhatMatters.
WHAT MATTERS

WHAT YOU NEED TO KNOW ABOUT HEALTH CARE REFORM & HEALTH INSURANCE

Wellmark.com/WhatMatters