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Health Net®

Small Business Group

Reform *Refresher*

A snapshot of key reform requirements

Health plans that are compliant with the Affordable Care Act are designed to meet a variety of requirements. Health Net's Small Group 2.0 portfolio incorporates all these requirements, including coverage for all Essential Health Benefits. Pediatric dental and vision coverage are also included with Small Group 2.0 plans.

ACA	*Definition*
Essential Health Benefits (EHBs)	All health plans offered in the individual and small group markets must provide a comprehensive package of items and services that are called Essential Health Benefits, which fit in 10 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 • Preventive and wellness services and chronic disease management • Pediatric services, including dental and vision care
100% coverage for preventive care	Plans must cover, without cost-sharing, a variety of preventive services as determined by organizations such as the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention. Expands women's preventive health services to include, without member cost-sharing, FDA-approved contraception methods, contraceptive counseling, breastfeeding support, supplies, counseling, and other preventive services.
No annual or lifetime limits	Prohibits annual limits and lifetime limits on the dollar value of coverage.
Annual limitation on cost-sharing and deductibles	2016 annual cost-sharing incurred must not exceed the maximum out-of-pocket amounts of $6,850 for self-only or $13,700 for family coverage.
Rating variation limits	Allows rating variation in the individual and small group market and Health Insurance Exchanges based only on: • Age – limited to a 3:1 ratio. This means that the rate for a 64-year-old can't be more than three times (i.e., 300 percent) the rate for a 21-year-old. • Geographic area. • Family composition – with member-level rating applied. Instead of composite rating, each family member will be rated individually. Carriers can charge only for the three oldest children in the family who are under 21. For example, in a family of six, the rate would be the subscriber rate + spouse rate + the 0–21 rate x 3. • Tobacco use (limited to 1.5:1 ratio). **Note**: Health Net does **not** factor tobacco use into our rates.
Over-age dependent coverage	Group and individual health plans providing coverage for dependent children must continue to make coverage available for an adult child until the child turns 26 years of age.
Limits on waiting periods	Group health plans and health insurers may not apply a waiting period that exceeds 90 days.

(continued)

ACA	*Definition*
No pre-existing conditions exclusions	Plans are prohibited from excluding from coverage all individuals with pre-existing conditions.
Guaranteed availability of insurance	Requires guaranteed issue and renewability of health insurance for individuals and business groups.
Emergency services	Plans covering emergency services must meet standards, such as not requiring prior authorization, covering services from nonparticipating providers and not allowing out-of-network cost-sharing to exceed in-network rates.
Choice of provider	Enrollees may designate any available participating primary care provider as their provider. Plans must also provide notice to enrollees informing them of the terms of the plan regarding designation of primary care providers.
Wellness programs	Permits employers to offer employees rewards of up to 30%, potentially increasing to 50%, of the cost of coverage for participating in a wellness program and meeting certain health-related standards. If certain conditions are met, health plans may provide a discount or rebate when an individual satisfies a standard related to a health factor.
Rescinding coverage	Insurers and group health plans may not rescind an enrollee's coverage unless the individual has performed an act that constitutes fraud against the plan or has intentionally misrepresented a material fact to the plan.

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