

Health Care Reform Frequently Asked Questions

On March 23, 2010, President Obama signed federal health care reform into law, also known as the Patient Protection and Affordability Act. A second, or reconciliation bill, was also signed by the President shortly after. This document addresses some of the frequently asked questions regarding these bills.

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Overview

Q. What are the key changes included in the new legislation?

A. Many of the changes are focused on access to coverage and insurance reform. There are some changes to the way care is delivered and some initial steps on addressing costs. Some of the major reform measures include:

- A requirement for individuals to have coverage
- Elimination of exclusion for pre-existing conditions
- No lifetime caps on insurance benefits
- People up to age 26 can remain on their parents' health plan
- Tax credits for small businesses
- Creation of state insurance exchanges to assist individuals with finding coverage
- The Medicare prescription benefit "donut hole" will be closed

Q. When do the changes kick in?

A. Some measures will be implemented in 2010 and 2011. The majority of the reforms will take effect in 2014. Some changes may not affect "grandfathered" plans.

Beginning in 2010

- Tax credits for businesses with 25 or fewer employees to help offset the employer's contribution to employees' health insurance costs.
- Prohibition of pre-existing condition exclusions for children.
- Medical coverage expanded to include dependents up to age 26. The current law in Minnesota for fully insured plans covers dependents up to age 25.
- Prohibition of lifetime limits on individual and group health plans.

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- Restrictions on annual limits on individual and group health plans.
- Coverage can only be rescinded due to fraud or misrepresentation by an individual. This is current Minnesota insurance law and HealthPartners practice.
- Creation of a federal high-risk pool for individuals.
- \$250 rebate for Medicare Part D beneficiaries who hit the coverage gap (“donut hole”) in 2010.

Beginning in 2011

- New medical loss ratio requirements for health insurance companies.
- Disallows reimbursement for over-the-counter medications for Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs).
- Pharmaceutical company discounts for Medicare Part D beneficiaries who hit the coverage gap.
- Medicare Part D premium subsidies reduced for beneficiaries with high incomes.
- Grants for businesses with 100 or fewer employees to implement new wellness programs.
- New tax on pharmaceutical industry for sales made in the previous year.

Beginning in 2013

- New tax on medical device manufacturers.
- New tax on high-income individuals.
- New limits on contribution amounts to FSAs.
- Phased-in reductions in out-of-pocket maximum paid by Medicare Part D beneficiaries in coverage gap.

Beginning in 2014

- Guaranteed issue of medical coverage.
- Prohibition of pre-existing condition exclusions.
- Requirement for individuals to have medical coverage or face a tax penalty. Subsidies will be available for people with incomes between 100 and 400 percent of the Federal Poverty Level to offset premium and cost-sharing expenses.
- Requirement for employers with 50 or more employees to pay a fee per employee who receives premium subsidies through the Exchange.
- Launch of insurance Exchange for individual and small group plans.
- Medical plans must cover routine care for those enrolled in clinical trials for cancer and other life-threatening conditions.
- New fee on insurance industry.
- Expansion of Medicaid. (States can opt to expand Medicaid sooner.)

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Beginning after 2014

- 2017: Per state discretion, large group plans can be offered in the insurance Exchange.
- 2018: New tax on high-cost plans (the so-called “Cadillac tax”).

Q. I read that the state of Minnesota along with other states filed a lawsuit challenging Federal health care reform. What is the status of that lawsuit and is there a chance health care reform won’t take effect?

A. The Governor has announced he will be challenging the federal health care reform law in some sort of litigation. It is not clear if Minnesota will join in with a dozen or so other states which have already commenced litigation. We’ll monitor these developments and continue to work on implementing the law as it evolves.

Employer-sponsored plans**Q. How will employers be affected by the changes?**

A. Employers will see a variety of changes – from the options available in the marketplace to specific product and eligibility changes. Small employers who offer coverage will be able to apply for tax credits. Larger employers could face penalties starting in 2014 if employees access subsidies available through the Exchange.

Q. Is my current HealthPartners policy going to be affected by health care reform?

A. Yes, it is likely that all HealthPartners health plans through will be impacted in some way by health care reform. We will continue to provide clarification as more specific information becomes available.

Q. Will self-funded plans be subject to these new laws or is there still some exception for self-funded plans?

A. Generally speaking, self-insured medical plans are subject to these reforms.

Q: I’ve heard a lot about grandfathered plans. What are they in the group market and how will they be impacted differently?

A: The law defines a grandfathered plan as a group health plan in existence on March 23, 2010, the date the law was enacted. Grandfathered plans will have to comply with some of the new coverage requirements, including dependent coverage up to age 26, no annual or lifetime limits (except for benefits outside the “essential benefits set,” which will be established by the Department of Health and Human Services) and no exclusions on pre-existing conditions. Grandfathered group plans can add new employees, spouses and dependents at later dates - and still be considered grandfathered. We are awaiting further federal guidance on what other kinds of changes are permissible to grandfathered plans.

Q. Will the lifetime limits need to be removed prior to renewal for self-insured groups in 2010?

A. No, the prohibition on lifetime limits is effective as groups renew, on or after September 23, 2010.

Q. What plan benefits will be changing?

A. Specific benefit changes will vary depending on the benefit plan. There are a number of reforms which will apply broadly including:

- Guaranteed issue and renewal (cannot be denied coverage)
- No annual or lifetime maximums
- No exclusion for pre-existing conditions
- Coverage to age 26 on a family policy
- Premium rates could vary based on location and age

Q. With the extension of coverage for dependents to age 26, what about issues of imputed income?

A. The federal health care reform bill does contain changes to the Internal Revenue Code which, practically speaking, removes the issues associated with imputed income for adult children, not otherwise meeting the dependent definition under the tax code, who have not yet turned 27 by the end of the taxable year. This took effect at the end of March. This does not, however, remove other imputed income implications for others not meeting the tax dependent requirement, such as domestic partners or the children of domestic partners. Please consult a tax specialist for details about how this impacts your plan.

Q. Can employees add a child, who is under 26-years-old, to their plan right now?

A. No, the effective date of this change for group plans is upon renewal, on or after September 23, 2010. For any dependents covered on a fully insured plan who would lose coverage by turning age 25, beginning in the month of May 2010, HealthPartners will extend their coverage to age 26.

Q. Does the law require health plans to offer dependent coverage to age 26 or through age 26? Are there any exceptions when a group does not have to provide coverage to dependents to age 26?

A. Dependent coverage for adult children must be offered until they turn 26 years of age and can be terminated effective 12:01 a.m. on a dependent's 26th birthday. The only situations where employers are not required to offer dependent coverage up to age 26 are:

1. For grandfathered plans, in cases where dependents are eligible for other group coverage ~or~
2. When a group health plan does not extend coverage to any dependents (single only coverage).

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Impacted plans must offer coverage until age 26 regardless of student status or if the dependent is married. The dependent's spouse is not eligible for coverage under the dependent's parents plan.

Q. Are these changes effective on the next renewal date? For example, for a January 2011 renewal date, when will the changes go into effect?

A. Both the dependent age change (to age 26) and the prohibition on pre-existing exclusions for children are effective for plan years beginning on or after September 23, 2010. Most changes in the group market are as groups renew.

Q. What is HealthPartners understanding of the Early Retiree Reinsurance Program? Is there clarity on how this would be administered, meaning are the plans obligated to submit on behalf of the groups, or do we provide them data and they submit for the subsidy?

A. The federal reform bill requires that the federal government to establish a temporary reinsurance program for employers who provide health insurance to retirees age 55 or older who are not Medicare eligible. The program has certain requirements for employer-based plans and will reimburse 80 percent of retiree claims between \$15,000 and \$90,000. The federal government has set aside \$5 Billion for this program.

In order to qualify for this program, an employer must:

- Apply for participation in the program and be certified (the federal government will develop the application by June).
- Provide documentation of the actual cost of medical claims.
- Implement programs to generate cost-savings for enrollees with chronic and high-cost conditions.

The dollars from this program must be used to lower costs for enrollees (reduce premium costs, contributions, copayments, deductibles or other out-of-pocket expenses). We are awaiting guidance from the federal government on exactly how this will be administered. This program is due to be in place by September 23, 2010.

Q. How are we interpreting the coverage for kids with pre-existing conditions provision?

A. We are awaiting rulemaking by the federal government, which we expect will require guaranteed issue (which means you cannot be denied coverage) for children (regardless of pre-existing conditions) with an effective date of September 23, 2010. This would apply to group plans as they renew after this date.

Q: When the state health insurance exchanges are created, is there anything that employer-sponsored group plans have to do?

A: Yes. No later than March 1, 2013, employers must provide notices to current employees about the availability of the exchange (to be provided upon hire thereafter). The notices must include the following information:

- Specific details about the exchange plans available to employees in the area along with contact information.
- Information about the possibility that the employee could lose employer contributions, which may be tax-free, if they purchase coverage through the exchange and the employer doesn't offer a free choice voucher.
- If their employer does not contribute to at least 60 percent of their total health care plans costs, employees may qualify for tax credits or cost sharing reductions if they purchase coverage through the exchange.

Q: Will employers be required to enroll newly-hired employees automatically?

A: Yes, most likely beginning in 2013. Employers with more than 200 full-time employees, who offer a health plan, will be required to auto-enroll newly hired employees in the group health plan and to provide instructions to new employees on how to opt-out of the automatic enrollment.

Q: What penalties will employers be subject to if they do not provide employees an appropriate level of coverage?

A: Beginning January 1, 2014, employers may be subject to "free rider assessments" if they employ 50 or more full-time equivalent employees. Full-time employees are defined as those working at least 30 hours per week on average.

If at least one full-time employee obtained the federal premium tax credit to purchase coverage via the exchange then:

- If their employer did not offer group health care coverage to employees, the employer is subject to a \$2,000 annual assessment for every full-time employee (excluding the first 30 employees) ~or~
- If their employer did offer group health coverage but the plan did not contribute at least 60 percent towards the total cost of coverage and/or requires employees to contribute 9.5 percent or more of their household income, employers are subject to the lesser of:
 - a \$3,000 annual assessment for every full-time employee who receives a tax credit through the exchange ~or~
 - the no coverage assessment amount (described above)

Employees may be eligible for the federal premium tax credit to purchase coverage via the exchange if their household income is equal to or less than 400 percent of the federal poverty level.

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Q: Will employers be able to give employees vouchers to purchase coverage through the exchange to avoid the free rider assessments?

A: Employers offering coverage may be able to avoid a free rider assessment for any employee who receives a voucher. Beginning January 1, 2014, employers must issue vouchers to an employee if:

- The employee's household income is equal to or less than 400 percent of the federal poverty level ~and~
- The employee is required to contribute 8 to 9.8 percent of their household incomes for coverage ~and~
- The employee does not purchase coverage through the employer

Vouchers must be for the same cash amount employers contribute toward the employees' coverage (single coverage, unless the employee chooses family coverage) – for the plan(s) where they contribute the largest portion. Employers can deduct the amount paid for vouchers under IRS Code 162(a) as a business expense and would not have to pay free rider assessments for employees receiving the required vouchers.

Q. What is the CLASS Act and is employer participation voluntary?

A. The Community Living Assistance Services and Supports (CLASS) Act would create a nationwide voluntary long term care insurance program. It becomes effective January 1, 2011. It is likely that employers will have to auto-enroll employees and make payroll deductions on their behalf. Employees can waive their participation in the program when first eligible, but then will only be allowed to enroll during established periods and may have to wait at least two years from the date they waived participation. Employees participating in the program may only drop coverage once a year during an established period. Details on this program and employers' role in it will be clarified in regulations by the Department of Labor later this year.

Q: Does the law require fully insured group health plans to satisfy the non-discrimination testing rules?

A: Yes, unless it is a grandfathered plan. Beginning with plans which renew on or after September 23, 2010, fully insured non-grandfathered group health plans will have to satisfy non-discrimination testing rules under IRS Code 105(h) when their plan renews. These rules previously only applied to self-insured groups.

Q: What do employers have to add to employees' W-2 Form?

A: For tax years beginning after December 31, 2010, employers must report the value of health benefits (including both employer and employee contributions) on all employees' Form W-2s. Employers can use the applicable COBRA rates (minus the 2 percent administrative fee, if charged) to calculate reportable values.

Individual mandate

Q. When will all individuals be required to have coverage?

A. Individuals will be required to have coverage starting in 2014. At that time, there will be financial penalties for not having coverage.

In 2014, a person who did not obtain coverage would pay a penalty of \$95 or 1 percent of income, whichever is greater. That penalty would rise to \$695 or 2.5 percent of income by 2016. The bill would exempt the lowest-income people from that insurance requirement.

Q. What if an individual can't afford coverage?

A. There are a few measures to help people with limited incomes:

- The legislation would offer subsidies to help pay for insurance premiums for people with incomes more than 133 percent but less than 400 percent of the federal poverty level (\$29,327 to \$88,200 for a family of four).
- Medicaid, the federal coverage program for individuals and families with low incomes and resources, would be expanded to cover those under age 65 with an income of up to 133 percent of the federal poverty level (below \$29,327 for a family of four).
- Individuals in their 20s would have the option to buy a lower-cost "catastrophic" health plan, to cover major accidents or illness.

Q. Can someone who was denied coverage previously resubmit their application now and get coverage?

A. We expect the federal government to issue rules soon which would require guaranteed issue for children to begin later in 2010. At that time children with pre-existing conditions cannot be denied coverage. Guaranteed issue of individual coverage for adults begins on January 1, 2014.

There is also a new program being developed by the federal government for individuals who have been previously denied coverage, which you may be able to access later this year.

In Minnesota, we already offer coverage for those residents who are turned down for individual insurance. The Minnesota Comprehensive Health Association provides coverage for these individuals who would be considered "high-risk" for insurance.

Medicare & Medicaid

Q. How does the bill affect Medicare recipients?

- A. There are no cuts to Medicare benefits required by the reform bill. The new law does incorporate a three-year extension of HealthPartners Medicare Freedom Plans (our most popular Medicare plans), creating more coverage stability for many Minnesota seniors. Medicare beneficiaries will also receive preventive screenings for free beginning in 2010. There will be some payment reductions to certain Medicare plans and to some Medicare providers.

Q. Is the Part D coverage gap closing (otherwise known as the “donut hole”)?

- A. Seniors will get immediate help on the "donut hole" - a gap in their coverage for prescription medications. This year, seniors would get \$250 to help cover the gap in coverage. That assistance would increase over the next few years and the donut hole will be entirely phased out by 2020.

Q. What changes will occur for employers participating in the Retiree Drug Subsidy (RDS) program?

- A. Beginning January 1, 2013, employers will no longer be able to deduct the amount of subsidy received for retiree health benefits that are reimbursed through the RDS program. As a result, companies who plan to receive the RDS should consult with their accountants regarding recognition of this change in their financial reports as early as 2010.

Q. What changes will occur in Medicaid?

- A. Medicaid will be expanded. Individuals and families with incomes up to 133 percent of the federal poverty level (below \$29,327 for a family of four) will gain coverage. Primary-care doctors treating Medicaid patients will get an increase in their fees.

Additional Helpful Resources

HealthReform.gov – The official Web site for federal health care reform