

Health Care Reform Frequent Questions

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DISCLAIMER: This material is intended only to provide brief commentary on the laws and issues of Healthcare Reform. Due to the general nature of this content and because Healthcare Reform is still being developed, the information contained herein may not be applicable in all situations and may not, beyond the date of this communication, even reflect the most recent authority. For these reasons, nothing contained in this communication should be relied or acted upon without the benefit of legal counsel, and nothing herein should be construed as an admission

What changes went into effect on 9/23/10?

- No-Pre-Existing condition Exclusion for Children under 19
- No Lifetime Limits
- Restrictions on Annual Limits
- Must cover preventive health services first dollar (Grandfathered)
- Cover children to age 26 (Grandfathered Group plans, before 2014, can exclude young adults who are eligible for other employer coverage)
- Loss Ratio of claims 80%/85% (Fully Insured Plans Only)
- Small Group Tax Credit
- Emergency Service Coverage - A group health plan or health insurance issuer offering group health insurance coverage that provides any benefits for emergency services must :
 - Not require prior authorization
 - Provide service without regard to whether the provider furnishing the emergency services is an in-network provider.
- Non-discrimination rules now apply to Fully-insured plans
- Establishment of Internal and External appeals process
- Choice of Provider—Network Plans
- **Primary Care Provider:** A group health plan or a health insurance issuer that permits or requires designation of a participating primary care provider must permit each participant to designate any participating primary care provider participant.
- **Pediatrician:** A group health plan or health insurance issuer that permits or requires designation of a primary care provider for a child must permit the designation of any participating physician who specializes in pediatrics as the child's primary care provider.
- **Obstetrical or Gynecological Care-Direct Access:** A group health plan or health insurance issuer that provides coverage for obstetrical or gynecological care may not require authorization or referral for a female participant who seeks obstetrical or gynecological care provided by an in-network provider who specializes in obstetrics or gynecology.

What are my penalties, as an employer, if the coverage I offer just is not good enough?

If an employer with 50 or more full-time employees does offer coverage but some of their employees receive a tax credit voucher because they cannot afford coverage there is a penalty of \$3,000 for each employee receiving tax credit.

What are my penalties, as an employer, if I do not offer coverage?

Beginning in 2014, if an employer with 50 or more full-time employees does not offer coverage there is a penalty of \$2,000 annually for each full-time employee (as long as one employee is receiving tax credit)

What are my penalties, as an employer, if the coverage I offer just is not good enough?

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What are the “premium assistance” & the “small business” tax credits?

Premium Assistance:

For tax years ending after 2013, the new law creates a refundable tax credit for eligible individuals and families who purchase health insurance through an Exchange. This credit will be available for individuals and families with incomes up to 400% of the federal poverty level who are not eligible for Medicaid, employer sponsored insurance, or other acceptable coverage.

Small Business Tax Credit:

The small business tax credit is already in effect (March 23, 2010) and includes both non-profit and profit organizations. Business must have fewer than the equivalent of 25 Full time employees (can have 50 part time workers), pay an annual average wages lower than \$50,000 and must cover at least 50% of the premium cost of Health Care Coverage for employees to be eligible.

Profit Organizations with fewer than 10 employees can receive the full tax credit of 35% for premium costs in 2010, increases to 50% credit starting 1/1/2014 and Non-Profit Organizations with fewer than 10 employees can receive the full tax credit 25% for premium costs in 2010, increases to 35% credit starting 1/1/2014. The credit will gradually phase out. Owners and Family members are generally not counted as employees.

What is the definition of a “qualified health plan”?

A qualified health plan (QHP) is an Exchange-certified “health plan” that offers an “essential health benefits package.” A QHP must be offered by an insurer that:

- is licensed and in good standing to offer health insurance coverage in each state in which it offers health coverage;
- agrees to offer at least one QHP in the silver level, and at least one QHP in the gold level, in each Exchange;
- agrees to charge the same premium rate for each QHP, whether offered through an Exchange or offered directly from the insurer or through an agent; and
- complies with regulations to be issued by HHS and any requirements established by an applicable Exchange. A QHP may vary premiums by rating area.

What about COBRA? Will that change?

No, there will be no changes to COBRA

What is a grandfathered plan?

Group health plans and health insurance coverage that had at least one participant on the day health care reform was enacted (March 23, 2010) are grandfathered health plans. To remain grandfathered, the plan or coverage must have continuously covered someone (although not necessarily the same person) since March 23, 2010.

How does a grandfathered plan help me?

Grandfathered health plans are excused from some but not all of the reforms set by the Patient Protection and Affordable Care Act (PPACA). The mandates below would not apply to grandfathered plans:

- Fair health insurance premiums
- Guaranteed renewability
- Guaranteed availability
- Nondiscrimination based on health status
- Nondiscrimination against health care providers
- Comprehensive health insurance coverage
- Coverage for clinical trials
- Coverage of preventive health services
- Transparency in coverage
- Nondiscrimination for insured plans
- Quality of care reporting
- Appeals process
- Patient protections

Do plans lose their grandfathered status if they make changes to the plan?

Changing Insurance Carriers

Changing the insurance contract or policy under an employer plan will cause the insurance coverage to lose its grandfathered status.

Changes to Benefits

The elimination of all or substantially all benefits to diagnose or treat a particular condition will cause a group health plan or insurance to lose its grandfathered status. For this purpose, elimination of any element necessary to diagnose or treat the condition is considered elimination of all or substantially all of the benefits for that condition.

Increases in Cost-Sharing

Any increase (measured from March 23, 2010) in percentage cost-sharing (e.g., an increase in co-insurance) will cause a group health plan or coverage to lose its grandfathered status.

Any increase (measured from March 23, 2010) in fixed-amount cost-sharing (other than co-payments) of more than 15% above medical inflation will cause a group health plan or insurer to lose its grandfathered status.

Any increase (measured from March 23, 2010) in fixed-amount co-payments above the greater of (a) \$5, increased by medical inflation; or (b) 15% above medical inflation, will cause a group health plan or insurer to lose its grandfathered status.

Decrease in Employer Contributions

A grandfather plan will lose its grandfather status if the employer (or employee organization) decreases its contribution rate (whether based on a formula or on cost of coverage) for any tier of similarly situated individuals by more than 5% below the contribution rate on March 23, 2010.

Certain Changes to Annual Limits

A grandfather plan that did not impose an annual or lifetime limit on March 23, 2010 will lose its grandfather status if it imposes an annual limit. A plan that had a lifetime limit but no annual limit will lose its grandfathered status if it imposes an annual limit at value that is lower than the lifetime limit in place on March 23, 2010. For plans with an annual limit on March 23, 2010, the grandfathered status will be lost if that annual limit is lowered (regardless of whether the plan had a lifetime limit).

Transition Rule for Certain Changes Effective After March 23, 2010

Under a transition rule, certain amendments that are effective after March 23, 2010 will not cause a grandfather plan to lose its grandfather status. These amendments are: (a) changes effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010; (b) changes effective after March 23, 2010 pursuant to a filing on or before March 23, 2010 with a State insurance department; or (c) changes effective after March 23, 2010 pursuant to written amendments to a plan that were adopted on or before March 23, 2010.

Furthermore, if plan changes that would cause a plan to lose grandfathered status were adopted after March 23, 2010 but before June 14, 2010 (the date the regulations were made publicly available), they will not cause the plan to lose grandfathered status if the plan modifies or revokes the changes as of the first day of the first plan year beginning on or after September 23, 2010.

Finally, according to the preamble to the regulations, the agencies will take into account good faith efforts to comply with a reasonable interpretation of the statutory requirements and may disregard changes to plan terms that “only modestly exceed” the changes that are not permitted and that occur before June 14, 2010 (the date the regulations were made publicly available).

What preventive services are required?

Group health plans and insurers that are subject to the preventive services coverage mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements:

Covered Preventive Services for Adults

- *Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked*
- *Alcohol Misuse screening and counseling*
- *Aspirin use for men and women of certain ages*
- *Blood Pressure screening for all adults*
- *Cholesterol screening for adults of certain ages or at higher risk*
- *Colorectal Cancer screening for adults over 5*
- *Depression screening for adult*
- *Type 2 Diabetes screening for adults with high blood pressure*
- *Diet counseling for adults at higher risk for chronic disease*
- *HIV screening for all adults at higher risk*
- *Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:*
 - Hepatitis A*
 - Hepatitis B*
 - Herpes Zoster*
 - Human Papillomavirus*
 - Influenza*
 - Measles, Mumps, Rubella*
 - Meningococcal*
 - Pneumococcal*
 - Tetanus, Diphtheria, Pertussis*
 - Varicella*
 - Obesity screening and counseling for all adults*
 - Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk*
 - Tobacco Use screening for all adults and cessation interventions for tobacco users*
 - Syphilis screening for all adults at higher risk*

Covered Preventive Services for Women, Including Pregnant Women

- *Anemia screening on a routine basis for pregnant women*
- *Bacteriuria urinary tract or other infection screening for pregnant women*
- *BRCA counseling about genetic testing for women at higher risk*
- *Breast Cancer Mammography screenings every 1 to 2 years for women over 40*
- *Breast Cancer Chemoprevention counseling for women at higher risk*
- *Breast Feeding interventions to support and promote breast feeding*
- *Cervical Cancer screening for sexually active women*
- *Chlamydia Infection screening for younger women and other women at higher risk*
- *Folic Acid supplements for women who may become pregnant*
- *Gonorrhea screening for all women at higher risk*

- *Hepatitis B screening for pregnant women at their first prenatal visit*
- *Osteoporosis screening for women over age 60 depending on risk factors*
- *Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk*
- *Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users*
- *Syphilis screening for all pregnant women or other women at increased risk*

Covered Preventive Services for Children

- *Alcohol and Drug Use assessments for adolescents*
- *Autism screening for children at 18 and 24 months*
- *Behavioral assessments for children of all ages*
- *Cervical Dysplasia screening for sexually active females*
- *Congenital Hypothyroidism screening for newborns*
- *Developmental screening for children under age 3, and surveillance throughout childhood*
- *Dyslipidemia screening for children at higher risk of lipid disorders*
- *Fluoride Chemoprevention supplements for children without fluoride in their water source*
- *Gonorrhea preventive medication for the eyes of all newborns*
- *Hearing screening for all newborns*
- *Height, Weight and Body Mass Index measurements for children*
- *Hematocrit or Hemoglobin screening for children*
- *Hemoglobinopathies or sickle cell screening for newborns*
- *HIV screening for adolescents at higher risk*
- *Immunization vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:*
 - Diphtheria, Tetanus, Pertussis*
 - Haemophilus influenza type b*
 - Hepatitis A*
 - Hepatitis B*
 - Human Papillomavirus*
 - Inactivated Poliovirus/Influenza*
 - Measles, Mumps, Rubella*
 - Meningococcal*
 - Pneumococcal*
 - Rotavirus*
 - Varicella*
- *Iron supplements for children ages 6 to 12 months at risk for anemia*
- *Lead screening for children at risk of exposure*
- *Medical History for all children throughout development*
- *Obesity screening and counseling*
- *Oral Health risk assessment for young children*
- *Phenylketonuria (PKU) screening for this genetic disorder in newborns*
- *Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk*
- *Tuberculin testing for children at higher risk of tuberculosis*
- *Vision screening for all children*