SIKO INSURANCE SERVICES

Health Care Reform Update

Health Care FAQ

What are Grandfathered Plans?

Plans in existence on March 23, 2010 were granted grandfathered status. Grandfathered plans are subject to much of the new reform, but there are specific instances, some outlined below, in which grandfathered plans are exempt from the new law. Plans wishing to maintain grandfathered status, must abide by strict rules. Therefore, it appears over the next two years the majority of employer-sponsored health plans will choose not to maintain grandfathered status due to the strict regulations established.

What provisions are now in place?

Small businesses qualify for tax credits of up to 35% of the cost of premiums. People with pre-existing medical conditions are eligible for a new federally funded "high-risk" insurance program. Insurance plans are barred from canceling policies when a patient gets sick. Also, many changes went into effect for all new plan years starting on or after September 23, 2010. See end of document for further explanation.

When do the main reform changes kick in?

In 2014, the insurance marketplaces, or exchanges, would be set up in states to offer competitive pricing on health policies for individuals and small businesses that don't have coverage. People with a pre-existing condition would no longer be denied coverage, and all lifetime and annual limits on coverage for "essential benefits" would be eliminated. Medicaid would be expanded to cover more low-income Americans.

What are the requirements for individuals to buy insurance?

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

Medicaid would be expanded to cover those under age 65 with an income of up to 133% of the federal poverty level (below $29, 327 for a family of four).

In order to make coverage more affordable, the legislation offers premium subsidies for people with incomes more than 133% but less than 400% of the federal poverty level ($29,327 to $88, 200 for a family of four).

In addition, people under 30 years of age have the option to buy a lower-cost "catastrophic" health plan.

How will small employers be affected by the changes?

Employers with 50 or more workers would face fines for not providing insurance coverage. Businesses with smaller workforces, though, would be exempt. Companies now get tax credits to help buy insurance if they have 25 or fewer employees and a workforce with an average wage of up to $50,000.

I'm covered by a large employer. How will it affect me?

Large employers now run their health plans, so there is not much change. Even though they have more insurance-buying clout, large businesses have seen steadily rising insurance premiums over the past decade without reform, as medical costs have increased. That pattern isn't likely to change much, at least immediately.

How does the bill affect Medicare recipients?

Seniors will get immediate help on the "doughnut hole" - a gap in their coverage for prescription drugs. This year, those reaching that hole would get $250 to help pay their drug costs. Next year, they would receive a 50% discount on the cost of brand-name drugs in the doughnut hole. Meanwhile, preventive screenings are free to beneficiaries beginning this year. But federal payments to Medicare Advantage plans will be cut substantially, starting in 2011. So seniors in those plans may lose some extra benefits, such as free eyeglasses.

What changes will occur in Medicaid?

Individuals and families with incomes up to 133% of the federal poverty level (below $29,327 for a family of four) will gain coverage. The federal government will pay all the states' costs for the newly eligible Medicaid beneficiaries for three years. Primary-care doctors treating Medicaid patients will get an increase in their fees.

How will the $940 billion price tag (over 10 years) be paid for?

Wealthier families will pay more in taxes. Starting in 2013, families with annual incomes above $250,000 (and individuals earning more than $200,000) would pay an additional 3.8% tax on investment income, and also face a higher Medicare payroll tax. Expensive, "Cadillac" insurance plans would draw a new tax starting in 2018. Also, the Medicare program would receive substantial cuts, including a $132 billion reduction in funding for Advantage plans run by private insurers.

What are some reform provisions that have gone under the radar?

A new, voluntary long-term care benefit (CLASS Act) would help people who become disabled. Indoor tanning sessions will face a new tax. Also, the bill requires chain restaurants with 20 or more outlets to post calorie counts on menus and menu boards.

Changes Starting after September 23, 2010

Dependent Coverage Up to Age 26

A predominant change to health care is that all group health plans that offer coverage for dependent children are required to make coverage available for any dependent until he/she reaches the age of 26. In addition, the only requirements for eligibility include the child's age and relationship to the employee. Non-grandfathered health plans cannot limit the dependent's eligibility based on factors such as student status, marital status, financial dependency, residency, or dependent's access to employer-sponsored coverage. Grandfathered health plans must follow the eligibility requirements, except for the dependent's access to employer-sponsored coverage.

Pre-existing Condition Limitations

Pre-existing conditions can no longer be applied to any child up to the age of 19 for plans beginning on or after September 23, 2010. This regulation applies to all under 19, including both dependents and employees, in group and individual plans. However, any adult 19 and over is still subject to pre-existing condition regulations until January 1, 2014, at which time pre-existing limitations cannot be placed on any Americans.

Preventative Services

Upon plan renewal, health plans offering coverage for evidence-based preventative services will no longer be able to apply cost sharing to members for these services. The new provisions allow patients to receive covered care for services including blood pressure, diabetes, cholesterol tests, many cancer screenings, routine vaccinations, pre-natal care, and wellness visits. Plan issuers may place cost-sharing on treatments excluded from the preventative services list. Grandfathered plans are excluded from this regulation.

Lifetime and Annual Limits

PPACA prohibits insured and self-insured health plans from imposing a lifetime dollar limit on essential health benefits for all plans as of September 23, 2010. Essential health benefits have not been identified, but the law allows for insurers to use their "best faith effort" until regulations define essential benefits. At this point, it appears that plans may still be permitted to apply lifetime and annual limits to benefits that are not considered essential health benefits. The annual limit for 2011 will be a minimum of $750,000, and by 2013, plans may apply an annual limit of no less than $2 million. Upon plan renewal beginning on or after January 1, 2014, group health plans are no longer permitted to impose any annual limit on essential health benefits.

Emergency Services Covered In-Network

Plans that provide coverage or any benefits for emergency services in hospital emergency departments are required to provide coverage without prior authorization, regardless if the service is in or out of network, for any treatment for an emergency diagnosis. The plan must pay for any emergency diagnosis service at the in-network benefit level. However, a member receiving care out-of-network may still be balanced billed.