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Blue Cross and Blue Shield companies are committed to working with the Administration and all other parties to implement the Patient Protection and Affordable Care Act (PPACA). As we have done throughout our 80-year history, we will continue to work in our local communities in every ZIP code to serve the approximately 100 million Blue Cross and Blue Shield members worldwide.

We have prepared these frequently asked questions to help Blue Cross and Blue Shield Plans work with their customers to better understand what healthcare reform will mean to them.

The contents of this reference guide are not intended to provide compliance, tax or legal advice or to be relied upon for these purposes. Customers should be advised to consult legal and tax experts to understand how the law will affect their individual or business circumstances.

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Effective in 2010

JANUARY 1, 2010

- Tax credits for qualifying small businesses
- Rebates for seniors who hit the Medicare gap in prescription drug coverage
- Medicare payment protections for rural medical providers
- Investments to expand and improve the healthcare workforce and new therapies

MARCH 23, 2010
(Enactment Date)

- Consumer information grants to states
- Grandfathered plan status for policies in effect on enactment date
- Enhanced screening procedures for healthcare providers to reduce fraud and waste in Medicare, Medicaid and CHIP

JUNE/JULY 2010

90 Days Out

- National high-risk pool bridge until Exchanges are running
- Temporary early-retiree reinsurance program

July 2010

- HHS Internet portal for individuals and small group
- Medicare Part D discounts for seniors who hit the gap in coverage

SEPTEMBER 2010

180 Days Out

- HHS regulations on state Exchange waivers
- Health Information Technology standards

Plan Years 6 Months Out

- Dependent coverage extended up to age 26
- Restrictions on rescissions
- No pre-existing condition exclusion for children
- Preventive services with no cost-sharing
- No lifetime dollar limits and restricted annual dollar limits
- Medical loss ratio reporting
- Patient protections

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Effective in 2011 and Beyond

JANUARY 1, 2011

- Funding for community health centers
- Medical loss ratio rebates
- Increased penalty for non-medical health savings account withdrawals
- Medicare Advantage changes
 - > 2010 payments frozen for 2011
 - > Authority to deny plan bids (MA/PDP)
 - > Limits on out of pocket costs
 - > Provisions for 50% discount on brand-name drugs in the Medicare Part D coverage gap

JANUARY 1, 2012

- Physician payment reforms and incentives to form “accountable care organizations”
- Value-based purchasing programs
- Implementation of uniform standards for electronic exchange of health information

JANUARY 1, 2013

- Cap on health flexible spending account contributions
- National pilot programs on payment bundling for Medicare
- Increased Medicaid payment for primary care doctors
- Health insurance fee to fund comparative effectiveness research

JANUARY 1, 2014

- Health insurance exchange is established for individual and small group markets
- Guaranteed issue requirements
- Individual and employer responsibility requirements
- No pre-existing condition exclusions
- Elimination of annual limits on insurance coverage
- Excise tax on health insurance imposed

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Q. I currently have health insurance coverage through a Blue Cross and Blue Shield company. Do I need to do anything now?

No. The new law will be implemented over the next several years. Blue Cross and Blue Shield companies will continue to provide excellent service and will work to implement the new healthcare law to best serve their members.

The 39 independent Blue Cross and Blue Shield companies are reviewing the law and working with the federal and state agencies that are charged to implement the law to ensure a smooth transition. We will be communicating with you as changes occur that may impact you.

Q. When will these new reforms become effective?

Beginning in July 2010, consumers with health problems who have been uninsured for six months may be eligible to obtain coverage through a new high-risk pool program. Also, a temporary reinsurance program, established in June, will help employers who provide coverage to their retirees under 65 maintain this coverage.

Beginning in plan years on or after September 23, 2010, pre-existing condition exclusions are prohibited for children under age 19. Also, dependents up to age 26 will be able to obtain coverage through their parents' health plans. For policies that are not [grandfathered](#), routine preventive care will be covered without cost-sharing (e.g., co-payments, deductibles). And certain annual or lifetime dollar limits on coverage will be eliminated. These requirements generally will apply at the beginning of the new plan year, which for many individuals will be January 1, 2011.

Starting in 2014, individuals will be required to purchase health insurance or pay a penalty. Consumers will be able to purchase health insurance regardless of health status, and premiums cannot vary because of health status. Both individuals and small businesses will be able to purchase coverage through state-based Exchanges. This coverage will cover specified minimum benefits established in the new law. For persons purchasing coverage in the individual market through the Exchange, subsidies will be available on a sliding scale to help individuals or families with incomes up to 400 percent of the federal poverty level. Individuals also will be able to purchase coverage outside the Exchange, but subsidies will not be available to them.

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Q. Will insurers have to cover everyone regardless of their health status?

Yes. Blue Cross and Blue Shield companies have long supported guaranteeing that everyone be able to purchase health insurance coverage regardless of their health condition, coupled with a requirement that everyone obtain and maintain coverage. Beginning in 2014, the new law requires that individuals have coverage, and insurers must offer coverage to anyone regardless of health status and cannot vary premiums based on health status. This coverage will be available during an annual open enrollment period or if someone loses eligibility for their current coverage.

Q. Does the law require that everyone buy health insurance?

Yes, with very few exceptions. Beginning in 2014, U.S. citizens and legal residents will be required to buy health insurance or pay a penalty. The penalty will be phased in, beginning at the greater of \$93.50 per person or 1 percent of a person's applicable household income that is in excess of the applicable tax filing threshold in 2014 and increasing to the greater of \$695 per person or 2.5 percent of a person's applicable household income that is in excess of the applicable tax filing threshold in 2016. For persons under the age of 18, the penalty is half of the above amount.

Individuals may be exempt from the mandate, for example, if they can't find affordable health insurance, as defined by the government, or if their income does not meet the federal tax-filing threshold. In 2010, the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples.

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Q. How will health reform affect my premiums?

There are a number of factors that drive health insurance premiums. Increasing use of medical services attributable to an aging population, obesity and chronic illnesses, new treatments, prescription drugs and expensive new technologies are the biggest causes of increasing healthcare premiums.

We believe that average premiums will increase as a result of provisions in the reform legislation that make it easier for high-cost individuals to obtain coverage and that guarantee richer levels of benefits than most consumers who obtain their own insurance purchase today. The extent to which premiums increase will depend on how the government implements the new reforms. New taxes on insurance mandated by the new law also will likely increase the cost of premiums as the taxes are phased in. Government payments may offset some or all of these costs for those who are eligible for subsidies.

Blue Cross and Blue Shield companies will continue to work with doctors, hospitals, employers and consumers to rein-in costs and insurance premiums while improving access to quality healthcare.

Q. I am currently uninsured. How will I obtain coverage in the future?

Beginning in 2014, state health insurance Exchanges will enable consumers to compare benefits, prices and networks of healthcare providers and to purchase coverage. In 2014, subsidies also will be made available as noted in the next question on [affordability](#).

Prior to the establishment of state Exchanges in 2014, a temporary high-risk pool program has been created by the federal government to provide coverage to certain high-risk individuals who have not had insurance during the prior 6-month period and do not have access to alternative coverage. A majority of states already have high-risk pools for their residents.

Many Blue Cross and Blue Shield companies already offer low-cost health insurance options that you may be able to enroll in today. You can find coverage options through your local Blue Cross and Blue Shield company.

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Q. What if I can't afford to purchase coverage?

Blue Cross and Blue Shield companies offer many different options, and some are much more affordable than you may realize. Contact your local Blue Cross and Blue Shield company about options that could fit your needs.

Beginning in 2014, consumers with incomes less than 400 percent of the federal poverty level and who purchase coverage on their own may qualify for federal subsidies to help purchase coverage beginning in 2014. While the federal agencies must work out how the subsidies will be paid, the Congressional Budget Office estimates that about 20 million American households will be eligible for subsidies.

In addition, eligibility in Medicaid, the federal-state program that provides health coverage to millions of Americans, will expand to cover families with incomes up to 133 percent of the federal poverty level. Measured in today's dollars, that means adults under 65 will qualify for coverage in 2014 if they earn no more than \$14,404 for a single adult and \$29,326 for a family of four.

Q. What does the law mean when referring to preventive services being provided without any cost-sharing? Which services is the law referring to?

For new health insurance policies, and for policies that are not [grandfathered](#) and that have renewal dates on or after September 23, 2010, members will be able to receive certain preventive services without having to pay deductibles, co-payments or coinsurance. The types of services include several evidence-based cancer and disease screenings, as well as specific immunizations. Contact your insurer to find out which specific services are covered.

Q. How is a policy year defined?

In the individual health insurance market, policy year means the 12-month period that is designated as the policy year in the policy documents of the individual health insurance coverage. Check your policy for specific information related to your policy year.

If there is no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. For example, if deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year.

Note: Policy year is defined differently for group policies.

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Q. Will my choice of doctors be eliminated?

No. The law does not interfere with the choice of doctors you have today. It is important to remember, though, that from time to time, doctors do leave health insurance networks or change which health plans they accept.

Q. Who decides what kind of treatment I can receive?

Treatment decisions will continue to be made between you and your doctor. However, in an effort to improve the healthcare system overall, the government will increase funding for research into evidence-based outcomes to improve quality of care. This means that over time, options that are available today may change if some treatments or procedures are found to be less effective than others. This already happens today and could help improve overall care.

Q. Will I have to pay extra if I have a high-cost health plan (known as a Cadillac Plan)?

Not if you purchase coverage on your own in the individual health insurance market. The excise tax on high-cost health plan coverage is on employer-based group health plans.

Q. What are the new provisions for emergency-related services?

For plans that are not [grandfathered](#), the new law generally states that coverage for emergency department services must be provided without prior authorization of services based on a prudent layperson standard. In addition, out-of-network emergency services must be covered and reimbursed the same as in-network emergency services, including cost-sharing requirements (i.e., copayments or coinsurance) for both in-network and out-of-network services.

Q. What are the new provisions for women’s health?

The new law includes many provisions that are designed to improve women’s health. The new law will eliminate cost-sharing for certain preventive screenings and ensure direct access to obstetricians and gynecologists. Many additional benefits are made available to women beginning in 2014, including: covering maternity services on all coverage; eliminating pre-existing coverage exclusions for women who are pregnant, have had a previous cesarean, or are the victims of domestic violence; and eliminating gender rating that may cause women to pay more than men for insurance at certain ages.

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The law creates new state-based health insurance Exchanges, marketplaces that will help consumers shop, compare and enroll in health insurance coverage. People who are not eligible for Medicaid or affordable employer-sponsored insurance may purchase coverage through an Exchange beginning in 2014. Consumers who purchase individual coverage on their own and who have incomes below 400 percent of the federal poverty level may qualify for federal subsidies to help offset premiums beginning in 2014. These subsidies are only available for coverage offered through an Exchange.

Q. How do I know if I am eligible to purchase insurance through the Exchanges in 2014?

Although the eligibility rules will be finalized over the next few years, you will be likely eligible to purchase insurance through the Exchanges in 2014 if you are unemployed, a sole proprietor or an employee of a company with fewer than 100 employees (or, in some states, fewer than 50 employees in 2014 and 2015) and you are not eligible for Medicaid or affordable employer-sponsored insurance. Affordable employer-sponsored insurance is defined as requiring an employee contribution of less than 9.5 percent of family income for a plan that covers at least 60 percent of medical costs on average. This standard also applies to dependents that are eligible to enroll.

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For plan years beginning on or after Sept. 23, 2010, the new law allows dependent children up to age 26 to obtain coverage under their parents' plans that offer dependent coverage. As of April 2010, all 39 independent Blue Cross and Blue Shield companies voluntarily agreed to extend coverage in their individually insured health plans to allow young adults to remain on their parents' policies up to age 26.

Q. I heard that many insurers are allowing young people to remain on their parents' insurance policies even before the new law goes into effect. How can I find out if my children are eligible?

The 39 independent Blue Cross and Blue Shield companies recognized that many young people could lose their coverage because of their age, student status, graduation from school or other factors prior to when the new law goes into effect for plan years beginning on or after Sept. 23, 2010. Blue Cross and Blue Shield companies proactively announced in April that, effective June 1, they would offer continued coverage of these hundreds of thousands of young adults under age 26 on the health insurance policies their parents purchased through the individual marketplace. Young adults may be eligible regardless of whether or not they are financially dependent on their parents.

This early extension of coverage also is being offered to employers that may want to offer the early extension for their employees. Also, many state laws and employers' policies already allow older dependents to be covered. Contact your health insurer or employer to determine eligibility.

Q. Does the extension of coverage to adult dependents up to the age of 26 also include coverage for the spouse or children of my adult dependent children (i.e. grandchildren)?

No, the extension of coverage to adult dependent children does not require coverage for your grandchild or the spouse of your adult dependent.

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No. You generally may keep your existing health insurance coverage. If you were enrolled in your plan on or before March 23, 2010, your coverage may be “grandfathered” so that it does not have to include some of the provisions required by the new law. Contact your Blue Cross and Blue Shield company for more specifics about maintaining your existing healthcare coverage.

Q. If I had health insurance prior to the healthcare reform enactment date, what major provisions of the new law will apply to my existing coverage and when?

Even with grandfathering, there are provisions of the new law that will be added to your coverage effective plan years on or after September 23, 2010. Some of the important additions you will see include:

- Extension of coverage to adult dependent children up to the age of 26, if the adult dependent is not eligible to enroll in other employer-provided coverage. The law does not require coverage for a child or spouse of any dependent children.
- Elimination of coverage rescissions. Cancellation of your policy by your insurer after the policy has been issued is permitted only if you committed fraud or intentionally misrepresented a material fact in your health insurance application or failed to pay your premium according to the terms of the policy.
- No lifetime dollar limits on total coverage.
- Requirements that your insurer pay out in claims, claims-related expenses, and activities that improve healthcare quality, a set amount of each premium dollar collected.

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The law appropriates funds to reimburse employers for offering group health coverage to early retirees, ages 55 through 64, who are not Medicare eligible. If your employer does not offer coverage, contact your local Blue Cross and Blue Shield Company to find out what health plans may work best for you.

Also, your state may have high-risk pools that allow you to purchase individual insurance coverage if you have been uninsured for six months. For example, individuals with preexisting conditions who have been uninsured for more than six months will be eligible to enroll in a national high-risk pool and pay regulated premiums.

Starting in 2014, insurers must accept all applicants during an annual open enrollment period, including anyone with preexisting medical conditions. The law limits what the insurance companies can charge older individuals and sets up competitive markets where consumers can buy a policy, in many cases with direct government assistance if their incomes are below 400 percent of the federal poverty level.

Q. What about the new law's early-retiree reinsurance provisions?

The law appropriates funds to reimburse employers for offering group health coverage to early retirees, ages 55 through 64, who are not Medicare eligible. The goal of the program is to help employers maintain their early-retiree coverage until the new Exchanges become operational in 2014. You could benefit from this provision if your previous employer decides to offer insurance coverage to early retirees. See the small and large group sections for additional detail on the early-retiree reinsurance provisions.

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Q. What immediate changes should I expect as an employer?

One of the earliest changes for employer-provided coverage, that is not [grandfathered](#), will be the requirement that beginning in plan years on or after September 23, 2010, employers pay the full cost of preventive coverage, including immunizations, breast cancer screening and recommendations of the U.S. Preventive Services Task Force and other agencies such as the Centers for Disease Control.

Effective for plan years beginning on or after September 23, 2010, dependents up to age 26 will be allowed to remain on their parents' policies. In April 2010, the 39 independent Blue Cross and Blue Shield companies announced that they would voluntarily offer to allow young adults who would age-off before September 23 to remain on their parents' policies. This offer was also extended to employers that may want to allow employees' dependent children to stay on their parents' coverage. For employer-provided group health insurance, employees should check with their health insurer or employer for specific information regarding coverage. See additional information in the [Adult Dependents](#) section.

Q. What other major provisions of the new law will apply to our existing group coverage and when?

There are a number of other near-term reforms included in the new law (effective for plan years beginning on or after September 23, 2010). Some of the important additions include:

- Elimination of coverage rescissions. Canceling of a member's policy by an insurer, after the policy has been issued, is permitted only if the member committed fraud or made an intentional misrepresentation of a material fact on his or her application for health insurance. The regulations clarify that cancellation or discontinuance of coverage can be made for failure to pay premiums in a timely manner.
- No lifetime or annual limits on dollar value of benefits. A group health plan and a health insurance issuer offering group health plans may not establish lifetime limits or annual limits on the dollar value of "essential" benefits (to be defined in future regulation) for any participant or beneficiary. (Restricted annual limits are allowed through 2013 and are to be further defined by the Department of Health and Human Services).
- Certain other health plan requirements, including provision of internal/external appeals, access to emergency services, and provisions related to pediatrician and OB/GYN choice.

Some plans may not be subject to these requirements because of their status as [grandfathered](#) plans.

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Q. Can I keep the group health plan I currently offer my employees?

Yes. Plans in existence on March 23, 2010, are [grandfathered](#) into the law, meaning that if existing group coverage is maintained they do not have to comply with certain provisions of the new law. Nevertheless, even grand-fathered plans must comply when certain rules go into effect at the first plan year after September 23, 2010, such as eliminating lifetime limits and “unreasonable” annual dollar limits on policies, and allowing dependents up to age 26 remain on their parent’s policy. The law itself specifies that enrolling new employees or adding family members will not affect grandfathered status, and the Department of Health and Human Services (HHS) has clarified what changes to an existing policy would alter a plan’s grandfathered status.

Q. Does the new law require that all employers offer healthcare coverage?

No. However, there are financial obligations for employers with at least 50 full-time employees.

Beginning in 2014, businesses with 50 or more full-time employees that do not offer coverage and have at least one full-time employee who receives a federal tax credit to purchase health insurance through an Exchange, must pay the federal government a \$2,000 per-employee penalty. In calculating the penalty, the employer excludes the first 30 employees from the payment calculation (i.e., a firm with 51 employees would pay the penalty on 21 of them).

Employers with 50 or more full-time employees that do provide coverage, but have at least one full-time employee who receives a federal tax credit to purchase health insurance on his or her own through an Exchange (i.e. the employer’s coverage is greater than 9.5% of the employee’s household income and so is determined to be “unaffordable”), will be assessed a penalty that is the lesser of \$3,000 per employee receiving a tax credit or \$2,000 for each full-time employee, excluding the first 30 employees.

Q. Can an employer still impose a waiting period on employees before health insurance becomes effective?

Yes, employers may still impose a waiting period; however, beginning in 2014, the waiting period may not exceed 90 days.

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Q. Does the new law require that part-time and seasonal employees be eligible for group coverage?

The new law provides that employees working an average of 30 hours per week or more in a month or seasonal workers who work more than 120 days in a year be eligible for coverage, or an employer may be subject to a penalty. Employers with 50 or more employees may be subject to a penalty if they do not comply with this provision.

Q. Will my employees have to pay extra because of the “Cadillac Tax” if they have high-cost health plans?

Starting January 1, 2018, a 40-percent excise tax will be imposed on group health insurance premiums exceeding \$10,200 per year for single coverage and \$27,500 per year for family coverage. The cost thresholds triggering the tax will be slightly higher for plans covering retirees or employees in certain high-risk industries (\$11,850 per year for an individual retiree or \$30,950 per year for family). In 2019, the thresholds would rise to match the increase in the Consumer Price Index (CPI), plus one percentage point. In 2020 and succeeding years, the thresholds will increase to match rises in the CPI rounded to the nearest \$50. Although this tax is on insurers (and self-funded group plans), it is possible that it will be passed on to employers and employees in the form of higher premiums. To avoid the tax, some employers may make changes to their plans.

Q. Are employers required to do any new reporting?

Yes, there are several new reporting requirements for employers, including the following:

- Employers that do not offer healthcare coverage must file a return stating that they do not offer coverage, the number of full-time employees and other as yet unspecified information to be required (but not spelled out in the law) by the Secretary of HHS.
- Employers must report the value of the benefits on each employee’s annual W-2 form beginning with W-2s issued in January 2012 (i.e., for tax year 2011). Current rules for COBRA continuation of coverage should be used in calculating the value of benefits (minus the 2-percent COBRA allowed administrative fee if charged). Contributions to Archer MSAs and HSAs, and salary reduction contributions to FSAs, are not required to be included in determining the value of benefits.

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- Beginning in March 2013, employers must provide information to employees about the Exchanges.
- Beginning in 2014, employers providing minimum essential coverage must report to the IRS annually with information about the coverage offered. Specifically, employers must report information such as:
 - > the length of any waiting period
 - > the months during the calendar year coverage was made available to employees
 - > the monthly premium for the lowest cost option for each enrollment category within the plan
 - > the employer's share of the total allowed costs of benefits provided under the plan
 - > the option for which the employer pays the largest portion of the cost of the plan, and the portion of the cost paid by the employer in each enrollment category for such option
 - > the name, address and tax identification number of each full-time employee during the calendar year and the months during which such employee (and any dependents) were covered under any health benefit plan
 - > additional information the Treasury Department may require in order to administer the [small business tax credit](#), if the employer is eligible for the credit and coverage is a qualified health plan offered through the [Exchange](#)
- Also beginning in 2014, employers providing minimum essential coverage must provide written statements with information to each covered individual, listing the information bulleted above as well as the name, address and contact information of the employer's insurer. Statements are to be given to individuals on or before January 31 for the previous calendar year.

Q. What are the new provisions for emergency room-related services?

For plans that are not [grandfathered](#), the new law generally states that coverage for emergency department services must be provided without prior authorization of services based on a prudent layperson standard. In addition, out-of-network emergency services generally must be covered and reimbursed the same as for in-network emergency services, including any cost-sharing requirement (i.e., co-payments or coinsurance) for both in-network and out-of-network services.

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The law creates new state-based health insurance Exchanges, marketplaces that will help consumers shop, compare and enroll in health insurance coverage. U.S. citizens and legal residents may purchase coverage through an Exchange beginning in 2014. Generally, small employers with 1 to 100 employees also can participate when the Exchanges first open in 2014. States have the option to limit the Exchange to employers with 1 to 50 employees in 2014 and 2015 and may choose to expand the Exchange to businesses larger than 100 employees beginning in 2017.

Q. Does my company have to buy through the Exchange beginning in 2014 if it is eligible to do so?

No. Employers of all sizes may continue to purchase coverage outside the Exchange.

Q. What are free-choice vouchers?

A provision in the new law requires an employer that offers minimum essential coverage to its employees to give certain low-paid employees not enrolled in the employer's group health plan vouchers to purchase coverage in state health insurance Exchanges beginning in 2014. An employee who earns up to 400 percent of the federal poverty level and whose employee premium contributions for group coverage are between 8 and 9.8 percent of household income is eligible for the voucher, which would be provided and paid for by his or her employer if the employee enrolls in coverage through the Exchange. The value of the voucher is equal to the highest employer contribution for a company plan for which the employee is eligible to enroll. If the employee buys coverage for less than the value of the voucher, the employee may keep the difference in taxable cash.

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Q. How does the new law change requirements for providing health coverage to dependents?

The law requires health plans that already provide dependent coverage for children to continue to make the coverage available for adult children up to the age of 26. This extended coverage must be provided no later than plan years beginning on or after September 23, 2010.

In addition, as of March 30, 2010, health coverage provided for an employee's children up to 26 years of age is now generally tax-free to the employee and employer. Employers with cafeteria plans (i.e., plans that allow employees to choose from a variety of benefits to formulate a plan that best suits their needs) may permit employees to immediately make pre-tax salary reduction contributions to provide coverage for children under age 26, even if the cafeteria plan has yet to be amended to cover adult children. Plan sponsors have until the end of 2010 to amend their cafeteria plan language to incorporate this change.

Q. What is the definition of an adult dependent under the new reform law?

In referring to adult dependents, the law intends to address adult children of individuals covered by a group or individual health plan. The law stipulates that coverage shall be made to dependents up to age 26 regardless of their tax filing status, marital status or financial dependency on the parent. However, coverage does not have to be granted to a spouse or child of a covered adult dependent.

Q. Do the adult dependents need to be dependents as defined by the IRS?

No, the regulation specifically says that this is not a requirement for dependents under this provision.

Q. Is the requirement up to age 26 or through age 26 (and to age 27)?

When companies do offer dependent coverage, the coverage must be offered to dependents up to age 26. Plan eligibility provisions can terminate coverage effective 12:01 a.m. on the dependents' 26th birthdays.

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No, the law contains no requirement that adult dependents under age 26 maintain student status in order to be eligible for coverage.

Q. Does the law require my company to offer dependent coverage?

No. The law does not require a company's health plans to cover dependents. The law requires a plan to provide coverage to dependents up to age 26, if it provides coverage for any dependent.

Q. Does my company have to provide coverage for dependents to age 26 even when they are married?

Yes. As long as the group policy allows for dependent coverage, companies' health plans must continue to offer married dependents coverage up to age 26. The policy does not require coverage to be granted to a spouse or child of the married dependent.

Q. Is coverage required for children of dependent children (i.e. grandchildren)?

No, the law does not require a company to make coverage available for a child of an adult dependent receiving dependent coverage.

Q. What are the exceptions to the requirement that plans offer dependent coverage up to age 26?

Plans are not required to offer dependent coverage up to age 26 only in the following cases:

- when group health plans do not extend coverage to any dependents
- for grandfathered plans for plan years beginning before January 1, 2014, where dependents are eligible to enroll in other employer-sponsored coverage

Beginning with the first plan year on or after January 1, 2014, plans must cover dependents up to age 26 regardless of their eligibility for coverage under other health plans.

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Adult Dependents

Q. How should my company determine the premium rates for the new adult dependents of their employees?

The regulation requires the same premium structure and rates plans use for currently covered dependents.

Q. Can my company create a separate plan to cover adult dependents of their employees?

No. Company health plans are required to offer adult dependents coverage on the same basis as any other dependents. Plan options should be the same as those offered to employees, and actual coverage should be determined by employee elections (just like with any other dependents).

Q. Can my company apply a rate surcharge for new adult dependents?

No. The regulation prohibits health plans from varying the terms of coverage based on age, so they would not be able to impose a premium surcharge for children older than age 18.

Q. Does my company have to offer COBRA when adult dependents reach age 26?

Yes. The new law does not change COBRA requirements, and COBRA will apply to adult dependents when they are qualified beneficiaries (the same as it applies to any other qualified beneficiaries).

Q. Does an adult dependent under age 26 and on COBRA based on his/her age, have the right to re-enroll?

Yes. An eligible dependent covered under a COBRA continuation provision must be given the opportunity to enroll as a dependent of an active employee. In this situation, if the child loses eligibility for coverage due to a qualifying event (including aging out of coverage at age 26), the dependent has another opportunity to elect COBRA continuation coverage.

Q. Does my company have to calculate imputed income for adult dependents based on their contributions towards coverage costs?

No. The tax code has been amended. Employer contributions toward adult dependents' coverage are not considered taxable. Contributions employees make toward adult dependents' coverage through pre-tax payroll deductions are also still considered tax-exempt.

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Grandfathering

Q. If my health insurance with my company was in force prior to the effective date of the law, will we have to purchase new insurance?

If coverage was in force on or before March 23, 2010, your group has grandfather status and can maintain its existing health insurance coverage. Grandfathered plans are exempt from certain requirements of the new law, with guidance from HHS stating that changes in premiums, changes in third-party administrators, and changes to comply with state and federal law will not cause the loss of grandfather status. However, the following changes, according to the HHS guidance, would cause the loss of grandfather status:

- eliminating benefits to diagnose or treat a condition
- increasing co-insurance above March 23, 2010 levels
- increasing fixed amount cost-sharing (e.g., deductibles and out-of-pocket maximums) by more than the sum of medical inflation plus 15 percentage points from March 23, 2010 levels
- increasing co-payments by an amount that exceeds the greater of: (1) a total percentage (measured from March 23, 2010) that is more than the sum of medical inflation, plus 15 percentage points, or (2) \$5, increased annually by medical inflation
- reducing employer contributions based on the cost of coverage or a formula by more than 5 percentage points below the contribution rate on March 23, 2010
- reducing an overall annual dollar limit or adding a new overall annual dollar limit, compared to what was in effect on March 23, 2010

The regulations governing grandfathered plan are complex and companies may not be able to maintain such plans if they make certain changes. Please consult a professional tax adviser or lawyer for details and further explanation of the regulations.

Q. Can employees still add family members (dependents) to existing coverage without losing grandfather status?

Yes. The group can continue to renew its policy, and covered employees may add family members as allowed under the terms of the existing group contract.

Q. Can employers add new employees to the existing plan without impacting its grandfathered status?

Yes.

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Early Retirees

Q. What is early-retiree reinsurance?

The law establishes an early-retiree reinsurance program that dedicates \$5 billion to help employers that offer group health coverage to early retirees, ages 55 through 64, who are not Medicare eligible. The program is effective June 1, 2010, until January 1, 2014, or until funds run out. The goal of the program is to help employers maintain their early-retiree coverage until the new [Exchanges](#) become operational in 2014.

Q. How does the early-retiree reinsurance program work?

The program, through the Secretary of HHS, will reimburse employers, state and local governments, and employer-sponsored health plans for 80 percent of the costs incurred by retirees (ages 55-64) between \$15,000 and \$90,000 annually, with a maximum of \$60,000 a year per early-retiree.

Costs are determined before co-payments, co-insurance and deductibles and will cover payments for medical, surgical, hospital and prescription drug costs, or other benefits as determined by the Secretary of HHS.

Q. Can claims for covered family members of the early retirees be reimbursed with program funds?

Yes, companies paying claims for early retirees' spouses, surviving spouses or dependents covered under the early retirees' health plan are eligible for the reinsurance program.

Q. When will the program begin?

The program began accepting applicants on June 29, 2010. Application forms are available at www.healthcare.gov.

Q. When will the program end?

The law appropriates not more than \$5 billion to carry out this program. The program will end at the earlier of the time of January 1, 2014, or when the funding runs out.

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Q. What determines a company's eligibility for the early-retiree reinsurance program?

To be eligible, companies must:

- offer healthcare coverage to early retirees ages 55-64
- demonstrate that they have cost-saving programs in place to for covered members with chronic and high-cost health conditions
- be able to provide documentation of the retirees' actual medical claim costs
- have a Protected Health Information (PHI) agreement in force with an insurer or plan administrator

Q. How can companies use the proceeds from the program?

The company receiving early-retiree reinsurance proceeds must use the proceeds to reduce its health benefit premiums or health benefit costs and/or its employees' health benefit premium contributions, copayments, deductibles, coinsurance or other out-of-pocket costs. Employers cannot use proceeds under this program as general revenue.

Q. How can my company participate in the early-retirement reinsurance program?

Your company must apply to HHS for participation in the reinsurance program and must be certified by the HHS Secretary. HHS began accepting applications to the early-retiree reinsurance program on June 29, 2010. Applications will be processed in the order they are received. Given the limited appropriation, you should file applications as soon as possible.

Q. Are amounts my company has paid prior to June 1, 2010, reimbursable?

No. To be eligible for reimbursement, claims must be incurred and paid during the program's life. If a plan year begins prior to June 1 and an eligible member incurs \$15,000 or more in expenses before June 1 of the plan year, it is treated as having met the \$15,000 threshold for the plan year and is eligible for reimbursement for costs incurred after June 1, 2010.

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Claims can be submitted only after your company's health plan is certified by the Secretary of HHS for the plan year in which the claims occur, and after the \$15,000 threshold has been met based on your actual plan payments. If a plan year begins prior to June 1 and an eligible member incurs \$15,000 or more in expenses before June 1 of the plan year, it is treated as having met the \$15,000 threshold for the plan year and is eligible for reimbursement for costs incurred after June 1, 2010.

Q. Does my company need to reapply each year?

No, not according to the law's interim final rule.

Q. What happens after the program ends?

The program will end by January 1, 2014, or prior to that date, should the appropriated funds be depleted. In 2014, if the employer no longer provides coverage for early retirees, those individuals will be able to choose from the coverage options that will be available through the health insurance [Exchanges](#).

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Small employers that provide healthcare coverage to their employees and meet certain requirements generally are eligible for a federal tax credit. This credit can be reflected in determining estimated tax payments for the year to which the credit applies in accordance with regular estimated tax rules. The credit is available immediately, and eligible employers may count premium contributions made for the entire 2010 tax year as part of the credit starting with the 2010 income tax return they file in 2011. The maximum credit is 35 percent of employer costs (25 percent if tax-exempt) for years 2010 through 2013. Eligible employers can claim this credit for all four years.

The amount of the credit available to a company is determined by the number of full-time equivalent employees and/or the average wages of its employees, with the smallest companies and those with the lowest average wages eligible for the maximum credit.

Starting in 2014, the maximum credit increases up to 50 percent of employer costs (35 percent if tax-exempt). Eligible employers must purchase insurance through the state-based Exchange. The tax credit is limited to the first two years of coverage, starting in 2014.¹

Q. Who qualifies as a small employer?

The credit is available to employers with fewer than 25 full-time equivalent employees (FTEs) and less than \$50,000 in average annual wages. Seasonal workers are disregarded in determining FTEs and annual wages unless they work more than 120 days during the tax year.

Eligible employers must also pay at least 50 percent of the premium cost under a “qualifying arrangement.” A qualifying arrangement is an arrangement under which the employer pays premiums for each employee enrolled in health insurance coverage offered by the employer in an amount equal to a uniform percentage (not less than 50 percent). Special [IRS transition rules](#) apply for 2010.

¹ For further information beyond what is listed here, the IRS has issued detailed guidelines (e.g., Notice 2010-44) as well as answers to common questions which can be found at www.irs.gov.

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Determining eligibility involves three steps:

1. Determine number of FTEs (not counting owners or family members). Sum the number of full-time employees (those who work at least 30 hours per week) and the number of full-time equivalents (total annual hours of part-time employees divided by 2,080). If the total number of FTEs is less than 25, then proceed to Step 2.
2. Determine average annual wages. Take total annual wages paid to employees (not counting owners or family members) and divide by the FTE number from Step 1. If average annual wages are less than \$50,000, then proceed to Step 3.
3. Determine premium contribution: In tax year 2010, during which the IRS transition rules apply, if the employer pays at least 50 percent of the premium rate for single (employee-only) coverage, then the employer may be eligible to claim the small business tax credit. Rules for determining premium contributions beyond 2010 have yet to be issued.

Q. Is there any transition relief available for tax years beginning in 2010 to make it easier for taxpayers to meet the requirements for a qualifying arrangement?

Yes. The IRS and Department of the Treasury have issued guidance providing that, for tax years beginning in 2010, the following transition relief applies with respect to a qualifying arrangement:

- Qualifying employers must only pay at least 50 percent of the premium rate for single (employee-only) coverage. If the employee is receiving coverage that is more expensive than single coverage, such as family coverage, the employer satisfies the contribution requirements if the employer pays an amount of the premium that is no less than 50 percent of the premium for single coverage for that employee.
- Under this special transition rule, employers will be treated as satisfying the uniformity requirement (to be treated as a qualifying arrangement) even if the same percentage is not paid for each employee, as long as the employer pays an amount for each employee that is no less than 50 percent of the cost of single coverage (even if the coverage provided is family coverage, which is more expensive.)

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Q. Can a tax-exempt organization claim this tax credit?

Yes. The same definition of qualifying employer applies to an organization described in the Internal Revenue Code section 501(c) that is exempt from tax under section 501(a). However, special rules apply in calculating the credit for a tax-exempt qualified employer. For tax-exempt employers, the IRS will provide further information on how to claim the credit.

An employer that is an agency or instrumentality of the federal government, or of a State, local or Indian tribal government, is not a qualified employer unless it is an organization described in Code section 501(c) that is exempt from tax under Code section 501(a).

Q. What is the eligibility for employers that are members of a controlled group or an affiliated group?

Members of a controlled group (e.g., businesses with the same owners) or an affiliated service group (e.g., related businesses of which one performs services for the other) are treated as a single employer for purposes of the credit.²

Q. Who is eligible for the maximum tax credit?

Employers with 10 or fewer full-time equivalent (FTE) employees and paying \$25,000 or less in average annual wages are eligible for the maximum credit.

Q. Who is eligible for a partial tax credit?

The tax credit gradually phases out for companies with average wages between \$25,000 and \$50,000 and for companies with 10 to 25 full-time equivalent (FTE) workers.

- **Phase-out Based on FTEs:** If the number of FTEs exceeds 10, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the number of FTEs in excess of 10 and the denominator of which is 15.
- **Phase-out Based on Average Annual Wages:** If average annual wages exceed \$25,000, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the amount by which average annual wages exceed \$25,000 and the denominator of which is \$25,000.

² Consult the Internal Revenue Code for specific rules for determining whether an employer is a member of a controlled group or an affiliated service group (i.e., Internal Revenue Code section 414(b), (c), (m), and (o)).

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- Phase-out based on both FTEs and Wages: For an employer with both greater than 10 FTEs and average annual wages exceeding \$25,000, the reduction is the sum of the amount of the two reductions. This sum may reduce the credit to zero for some employers with fewer than 25 FTEs and average annual wages of less than \$50,000.

Q. Which employees are ineligible for this tax credit?

The following employees are ineligible for the tax credit and should NOT be included in any FTE or wage calculations. Premiums paid on behalf of these individuals are not counted in determining the tax credit.

- self-employed individuals or sole proprietors
- partners in a partnership
- any 2 percent (or greater) shareholders of an S corporation
- any 5 percent (or greater) owner of an eligible small business
- employees with a relationship to above bullets (i.e., family members)

For this purpose, a family member is defined as a child (or descendant of a child); a sibling or step-sibling; a parent (or ancestor of a parent); a step-parent; a niece or nephew; an aunt or uncle; or a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law. Finally, any other member of the household of these owners and partners who qualifies as a dependent under section 152(d)(2)(H) of the Internal Revenue Code is not taken into account as an employee for purposes of the small business tax credit.

Seasonal employees working for fewer than 120 days per year are also generally disregarded in determining FTEs and average annual wages, but premiums paid on their behalf may be counted in determining the amount of the small business tax credit.

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Small Business Tax Credits

Q. What health insurance plans are eligible for the tax credit?

For years prior to 2014, health insurance plans with premiums for traditional coverage for a wide variety of conditions, such as a major medical plan, are eligible. In addition, plans with premiums for certain coverage that is more limited in scope, such as limited dental or vision coverage, are also eligible. However, if an employer offers more than one type of coverage, such as a major medical plan and a separate limited scope dental or vision plan, the employer must separately satisfy the requirements for a qualifying arrangement with respect to each type of coverage the employer offers (meaning the employer cannot aggregate these different plans for purposes of meeting the qualifying arrangement requirement).³

If an employer pays only a portion of the premiums for the coverage provided to employees under the arrangement, with employees paying the rest, the amount of premiums counted in calculating the credit is only the portion paid by the employer.

In years 2014 and beyond, only health plans offered through the Exchange are eligible for the tax credit.

Q. Eligibility and the amount of the tax credit is determined, in part, by employer costs. How do I determine employer costs?

Employer costs are determined as the lesser of:

- the employer's contribution to its employees' health insurance premiums
- the contributions the employer would have made if its employees enrolled in a health plan with a premium equal to the average premium for the small group market in a given state or area within a state⁴

Any premiums paid through a salary reduction arrangement under a cafeteria plan are not treated as paid by the employer.

For firms that are tax-exempt, the same rules for determining employer costs apply. However, the amount of the credit cannot exceed the total amount of income and Medicare (i.e., Hospital Insurance) tax the employer is required to withhold from employees' wages for the year and the employer share of Medicare tax on employees' wages.

³ For a detailed description of the types of coverage that are counted for the credit, see IRS Notice 2010-44.

⁴ The average premium for the small group market on a state-by-state basis were issued by the IRS in Revenue Ruling 2010-13.

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Generally, no. Except in the case of a tax-exempt employer, the credit for a year offsets only an employer's actual income tax liability (or alternative minimum tax liability) for the year. However, as a general business credit, an unused credit for 2010 can be carried forward 20 years.

Q. Can a tax-exempt employer claim the credit if it has no taxable income for the year?

Yes. For a tax-exempt employer, the credit is a refundable credit, so that even if the employer has no taxable income, the employer may receive a refund as long as it does not exceed the income tax withholding and Medicare tax liability, as discussed above.

Q. Does taking the credit affect an employer's deduction for health insurance premiums?

Yes. In determining the employer's deduction for health insurance premiums, the amount of premiums that can be deducted is reduced by the amount of the credit.

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Small Business Wellness Grants

Q. What type of assistance is available to my company if it offers wellness programs to employees?

Beginning in 2011, small employers (i.e., those with fewer than 100 employees working 25 hours per week or more) that did not provide wellness programs as of March 23, 2010 will be eligible to receive federal grants to provide their employees comprehensive workplace wellness programs.

Q. How much money will be available to my company if it does begin to offer a wellness program and for how long?

In aggregate, the government has appropriated \$200 million to this temporary program for fiscal years 2011 through 2015. How that money will be allocated to qualifying employers has not been defined. However, the federal money appropriated will remain available to eligible employers until funding is exhausted.

Q. What defines a wellness program for purposes of determining eligibility for a federal grant?

A wellness program must include the following components to be eligible for funding:

- health awareness initiatives (including health education, preventive screenings and health risk assessments)
- efforts to maximize employee engagement in the program
- initiatives to change unhealthy behaviors and lifestyle choices (including counseling, seminars, online programs and self-help materials)
- supportive environment efforts to encourage healthy lifestyle choices (including workplace policies to encourage health lifestyles, healthy eating, increased physical activity and improved mental health)

In order to expand the use of prevention and health promotion approaches, employers will be provided with technical assistance, consultation, tools and other resources in evaluating their wellness programs.

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Q. What immediate changes should I expect as an employer?

One of the earliest changes for employer-provided coverage, that is not [grandfathered](#), will be the requirement that, beginning in plan years on or after September 23, 2010, employers pay the full cost of preventive coverage, including immunizations, breast cancer screening and recommendations of the U.S. Preventive Services Task Force and other agencies such as the Centers for Disease Control.

Effective for plan years beginning on or after September 23, 2010, dependents up to age 26 will be allowed to remain on their parents' policies. In April 2010, the 39 independent Blue Cross and Blue Shield companies announced that they would voluntarily offer to allow young adults who would age-off before September 23 to remain on their parents' policies. This offer was also extended to employers that may want to allow employees' dependent children to stay on their parents' coverage. For employer-provided group health insurance, employees should check with their health insurer or employer for specific information regarding [Adult Dependent](#) coverage.

Q. What other major provisions of the new law will apply to our existing group coverage and when?

There are a number of other near-term reforms included in the new law (effective for plan years beginning on or after September 23, 2010).

Some of the important additions include:

- Extension of coverage to adult dependent children up until the age of 26. The adult dependent must not be eligible to enroll in other employer provided coverage. The law does not require coverage for a child or spouse of any [adult dependent](#) children.
- No lifetime or annual limits on dollar value of benefits. A group health plan and a health insurance issuer offering group health plans may not establish lifetime limits or annual limits on the dollar value of "essential" benefits (to be defined in future regulation) for any participant or beneficiary. (Restricted annual limits are allowed through 2013 and are to be further defined by the Department of Health and Human Services).
- Certain health plan requirements, including provision of internal/external appeals, access to emergency services and provisions related to pediatrician and OB/GYN choice.

Some plans may not be subject to these requirements because of their status as [grandfathered](#) plans.

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Q. Does the new law require that all employers offer healthcare coverage?

No. However, there are financial obligations for employers with at least 50 full-time employees.

Beginning in 2014, businesses with 50 or more full-time employees that do not offer coverage and have at least one full-time employee who receives a federal tax credit to purchase health insurance through an [Exchange](#), must pay the federal government a \$2,000 per-employee penalty. In calculating the penalty, the employer excludes the first 30 employees from the payment calculation (i.e., a firm with 51 employees would pay the penalty on 21 of them).

Employers with 50 or more full-time employees that do provide coverage, but have at least one full-time employee who receives a federal tax credit to purchase health insurance on his or her own through an Exchange (i.e. the employer's coverage is greater than 9.5 percent of the employee's household income and so is determined to be "unaffordable"), will be assessed a penalty that is the lesser of \$3,000 per employee receiving a tax credit or \$2,000 for each full-time employee, excluding the first 30 employees.

Q. Can an employer still impose a waiting period on employees before health insurance becomes effective?

Yes, employers may still impose a waiting period. However, beginning in 2014, the waiting period may not exceed 90 days.

Q. Does the new law require that part-time and seasonal employees be eligible for group coverage?

The new law provides that employees working an average of 30 hours per week or more in a month or seasonal workers who work more than 120 days in a year be eligible for coverage, or an employer may be subject to a penalty. Employers with 50 or more employees may be subject to a penalty if they do not comply with this provision.

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Q. Will my employees have to pay extra because of the “Cadillac Tax” if they have high cost health plans?

Starting January 1, 2018, a 40-percent excise tax will be imposed on group health insurance premiums exceeding \$10,200 per year for single coverage and \$27,500 per year for family coverage. The cost thresholds triggering the tax will be slightly higher for plans covering retirees or employees in certain high-risk industries (\$11,850 per year for an individual retiree or \$30,950 per year for family). In 2019, the thresholds rise to match the increase in the Consumer Price Index (CPI), plus one percentage point. In 2020 and succeeding years, the thresholds increase to match rises in the CPI rounded to the nearest \$50. Although this tax is on insurers (and self-funded group plans) it is possible that it will be passed on to employers and employees in the form of higher premiums. To avoid the tax, some employers may make changes to their plans.

Q. Are employers required to do any new reporting?

Yes, there are several new reporting requirements for employers, including the following:

- Employers that do not offer healthcare coverage must file a return stating that they do not offer coverage, the number of full-time employees and as yet unspecified information to be required by the Secretary of HHS.
- Employers must report the value of the benefits on each employee’s annual W-2 form beginning with W-2s issued in January 2012 (i.e., for tax year 2011). Current rules for COBRA continuation of coverage should be used in calculating the value of benefits (minus the 2 percent COBRA allowed administrative fee if charged). Contributions to Archer MSAs and HSAs, and salary reduction contributions to FSAs are not required to be included in determining the value of benefits.
- Beginning in March 2013, employers must provide information to employees about the Exchanges.
- Beginning in 2014, employers providing minimum essential coverage must report to the IRS annually with information about the coverage offered. Specifically, employers must report information such as:
 - > the length of any waiting period
 - > the months during the calendar year coverage was made available to employees
 - > the monthly premium for the lowest cost option for each enrollment category within the plan

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- > the employer's share of the total allowed costs of benefits provided under the plan
- > the option for which the employer pays the largest portion of the cost of the plan, and the portion of the cost paid by the employer in each enrollment category for such option
- > the name, address and tax identification number of each full-time employee during the calendar year and the months during which such employee (and any dependents) were covered under any health benefit plan
- > additional information the Treasury Department may require in order to administer the [small business tax credit](#), if the employer is eligible for the credit and the coverage is a qualified health plan offered through the [Exchange](#).
- Also beginning in 2014, employers providing minimum essential coverage also must provide written statements with information to each covered individual, listing the information bulleted above as well as the name, address and contact information of the employer's insurer. Statements are to be given to individuals on or before January 31 for the previous calendar year.

Q. What are the new provisions for emergency-related services?

For plans that are not [grandfathered](#), the new law generally states that coverage for emergency department services must be provided without prior authorization of services based on a prudent layperson standard. In addition, out-of-network emergency services must be covered and reimbursed the same as in-network emergency services, including cost-sharing requirements (i.e., copayments or coinsurance) for both in-network and out-of-network services.

Q. What are the auto-enrollment requirements for my company?

Large businesses of more than 200 full-time employees that offer health insurance will have to automatically enroll workers into a health plan. An employee, however, must receive adequate notice and the opportunity to opt out of this automatic enrollment. This does not supersede any state law that establishes, implements or continues in effect any standard or requirement relating to employers in connection with payroll, unless the state law would prevent instituting automatic enrollment.

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Exchanges

Q. What is an Exchange and who can utilize it?

The law creates new state-based health insurance Exchanges, marketplaces that will help consumers shop, compare and enroll in health insurance coverage. U.S. citizens and legal residents may purchase coverage through an Exchange beginning in 2014. Generally, small employers with 1 to 100 employees also can participate when the Exchanges first open in 2014. States have the option to limit Exchanges to employers with 1 to 50 employees in 2014 and 2015 and may choose to expand the Exchange to businesses larger than 100 employees beginning in 2017.

Q. Does my company have to buy through an Exchange beginning in 2014 if it is eligible to do so?

No. Employers of all sizes may also continue to purchase coverage outside the Exchange. And if you have more than 100 full-time employees, as defined by the law, you are not eligible to purchase coverage for your group through the Exchange unless your state elects the option of allowing employers with more than 100 employees to purchase through the Exchange, which is first allowed in 2017.

Q. What are free-choice vouchers?

A provision in the new law requires an employer that offers minimum essential coverage to its employees to give certain low-paid employees not enrolled in the employer's group health plan vouchers to purchase coverage in state health insurance Exchanges beginning in 2014. An employee who earns up to 400 percent of the federal poverty level and whose employee premium contributions for group coverage are between 8 and 9.8 percent of household income is eligible for the vouchers, which would be provided and paid for by his or her employer, if the employee enrolls in coverage through the Exchange. The value of the voucher is equal to the highest employer contribution for a company plan for which the employee is eligible to enroll. If the employee buys coverage for less than the value of the voucher, the employee may keep the difference in taxable cash.

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Adult Dependents

Q. How does the new law change requirements for providing health coverage to dependents?

The law requires health plans that provide dependent coverage for children to continue to make the coverage available for adult children up to the age of 26. This extended coverage must be provided no later than plan years beginning on or after September 23, 2010.

In addition, as of March 30, 2010, health coverage provided for an employee's children up to 26 years of age is now generally tax-free to the employee and employer. Employers with cafeteria plans (i.e., plans that allow staff to choose from a variety of benefits to formulate a plan that best suits their needs) may permit employees to immediately make pre-tax salary reduction contributions to provide coverage for children under age 26, even if the cafeteria plan has yet to be amended to cover adult children. Plan sponsors have until the end of 2010 to amend their cafeteria plan language to incorporate this change.

Q. What is the definition of an adult dependent under the new reform law?

In referring to adult dependents, the law intends to address adult children of individuals covered by a group or individual health plan. The law stipulates that coverage shall be made to dependents up to age 26 regardless of their tax filing status, marital status or financial dependency on the parent. However, coverage does not have to be granted to a spouse or child of a covered adult dependent.

Q. Do the adult dependents need to be dependents as defined by the IRS?

No, the regulation specifically says that this is not a requirement for dependents under this provision.

Q. Is the requirement up to age 26 or through age 26 (and to age 27)?

When companies do offer dependent coverage, the coverage must be offered to dependents up to age 26. Plan eligibility provisions can terminate coverage effective 12:01 a.m. on the dependents' 26th birthday.

Q. Do the adult dependents need to be full-time students?

No, the regulations contain no requirement that adult dependents under age 26 maintain student status in order to be eligible for coverage.

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Q. Does the law require my company to offer dependent coverage?

No. The law does not require a company's health plans to cover dependents. The law requires a plan to provide coverage to dependents up to age 26, if it provides for any dependent coverage.

Q. Does my company have to provide coverage for dependents to age 26 even when they are married?

Yes. As long as the group policy allows for dependent coverage, companies' health plans must continue to offer married dependents coverage up to age 26. The policy does not require coverage to be granted to a spouse or child of the married dependent.

Q. Is coverage required for children of dependent children (i.e. grandchildren)?

No, the law does not require a company to make coverage available for a child of an adult dependent receiving dependent coverage.

Q. Can my company apply a rate surcharge for new adult dependents?

No. The regulation prohibits health plans from varying the terms of coverage based on age, so they would not be able to impose a premium surcharge for children older than age 18.

Q. Does my company have to offer COBRA when adult dependents reach age 26?

Yes. The new law does not change COBRA requirements, and COBRA will apply to adult dependents when they are qualified beneficiaries (the same as it applies to any other qualified beneficiaries).

Q. Does an adult dependent under age 26 and on COBRA based on his/her age, have the right to re-enroll?

Yes. An eligible dependent covered under a COBRA continuation provision must be given the opportunity to enroll as a dependent of an active employee. In this situation, if the child loses eligibility for coverage due to a qualifying event (including aging out of coverage at age 26), the dependent has another opportunity to elect COBRA continuation coverage.

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Q. Does my company have to calculate imputed income for adult dependents based on their contributions towards coverage costs?

No. The tax code has been amended. Employer contributions toward adult dependents' coverage are not considered taxable. Contributions employees make toward adult dependents' coverage through pre-tax payroll deductions are also still considered tax-exempt.

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Grandfathering

Q. If my company had its health insurance coverage prior to the effective date of the law, will we have to purchase new insurance?

If coverage was in force on or before March 23, 2010, your group has grandfather status and can maintain its existing health insurance coverage. Grandfathered plans are exempt from certain requirements of the new law, with guidance from HHS stating that changes in premiums, changes in third party administrators, and changes to comply with state and federal law will not cause the loss of grandfather status. However, the following changes, according to the HHS guidance, would cause the loss of grandfather status:

- eliminating benefits to diagnose or treat a condition
- increasing co-insurance above March 23, 2010 levels
- increasing fixed amount cost-sharing (e.g., deductibles and out-of-pocket maximums) more than the sum of medical inflation plus 15 percentage points from March 23, 2010 levels
- increasing co-payments by an amount that exceeds the greater of: (1) a total percentage (measured from March 23, 2010) that is more than the sum of medical inflation, plus 15 percentage points, or (2) \$5, increased annually by medical inflation
- reducing employer contributions based on the cost of coverage or a formula by more than 5 percentage points below the contribution rate on March 23, 2010
- reducing an overall annual dollar limit or adding a new overall annual dollar limit, compared to what was in effect on March 23, 2010

The regulations governing grandfathered plans are complex, and companies may not be able to maintain such plans if they make certain changes. Please consult a professional tax adviser or lawyer for details and further explanation of the regulations.

Q. Can employees still add family members (dependents) to existing coverage without losing grandfather status?

Yes. The group can continue to renew its policy, and covered employees may add family members as allowed under the terms of the existing group contract.

Q. Can employers add new employees to the existing plan without impacting its grandfathered status?

Yes.

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Early Retirees

Q. What is early-retiree reinsurance?

The law establishes an early-retiree reinsurance program that dedicates \$5 billion to help employers that offer group health coverage to early retirees, ages 55 through 64, who are not Medicare eligible. The program is effective June 1, 2010, until January 1, 2014, or until funds run out. The goal of the program is to help employers maintain their early-retiree coverage until the new [Exchanges](#) become operational in 2014.

Q. How does the early-retiree reinsurance program work?

The program, through the Secretary of HHS, will reimburse employers, state and local governments and employer-sponsored health plans for 80 percent of the costs incurred by retirees (ages 55-64) between \$15,000 and \$90,000 annually, with a maximum of \$60,000 a year per early retiree.

Costs are determined before co-payments, co-insurance and deductibles and will cover payments for medical, surgical, hospital and prescription drug costs, or other benefits as determined by the Secretary of HHS.

Q. Can claims for covered family members of the early-retirees be reimbursed with program funds?

Yes, companies paying claims for early retirees' spouses, surviving spouses or dependents covered under the early-retirees' health plan are eligible for the reinsurance program.

Q. When will the program begin?

The program began accepting applicants on June 29, 2010. Application forms are available at www.healthcare.gov.

Q. When will the program end?

The law appropriates not more than \$5 billion to carry out this program. The program will end at the earlier of the time of January 1, 2014, or when the funding runs out.

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Q. What determines a company’s eligibility for the early-retiree reinsurance program?

To be eligible, companies must:

- offer healthcare coverage to early retirees ages 55-64
- demonstrate that they have cost-saving programs in place for covered members with chronic and high-cost health conditions
- be able to provide documentation of the retiree’s actual medical claim costs
- have a Protected Health Information (PHI) agreement in force with an insurer or plan administrator

Q. How can companies use the proceeds from the program?

The company receiving early-retiree reinsurance proceeds must use the proceeds to reduce its health benefit premiums or health benefit costs and/or its employees’ health benefit premium contributions, copayments, deductibles, coinsurance or other out-of-pocket costs. Employers cannot use proceeds under this program as general revenue.

Q. How can my company participate in the early-retiree reinsurance program?

Your company must apply to HHS for participation in the reinsurance program and must be certified by the HHS Secretary. HHS began accepting applications to the early-retiree reinsurance program on June 29, 2010. Applications will be processed in the order they are received. Given the limited appropriation, you should file applications as soon as possible.

Q. Are amounts my company has paid prior to June 1, 2010, reimbursable?

No. To be eligible for reimbursement, claims must be incurred and paid during the program’s life. If a plan year begins prior to June 1 and an eligible member incurs \$15,000 or more in expenses during the plan year but before June 1, it is treated as having met the \$15,000 threshold for the plan year and is eligible for reimbursement for costs incurred after June 1, 2010.

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Claims can be submitted only after your company's health plan is certified by the Secretary of HHS for the plan year in which the claims occur, and after the \$15,000 threshold has been met based on your actual plan payments. If a plan year begins prior to June 1 and an eligible member incurs \$15,000 expenses during the plan year but before June 1, it is treated as having met the \$15,000 threshold for the plan year and is eligible for reimbursement for costs incurred after June 1, 2010.

Q. Does my company need to reapply each year?

No, not according to the interim final regulation.

Q. What happens after the program ends?

The program will end by January 1, 2014, or prior to that date, should the appropriated funds be depleted. In 2014, if the employer no longer provides coverage for early retirees, those individuals will be able to choose from the coverage options that will be available through the health insurance [Exchanges](#).

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Q. Are companies that self-fund their employee health coverage subject to all the same provisions as fully insured companies?

No. Certain provisions do not apply to self-funded plans, while others apply only to self-funded plans. For instance, self-funded plans are not subject to the 80 percent medical loss ratio requirement and so will not need to offer refunds to employees. However, most benefit and patient protections applicable to large-group plans apply to self-funded plans as well.

Q. Will self-funded plans have to offer benefits similar to those operating on the government’s insurance Exchange?

Self-funded plans tend to be large group plans, and large groups under the law are not subject to all of the same benefit requirements as Exchange-based plans, which will offer coverage (initially) to small employers. For example, Exchanges must offer plans with essential benefits and specified cost-sharing requirements. Large group plans must meet the cost-sharing requirements and annual out-of-pocket requirements, but are not required to offer coverage of the essential benefits packages. In addition, unlike plans to be sold on the [Exchange](#), they will not be subject to provider-network requirements, quality accreditation, uniform enrollment, marketing and Internet portal rules.

Q. How does the law’s exclusion of self-funded plans from its non-discrimination provision affect my business?

Very little. Although self-funded plans are exempt from the law’s provision that prohibits companies from establishing rules relating to health insurance eligibility of any full-time employee that are based on the total hourly or annual salary of the employee, they are already subject to ERISA’s non-discrimination rules, which effectively prevent the same discrimination.

Q. How would the new excise tax on health insurance premiums work?

Starting in 2018, a 40-percent excise tax will be imposed on group health insurance premiums exceeding \$10,200 for single coverage and \$27,500 for family coverage. The cost thresholds triggering the tax will be slightly higher for plans covering retirees or employees in certain high-risk industries. In 2019, the thresholds would rise to match the increase in the Consumer Price Index, plus one percentage point. In 2020 and succeeding years, the thresholds will increase to match rises in the index.

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Q. Who would pay the new excise tax?

The tax is to be paid by insurers for fully insured plans and by plan administrators for self-funded plans. Insurers and plan administrators likely will have to pass on the additional cost to employers.

Q. What reporting requirements will self-funded plans be subject to?

Form 5500, currently being submitted by companies with self-funded health plans, will continue to be required and will be used by the Secretary of Labor to prepare an annual report including plan type, number of participants, benefits offered, funding arrangements, benefit arrangements, assets, liabilities, contributions, investments and expenses.

Q. What is the purpose of the law’s provision that directs HHS to conduct a study of self-funded plans?

HHS is directed to:

- depict what kind of employers self-fund, including their financial solvency
- see whether new insurance market reforms cause adverse selection in the large group market or encourage small and midsize employers to self-insure
- explore the extent to which self-funded group health plans can offer less costly coverage and, if so, whether lower costs are due to more efficient plan administration and lower overhead, or to claims, denials and limited benefit offerings
- quantify claim denial rates and plan benefit changes to see the extent to which plans scale back health benefits during economic downturns
- study the effect of conflicts of interest on plan administration and claims denials

Under these new requirements, HHS can determine if an employer is “financially sound enough” to offer a self-funded insurance plan.

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General Questions

Q. If I am currently on Medicare, will my benefits be cut?

No. The law does not contain cuts to your guaranteed Medicare Part A and B benefits. Beginning in 2011, you will have some additional benefits you do not have today, including Medicare-covered preventive services, at no cost.

However, under the law, government payments to Medicare Advantage — health plans that are run by private insurers — will be reduced over the next decade. Currently, Medicare Advantage plans often offer extra benefits that beneficiaries in traditional Medicare do not get. It is possible that some of these extras may change, and premiums and benefits may change due to the reductions in government payments.

Q. What is the Medicare prescription drug “donut hole,” or coverage gap, and does it affect me as a current Medicare beneficiary?

In 2010, about 4 million beneficiaries will hit the donut hole also known as the coverage gap in Medicare prescription drug coverage. Generally this means you have spent \$2,830 on prescription drugs this year, and your coverage has put you in the donut hole.

- As part of the new law, if you hit the coverage gap in Medicare prescription drug coverage this year (2010), you will be provided with a \$250 government-issued check. Checks began going out to beneficiaries in June 2010.
- Beginning in 2011, beneficiaries who reach the donut hole will have a lower coinsurance rate of 93 percent for generic drugs (vs. 100 percent today) and also receive a 50-percent discount on brand name drugs and biologics. These brand-name discounts and also your out-of-pocket costs will count toward your catastrophic threshold calculation.
- Over time, the healthcare reform law will narrow and eventually eliminate the donut hole, and will continue to phase-down cost-sharing for both brand and generic drugs.

Q. When can I begin receiving preventive care at no cost, and what does it cover?

Beginning in January 2011, Medicare-covered preventive services will be offered with no cost-sharing. Detailed information will be available on the Medicare website at www.medicare.gov.

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▶ **LABOR MARKET****OTHER TOPICS****GLOSSARY OF KEY TERMS****MEDICARE MARKET****General Questions****Q. Will Medicare cover adult dependents in the same way that private health insurance will?**

No. The provision related to coverage of dependents up to age 26 does not apply to Medicare.

Q. Do the benefit coverage requirements that are part of the new healthcare reform law apply to Medicare and Medicare Advantage?

Medicare Advantage plans have to offer all Medicare Parts A and B benefits, and most Medicare Advantage plans also include Medicare prescription drug benefits. These are not the same as the “essential benefits” required for the individual and small group insurance markets.

Q. Does the new healthcare reform law make any changes to long-term care?

The new law creates a new voluntary insurance program called the Community Living Assistance Services and Support (CLASS) Act to help pay for long-term care and support at home.

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Early Retirees

Q. What is the reinsurance program for early retirees?

The early-retiree reinsurance program is a new federal program for qualified employers and unions. The program reimburses 80 percent of claims between \$15,000 and \$90,000 submitted by employers that provide health insurance coverage to retirees from age 55 through 64 and meet other specified conditions. The early-retiree reinsurance program is not applicable to Medicare-eligible recipients.

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General Questions

Q. How does the new law affect collective bargaining agreements (CBAs), and what are the rules that apply to these agreements?

The new law applies to CBAs but the timing differs. (See [Large Group](#) Section for additional information on the laws.) The law states that health insurance established as part of a CBA and was ratified before March 23, 2010, is not subject to the rules and requirements of the law until the last of the CBAs entered into prior to the law's enactment related to the coverage terminates. However, a CBA is allowed, at its option, to be amended early to include some or all of the new law's provisions. Making these changes voluntarily does not mean the CBA is considered to have been terminated. This provision only applies to fully insured plans and not to [self-funded plans](#).

Q. When is a CBA considered "terminated" under the new law?

Each agreement is governed by its own terms and conditions. For some CBAs, agreements can go on for several years. Carefully review the text of the actual agreement to be sure when the agreement is terminating and consult legal counsel for specific guidance.

Q. Is the new law applicable to both fully insured AND self-funded CBAs?

The law, as it relates to CBAs, refers to health insurance coverage, a defined term referring to an insurance policy, but not a self-funded plan.

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Grandfathering**OTHER TOPICS****GLOSSARY OF KEY TERMS****LABOR MARKET****Grandfathering****Q. When do the new legal requirements take effect for plans that are collectively bargained?**

Based on the new law fully insured health plans that are subject to CBAs have an extended grace period before they must be in compliance with the law. A plan under a CBA ratified before March 23, 2010, must implement the new plan standards no later than the last CBA termination date.

Many CBAs are in effect for more than one year. For example, if there is a two-year agreement ratified on March 21, 2010, the new standards for the health plan would have to be in place no later than March 20, 2012.

Q. Does the presence of non-union employees prevent a CBA from taking advantage of the provisions allowing for delayed implementation of the new standards?

Further clarification is needed to fully understand how the law will apply in instances where coverage includes both union and non-union employees. It is likely that reform provisions would be delayed only for employees subject to the CBA, and new provisions will apply to the remaining non-CBA employees.

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Comparative effectiveness research is the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat and monitor a clinical condition or to improve the delivery of care. The research is used to assist consumers, clinicians, purchasers and policy makers to make informed decisions that will improve healthcare at the individual and population levels. Hard evidence is often unavailable about which treatments work best for which patients and whether the added benefits of more effective but more expensive services are sufficient to warrant their added costs — yet the current health system is geared toward adopting more expensive treatments even when evidence about their impact is lacking. Variations in medical treatment cost that do not appear to be related to outcomes suggest a substantial area for improvement and savings. A robust program of comparative effectiveness research would make it easier to incorporate comparisons of effectiveness into the routine practice of medical care and support shared decision making between providers and their patients.

The law creates a nonprofit Patient-Centered Outcomes Research Institute responsible for carrying out or funding comparative effectiveness studies and disseminating results. The Institute will be run by a 19-member board of governors with three members representing private payers and the rest representing patients, providers, drug and device manufacturers, health services researchers, and federal and state governments. The Institute will be funded through federal appropriations and fees assessed against private payers and Medicare (by fiscal year 2014, total annual funding is to exceed \$500 million).

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An adult dependent, as referenced in the new law, is defined as a child under the age of 26. Even if the young adult is married, no longer lives with his or her parents, is not a dependent on a parent's tax return, or is no longer a student, they are still considered an adult dependent for purposes of determining eligibility for a parent's insurance coverage.

CBA – Collective Bargaining Agreement

A CBA, in the case of health insurance, is an agreement between one or more employers and employee representatives (usually a labor union) that defines the terms and conditions of the healthcare coverage offered to the employees.

CMS – Centers for Medicare and Medicaid Services

CMS, previously known as the Health Care Financing Administration (HCFA), is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP) and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities through its survey and certification process, and clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments.

Cadillac Health Plan

"Cadillac," or high-cost, employer sponsored healthcare plans are defined by the total cost of premiums. Applicable dollar thresholds for health plans to be considered Cadillac plans are greater than \$10,200 per year for single coverage or \$27,500 per year for family coverage when the tax on these plans goes into effect in 2018.

COBRA – Consolidated Omnibus Budget Reconciliation Act

COBRA refers to protections that give most workers who lose their health benefits the right to choose to continue group health coverage benefits during times of voluntary or involuntary job loss, reduction in the hours worked, transition between jobs and in certain other cases. Under COBRA, the employee or family member may qualify to keep their group health plan benefits for a set period of time, depending on the reason for losing the health coverage. The new law does not change COBRA requirements.

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Efficacy

Efficacy measures or indicates how well an intervention or solution works in a controlled environment such as clinical trials or laboratory studies.

Effectiveness

Effectiveness relates to how well a treatment works in practice.

Effective Date

The effective date is the date on which an agreement, such as an insurance coverage, takes effect and is the first day of active benefits from a policy.

Employer-based Healthcare

Employer-based healthcare refers to health plans that are offered at the workplace for employees as part of a benefit package.

Enactment Date

The enactment date is the date the Patient Protection and Affordable Care Act (PPACA) was signed into law – March 23, 2010.

ERISA – Employee Retirement Income Security Act

ERISA is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.

Evidence-based Medicine

Evidence-based medicine is a method of improving and evaluating patient care. It involves combining the best research evidence with the patient's values to make decisions about medical care. Looking at all available medical studies and literature that pertain to an individual patient or a group of patients helps doctors properly diagnose illnesses, choose the best testing plan and select the best treatments and methods of disease prevention. Using evidence-based medicine techniques for large groups of patients with the same illness, doctors can develop practice guidelines for evaluation and treatment of particular conditions. In addition to improving treatment, such guidelines can help individual physicians and institutions measure their performance and identify areas for further study and improvement.

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An Exchange is a marketplace of insurance plans run by a government or non-profit agency, to help individuals and small employers obtain health insurance coverage. A provision of the new law is that each state will establish an Exchange by 2014. Plans participating in the Exchanges will be accredited for quality, will present their benefit options in a standardized manner for easy comparison and will use one, simple enrollment form. Individuals qualified to receive tax credits for Exchange coverage must be ineligible for affordable, employer-sponsored insurance or any form of public insurance coverage. Federal support will be available for new non-profit, member run insurance cooperatives, and the Office of Personnel Management will supervise the offering by private insurers of multi-State plans, available nationwide. States will have flexibility to establish basic health plans for non-Medicaid, lower-income individuals may seek waivers to explore other reform options and may form compacts with other states to permit cross-state sale of health insurance.

Federal High Risk Pool

The Federal High Risk Pool is a federally funded initiative to provide affordable health insurance coverage to uninsured individuals with pre-existing conditions. The law appropriates \$5 billion in federal funds to support the new temporary high risk pool program. The program will be available in all states, and states may choose whether and how they participate in the program. The program will be available starting July 1, 2010, and end on January 1, 2014, when individual insurance coverage will be available through the Exchanges on a guarantee issue basis without regard to health status and without pre-existing condition provisions.

FTE – Full-Time Equivalent Employee

A full-time employee is defined as an employee that works an average of at least 30 hours of service per week.

Grandfather Clause (or Grandfathered, or Grandfathering)

A grandfather clause is an exception that allows an old rule to continue to apply to some existing situations, while a new rule will apply to all future situations. Persons or group health plans in effect prior to the law's enactment date of March 23, 2010, will be considered grandfathered unless they make certain changes that would cause the plan to lose its grandfathered status. Changes that would result in a loss of grandfathered status include: increasing deductibles, co-payments or out-of-pocket maximums by more than allowed in the Interim Final Regulation related to grandfathering; increasing the co-insurance; or adding or decreasing an annual maximum.

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Group Health Plan

A group health plan is an employee welfare benefit plan that provides medical care, and items and services paid for as medical care, to employees or their dependents (as defined under the terms of the group health plan).

Household Income

Household income for the law's purposes, with respect to any taxpayer, is defined as an amount equal to the sum of the modified adjusted gross income of the taxpayer, plus the aggregate modified adjusted gross incomes of all other individuals who were taken into account in determining the taxpayer's family size. (see also: Modified Adjusted Gross Income)

HHS – U.S. Department of Health and Human Services

HHS is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Health Information Technology

Health information technology (HIT) allows comprehensive management of medical information and its secure exchange between healthcare consumers and providers.

Individual Mandate

An individual mandate is the requirement for all individuals, and dependents of individuals, to have health insurance coverage (with limited exceptions such as religious beliefs). Beginning in 2014, all individuals, and dependents of the individual, shall be required to maintain minimum essential health insurance coverage each month. If the individual fails to meet the requirement, they will incur a penalty, the amount of which is defined by the law.

Individual Market

The individual market is the market for health insurance coverage for direct purchase by individuals, rather than in connection with an employer based group health plan or any other group health plan.

Large Employer

A large employer is an employer with an average of at least 101 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

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Medicaid provides health coverage to low-income individuals and families who are determined as eligible by federal and state law; eligibility rules vary from state to state. Medicaid sends payments directly to providers for individuals and/or families who qualify, but, depending on state rules, beneficiaries may pay a copayment for some medical services.

Medicare

Medicare is a government health insurance program that provides medical care to people age 65 and older, under the age 65 with certain disabilities and people of any age with end-stage renal disease. Medicare is broken down into four parts: Hospital Insurance (Part A), Medical Insurance (Part B), Medical Advantage Plan (Part C), and Prescription Drug Coverage (Part D).

Medicare Advantage

Medicare Advantage is a plan offered by Medicare-approved private insurance companies to provide additional health insurance coverage to Medicare recipients. Plan owners pay a monthly premium, in addition to Medicare Part B, and a copayment or coinsurance on covered services including prescription drug plans, wellness and prevention benefits. The plan costs, extra coverage and rules vary by private health insurance plan.

Modified Adjusted Gross Income

Modified adjusted gross income for the law's purposes is defined as adjusted gross income increased by any amount excluded from gross income and any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

Plan Year

The plan year is the year designated in the ERISA Master Plan document of an employment-based healthcare plan. ERISA plans are employer-established plans that can include a number of benefits. The employer creates a Master Plan Document including several components such as the ERISA plan name, plan year, plan number and plan benefits.

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The policy year in the individual health insurance market is the 12-month period designated in the policy documents of the individual health insurance coverage. If there is no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year.

PPACA – Patient Protection and Affordable Care Act (or the law)

The Patient Protection and Affordable Care Act (PPACA) is a federal statute that was signed into law in the United States by President Barack Obama on March 23, 2010.

Pre-existing Condition

A pre-existing condition is defined for group health plans as any condition, illness, or injury for which medical advice or treatment was recommended or received before a person enrolls in a new medical insurance plan.

A pre-existing condition can also be defined as anything for which symptoms were present and a prudent person would have sought treatment. (A prudent person is defined as: The model of all legal behavior. This person does everything in moderation, follows the community ethic and always exercises due care.)

Preventive Care (or Preventative Medicine)

Preventive care refers to measures taken to prevent diseases or injuries rather than treating the symptoms of disease or injury, or curing the disease or injury after it is present.

Reform Law (or the law, or PPACA)

The reform law is the federal statute that was signed into law in the United States by President Barack Obama on March 23, 2010. The law includes a large number of health-related provisions to take effect over the next four years, including expanding Medicaid eligibility, subsidizing insurance premiums, providing incentives for businesses to provide healthcare benefits, prohibiting denial of coverage/claims based on pre-existing conditions, establishing health insurance exchanges and providing support for medical research.

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SCHIP (or CHIP) — State Children’s Health Insurance Program

SCHIP is a program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children that have a modest income but cannot qualify for Medicaid. Some states use private companies to administer SCHIP benefits to eligible beneficiaries.

Small Employer

A small employer is an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. States have the option to treat 50 employees as small employers in plan years beginning before January 1, 2016. Currently, a small employer is classified as a company with two to 50 employees.