Understanding

Health Care Reform

Changes to your medical insurance since Health Care Reform became law on March 23, 2010

All employers have had to make many changes to their medical plans, including but not limited to:

Cover pre-existing conditions for eligible individuals under age 19 (this protection broadens to cover all adults in 2014).

Remove lifetime dollar limits.

Any annual dollar limit must meet federal requirements:

- $750,000 in 2010-2011,
- $1.25 million 2011-2012,
- $2 million 2012-2013, and
- unlimited in 2014

(mini-medical plans and college plans for students have different thresholds but will also be unlimited in 2014).

Cover children until age 26.

For eligibility under health flexible spending accounts (FSAs) and health savings accounts (HSAs), over-the-counter medications require a written prescription to be eligible for reimbursement.

Grandfathered Status/Addtional Changes

All employer plans that were offered in March 2010 were granted "grandfathered" status to exempt them from some (not all) requirements of the law. These plans may remain grandfathered for as long as plan parameters stay within the allowed margins of change.

Non-grandfathered plans have had to make additional changes, including but not limited to:

- Certain appealed claims may have the opportunity to be reviewed by an independent review organization. Also, in certain counties in the US, the plan must offer an opportunity to appeal in an alternate language (usually Spanish).
- Certain preventive services are covered at 100% by the plan with no cost-share to the participant. A list of those services is provided at http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html

Understanding

Health Care Reform

Changes your employer is working on in 2013

Employer-sponsored plans are mandated to make additional changes, including but not limited to:

- Limit health flexible spending accounts to $2,500 per year (this limit will increase with inflation).
- Some employers (not all) must report the cost of medical insurance on your Form W-2 for informational purposes only (not to impose a new tax on health benefits).
- Issue a Summary of Benefits and Coverage (SBC) and Uniform Glossary with open enrollment materials.
- Eligibility waiting periods for full-time employees generally cannot be longer than 90 days.
- Employers with 50 or more "full-time equivalent" employees will be required to report to the government annually: employee status, the value of the benefits offered, and the costs to employees. In certain circumstances, employers will be required to track employees' hours of service.
- Compile new reports, collect new taxes, and pay new fees under the law. Some fees are temporary while others are permanent.
- Employers may evaluate wellness program structures due to additional considerations under health care reform. The federal government is placing strong emphasis on tobacco cessation programs

Changes to non-grandfathered plans in 2014

Beginning in 2014, non-grandfathered plans will be mandated to make additional changes including but not limited to:

- Include deductibles, coinsurance, and copays in the out-of-pocket maximums.
- Out-of-pocket maximums can be no greater than $6,350 for an individual and $12,700 for a family. Those limits will be indexed for inflation after 2014.
- Allow eligible individuals with life-threatening conditions to participate in approved clinical trials. The trial treatment itself is not required to be covered by the plan. Plan coverage may include routine expenses related to the trial, such as physician follow-ups, lab work, and imaging services.
- For fully insured employer-sponsored plans when there are fewer than 50 total employees, medical insurance pricing must be revised. These modifications to how plans are priced (often referred to as community rating) are generally expected to result in higher premiums.
- For fully insured employer-sponsored plans when there are fewer than 50 total employees, insurance companies will be required to limit in-network deductibles to $2,000 for an individual and $4,000 for a family. Those limits will be indexed for inflation after 2014.
- For fully insured employer-sponsored plans when there are fewer than 50 total employees or any coverage purchased in the Marketplace, insurance companies will be required to include all "essential health benefits" defined by their State.