Employee FAQs (general)

1. What is the Health Care Reform law?

Often referred to as Obamacare, the Affordable Care Act, or the ACA, Health Care Reform was signed into law March 23, 2010. It makes changes to the way health care is paid for and delivered in America by imposing new requirements on employers, individuals, insurance companies, doctors, hospitals, health device and drug manufacturers, and others. The 2,700+ page law has been controversial and complex and has been challenged in many courts but continues to be the law of the land.

2. What are the primary objectives of the Health Care Reform law?

The major goals of Health Care Reform legislation are to provide greater access to health care and health insurance, slow the growth and potentially reduce out-of-control health care costs, and provide additional consumer benefits and protections.

3. Did the U.S. Supreme Court uphold the Health Care Reform law?

During the first two years of the law, 26 State governments challenged the constitutional authority of the federal government to impose the requirement for its respective residents to purchase health insurance. The U.S. Supreme Court ruled in June 2012 that the individual coverage mandate is a lawful tax, clearing the way for continued implementation.

In addition, the U.S. Supreme Court ruled the federal government could not force states to expand Medicaid coverage. In effect, potential expansion of Medicaid eligibility will be left to each individual State to determine.

The U.S. Supreme Court did not render an opinion or decision on any other aspects of the Health Care Reform law.

4. Will Health Care Reform require me to change doctors?

No. The importance of a primary care physician relationship is accentuated under Health Care Reform. The law encourages individuals to develop a meaningful relationship with their physician, seek regular preventive care, and coordinate a plan with their physician to achieve positive health outcomes.

One of the potential challenges of Health Care Reform is the expected influx of newly insured individuals, which may create additional pressures on an already depleting pool of primary care physicians and nurses.

5. Does Health Care Reform allow people to keep their current health insurance coverage?

Yes. Nothing in the law requires individuals or employers to terminate coverage they already have. However, the coverage may be modified to comply with new requirements. If an employer's plan existed on March 23, 2010 and the employer has not made any changes beyond the regulatory allowances, the plan may have "grandfathered" status. Grandfathered plans are subject to some, but not all, the requirements under the Health Care Reform law.

6. Are individuals required to have health insurance coverage?

Yes, beginning January 1, 2014, U.S. residents must obtain minimum essential health insurance coverage or they will be subject to a tax penalty. There are limited exceptions for circumstances such as financial hardship and religious objection.

7. What are the penalties for individuals who don't have health insurance coverage?

The penalties for individuals without minimum essential health insurance coverage will be the greater of a flat dollar amount or a percentage of income. In 2014, an individual pays $95 or 1% of income. In 2015, an individual pays $325 or 2% of income. In 2016 and thereafter, an individual pays $695 or 2.5% of income annually.

8. Can I keep coverage provided through my employer and avoid being assessed a penalty?

Yes, qualifying employer-sponsored medical coverage is still a viable option for many employees that can satisfy the requirement to have health insurance coverage.

9. Do employers have to offer medical insurance to all employees?

No, employers are not mandated to offer coverage to all employees. However, beginning in 2014, employers with 50 or more "full-time equivalent" employees will be subject to a penalty if they don't offer qualifying coverage to at least 95% of all employees working 30 or more hours per week.

10. How will Health Care Reform affect my costs as an employee?

The costs of health care and health insurance have been rising faster than general inflation for decades. The government has predicted that costs under the Health Care Reform law will not slow down until around 2020.

The Reform law includes a number of consumer-directed enhancements in coverage that will shift risk from the consumer to the insurance plan which will impact premiums. In addition, new taxes and fees are expected to increase plan costs.

Employers nationwide have struggled to keep medical insurance costs affordable. While employers have typically shouldered the lion's share of cost increases, they've also had to modify coverage parameters to help keep coverage affordable. It seems inevitable employees will be responsible for more of their own health care expenses and overall health as costs continue to rise.

11. Are there new taxes and fees impacting my employer's plan?

In order to fund Health Care Reform over the next decade, revenue will come from a variety of sources. The largest source of funding for Health Care Reform comes from Medicare spending cuts, followed by an assortment of new taxes and fees. Several of the new taxes and fees will have a direct impact to employer-sponsored health plan costs and premiums.

12. Do insurance companies have to offer me coverage, even if I have pre-existing conditions?

All lawful residents in the U.S. must be accepted when applying for health insurance and cannot have their coverage restricted for a pre-existing condition.

13. What are the new Exchanges/public Marketplaces?

Health Insurance public Marketplaces (formerly called "Exchanges") are government-regulated online shopping sites and call centers for lawful residents to shop for medical insurance. These websites are intended for those who need to purchase their own insurance or who may qualify for Medicaid or CHIP. Public Marketplaces are not intended to serve individuals with access to qualifying employer-sponsored insurance that meets the regulatory thresholds of affordability and minimum value.

The government is hoping most insurance companies will offer their insurance plans in the public Marketplaces. Public Marketplaces are scheduled to be open for browsing and applying in October 2013 for coverage to be effective January 1, 2014 or later.

14. Will the public Marketplaces be different by state?

Each State that opts to run its own public Marketplace will be able to design a unique website, whereas the federally run public Marketplaces will all look and operate the same. However, each State will have a different list of specific insurance companies and available plans.

As of mid-2013, 27 States will be part of the federally-operated public Marketplace, 16 States and D.C. will be operating their own public Marketplace, and 7 States will operate a public Marketplace in partnership with the federal government.

15. What type of coverage is available in the public Marketplace?

Health insurance provided in the public Marketplace will be standardized and regulated by the government. Coverage will be classified into four metal tiers (bronze, silver, gold and platinum) to reflect the different levels of out-of-pocket responsibility each tier will require. Plans offered in the public Marketplace must meet State-defined minimum coverage requirements and be priced according to government-defined guidelines.

16. With the government standardizing plans and premium calculations in the public Marketplace, does this mean public Marketplace insurance will be less expensive than coverage through my employer?

Not necessarily. With the restrictions on plan designs and premium calculations in the public Marketplace, most individuals with access to qualifying employer-sponsored coverage will likely be better served by accessing coverage through their employer.

17. Can I get help to pay for health insurance?

For coverage purchased through the public Marketplace, individuals meeting certain income thresholds may apply for tax credits (aka subsidies) if specific requirements are satisfied. Some of the standards include:

- No access to employer-sponsored coverage
- Ineligible for government-provided coverage, such as Medicare, Medicaid, or TRICARE
- Eligible for employer-sponsored coverage that doesn’t satisfy certain minimum standards

18. If I can qualify for a public Marketplace subsidy, how does it work?

The federal government determines the amount of each person's subsidy based on household size, household income, and the premium for the second-lowest cost silver plan in that individual's public Marketplace. For qualified individuals with household income up to 400% of the federal poverty level (FPL), a premium tax credit is calculated and paid directly to the insurance company the individual chooses so that person only has to pay their share of the cost of the plan. For qualified individuals with household income up to 250% of FPL, the government will also pay the insurance company some portions of the individual's deductible, coinsurance, and copays.

In order to qualify for subsidies, the individual cannot have access to qualifying employer-sponsored coverage that meets the regulatory thresholds of affordability and minimum value. Some individuals may qualify for State-assisted programs such as Medicaid and CHIP.

19. Since the subsidies are actually tax credits paid in advance, is there a chance I'll have to pay any subsidies back when I file my tax return?

Subsidies function as real-time tax credits that reduce the monthly insurance premium. When applying for subsidies to help pay for insurance in the public Marketplace, individuals will be estimating what they expect their household income to be for the year. For individuals that end up earning more than estimated, they may owe some or all of the tax credits back on their personal tax return the following April. Some examples that may affect earnings include a mid-year bonus, promotion, or change in employment.

20. How do I apply for public Marketplace coverage (and subsidies)?

Most individuals are expected to apply directly on their own state's public Marketplace website. The online application will start off with basic questions and only show more complex questions as needed depending on each answer during the application process. Paper applications will also be available, as well as call centers to apply by phone.

21. Can I apply for coverage in the public Marketplace whenever I want? Why not just wait until I need insurance to buy it?

Public Marketplaces will have a special "open enrollment" each fall for individuals to apply for coverage that will begin the following January. Outside the open enrollment period, an individual would have to experience a "qualifying event" (QE) such as marriage or birth/adoption of a child that grants them a special enrollment opportunity. The risk is very

high that an uninsured individual experiencing an unexpected medical event won't be able to quickly secure new insurance in time to pay for the medical treatments needed.

22. Is there special, low-cost coverage for young adults?

Insurance companies may offer lower-cost catastrophic insurance plans in the public Marketplace in order to attract those under the age of 30 or those where coverage options are so expensive that they qualify for a hardship exemption from the individual coverage mandate. These plans will have high deductibles and apply all services except the first 3 physician visits per year toward that deductible.

23. Are there new provisions promoting wellness in the law?

Yes, some examples are:

- Larger restaurant chains with 20 or more locations have to provide nutritional information and calorie counts on their menus
- Increased funding is being provided for preventive services in Medicare and Medicaid
- Additional wellness incentive considerations for employers, with an emphasis on tobacco cessation
- Government-defined preventive services covered at 100% by the plan with no individual cost-sharing (for non-grandfathered plans)
    - Creation of national prevention, health promotion and public health council to assist government efforts in promoting personal wellness

24. Since losing coverage under an employer's plan will be a special enrollment opportunity for public Marketplace coverage, does that mean continuing the employer's plan under COBRA goes away?

No. While the public Marketplace will present a viable alternative for individuals faced with exercising their COBRA right to continue lost coverage, continuing the coverage you had could be a better fit than the public Marketplace in certain circumstances.

25. Does the law make changes to flexible spending accounts (FSAs) or health savings accounts (HSAs)?

The law changed the penalty for non-medical HSA withdrawals from 10% to 20%. Over-the-counter medications require a prescription to be paid with FSA or HSA funds. Also, FSAs are limited to $2,500 in 2013 (this will be increased in future years to keep up with inflation).

26. Why is the value of my health insurance coverage reported on my W-2?

Employers filing 250 or more W-2s are required to report the aggregate cost of employer-sponsored health coverage on your W-2. This is for general data gathering purposes as required under the regulations, not to impose a new tax on your coverage.

27. How does Health Care Reform impact my community?

Community health centers, which are federally-subsidized clinics that provide health care for uninsured individuals, are allocated $11 billion in funding under the law. Despite the individual coverage mandate and Medicaid expansion in several states, the Congressional Budget Office estimates there will still be 30 million uninsured individuals in the U.S. by the end of 2016.

28. How does the Health Care Reform law impact seniors in Medicare?

The law has added coverage of additional preventive services under Medicare, such as free screenings for colon, prostate, and breast cancer, and is incrementally closing the Medicare Part D prescription drug plan "donut hole" until it is eliminated in 2020. On the other hand, the law has reduced the federal government's payments to Medicare Advantage plans run by private insurers as an alternative to basic Medicare. As a result of those cuts, benefit enhancements such as free eyeglasses and hearing aids or offering low prescription drug copays may disappear. Medicare beneficiaries earning $85,000 or more will pay higher Part B premiums until 2019.

29. I heard the Health Care Reform law creates new "death panels" to decide what treatments are covered at end of life. Is that true?

No. Health Care Reform guarantees that the government must " ensure that the health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individual's age or expected length of life or the individual's present or predicted disability, degree of medical dependency or quality of life."

30. Are employees of the federal government subject to the Health Care Reform law?

Yes, federal employees must comply with Health Care Reform requirements. Members of Congress and their staff will be required to purchase their health insurance through the new public Marketplace.

31. How long will Health Care Reform take to implement?

The Health Care Reform legislation is the most sweeping health care legislation in our nation's history, impacting an industry that comprises a fifth of our nation's economy. The requirements of the law will be implemented over many years, and rules for implementation will continue to be developed and modified for several decades.

32. How will my employer help me evaluate my options?

Your employer can help you understand the coverage offered to you at work and will help you understand that the coverage they offer you provides "minimum value" and is generally considered "affordable" under the Health Care Reform law. Your employer will not be able to help evaluate your options under Medicaid or the public Marketplace.