FAQ

New Health Insurance Law

(Enacted on March 21, signed into law on March 23, and amended on March 25)

On March 23, 2010 President Barack Obama signed the Patient Protection & Affordable Care Act (H.R. 3590) into law. Congress made changes occurred to the new law when it enacted the health reconciliation bill, H.R. 4872, on March 25, 2010. President Obama signed these amendments into law on March 30, 2010. That makes “date of enactment” (key to some of the effective dates) 3/23/10 for most of the new law’s provisions, and 3/30/10 for the provisions enacted by amendment via H.R.4872.

Following are some frequently asked questions about how the new law will affect both the consumer and the insurance advisor.

<u>Insurance Market Reforms</u>

Q: Does the legislation make it easier for individuals who have health problems to obtain coverage?
A: Yes— insurance can no longer base coverage (availability or price) on preexisting conditions effective for plan years beginning on or after January 1, 2014. For children enrolled in the plan who are under 19 years old, this prohibition takes effect for plan years beginning on or after September 23, 2010 (plan years beginning on or after six months after date of enactment).

Q: What are the new rating rules?
A: Effective in 2014, no rating based on health or gender will be permitted. There is a 3:1 rating (pricing) ratio for age, and 1.5:1 for tobacco use.

Q: Are plans required to cover preventive care?

A: The new law requires plans to cover, at no charge, most preventive care (effective for plan years beginning on or after 9/23/10).

Q: Are existing plans grandfathered?
A; The new law grandfathers existing individual and group plans with respect to new benefit standards, but requires these grandfathered plans to extend dependent coverage to adult children to age 26, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days.

Q: When are grandfathered plans prohibited from rescinding policies?
A: Grandfathered health plans are prohibited from rescinding coverage for individuals who are enrolled under the plan or insurance coverage, except in cases where the individual has engaged in fraud or made an intentional misrepresentation, effective for plan years beginning on or after September 23, 2010.

Q: When are grandfathered plans prohibited from applying waiting periods over 90 days?
A: Grandfathered group health plans may not apply an excessive waiting period (in excess of 90 days), effective for plan years beginning on or after January 1, 2014.

Q: Are there annual and lifetime benefit limits?

A: The new law restricts annual and lifetime benefit limits for plan years beginning on or after September 23, 2010, and prohibits them starting in 2014.

Q: Are waiting periods for coverage allowed?

A: The new law eliminates waiting periods greater than 90 days beginning in 2014.

Q: Are there any new options for individuals with preexisting conditions?
A: Yes – beginning in 2010 there will be a temporary national high-risk pool. The pool will end on January 1, 2014 once the exchanges are operational. Employers are prohibited from putting individuals in the high-risk pool.

Q: Are there changes to Health Savings Account (HSA) distributions?
A: Beginning in 2011, account holders will no longer be allowed to use Flexible Spending Account (FSA), HSA, Health Reimbursement Account (HRA), and Archer Medical Savings Account (MSA) distributions for over the counter (non-prescription) medicines.

Q: Are there new penalties for non-qualified HSA distributions?

A: Yes - penalties for nonqualified HSA and Archer MSA distributions double (to 20%) in 2011.

Q: Are there medical loss ratios that must be met?

A: Yes – Effective 2011, health plans are required to spend a minimum of 80% in the group market and 75% in the individual market of premiums on medical claims – and rebate any excessive overhead to enrollees.

Q: How will the new medical loss ratio provision impact high-deductible health plans (HDHPs)?
A: Most of details on how the medical loss ratio provision will work will not be clear until the Secretary of the Department of Health and Human Services (HHS) issues regulations.

Q: How is dependent coverage extended?
A: Beginning September 23, 2010, insurance policies will be required to allow coverage for adult children up to age 26 under their parents' policies.

Q: Is there a national exchange?

A: No – the exchanges are state-based. The exchanges will be operational by 2014, and will be open to individuals without access to affordable health insurance and to small businesses.

Q: Are insurance advisors allowed to participate in the state-based exchanges?
A: Yes –Agents are specifically authorized to help individuals and small businesses buy their insurance through exchanges.

Q: Is there a government-run plan in the exchanges?
A: No - There will be no government-underwritten health insurance plan offered through the exchanges. All the insurance sold through the exchanges will be private insurance (that has to comply, by statute, with extensive rules regarding benefits that must be included in the policies, and with restrictions on cost-sharing (deductibles and co-pays)).

Q: Can large employers purchase coverage in the exchange?

A: Beginning in 2017, states may allow large employers and multi-employer health plans to purchase coverage in the exchange.

Q: Can illegal immigrants participate in the exchange?
A: No. Access to coverage through the exchanges is only available to U.S. citizens and legal immigrants who are not incarcerated.

Q: Are multi-state plans allowed in the exchanges?
A: Yes. The Office of Personnel Management (OPM) is required to contract with private insurers to offer at least two multi-state plans in each exchange.

Q: Can states form interstate insurance compacts?

A: Beginning in 2016, with HHS approval, States can form interstate insurance compacts.

Q: Exchange-based insurance must be one of five types. The types are based on benefit categories. What are the benefit categories in the insurance that an exchange may offer?
A: There will be four benefit categories of plans plus a separate catastrophic plan to be offered through the exchange, and in the individual and small group markets:

– The Bronze Plan is minimum creditable (qualifying) coverage. It must provide the essential health benefits laid out in the statute and further developed by regulations to be issued by HHS and the Department of Labor (DOL). It must cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010)
– The Silver Plan must provide the essential health benefits, and cover 70% of the benefit costs of the plan, with the HSA out-of-pocket limits
– The Gold Plan must provide the essential health benefits, and cover 80% of the benefit costs of the plan, with the HSA out-of-pocket limits
– The Platinum Plan must provide the essential health benefits, and cover 90% of the benefit costs of the plan, with the HSA out-of-pocket limits

- There is a catastrophic-only plan, called the "young invincibles" plan, available only to those up to age 30, and/or to those who are exempt from the mandate to purchase coverage. The young invincibles plan provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market.

Q: What are essential health benefits?
A: The HHS Secretary in conjunction with the Secretary of Labor will further define the essential health benefits that are laid out in the statute. By statute, essential benefits must include at least the following items and services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management
- Pediatric services including oral and vision care

Q: What is the CO-OP?
A: The new law provides for the creation of the Consumer Operated and Oriented Plan (CO-OP) Program to enable nonprofit, member-run health insurance companies. There will be $6 billion in federal funding to finance the program awarded by 2013. The CO-OP must meet state solvency and consumer protection standards.

Q: Does the new law repeal the limited antitrust exemption provided by the McCarran-Ferguson Act?

A: No – the new law does not repeal (or restrict) health insurers' limited antitrust immunity contained in the McCarran-Ferguson Act of 1945.

Q: Are there rules regarding highly compensated individuals?

A: Yes – the new law requires all group health plans to comply with the Internal Revenue Code (IRC) section 105(h) rules (self-insurance plans) that prohibit discrimination in favor of highly compensated individuals.

Q: Will the grants for state insurance ombudsman programs diminish the role of the agent?

A: The Secretary of HHS is authorized to award grants to states to establish, expand or provide support for offices of health insurance consumer assistance. It is unlikely these programs will be able to provide the professional advice and service offered by licensed agents. One of the health insurance consumer assistance offices' stated duties is to coordinate with consumer assistance organizations to receive and respond to inquiries

and complaints. These programs will need to establish relationships with trusted advisors to which they can refer consumers. This represents a significant opportunity for licensed, professional health insurance advisors.

Individual Roles & Requirements

Q: What does this new law mean for individuals who do not currently have health insurance?
A: The law mandates that starting in 2014, any individual who is not exempt (due to financial hardship or religious beliefs) is required to obtain coverage or pay a penalty.

Q: What is the penalty for individuals who do not obtain insurance?

A: The new law will fine those who fail to carry health insurance coverage, and whose income exceeds the amount needed to be required to file federal income tax returns, as follows:

- In 2014, the fine will be the greater of $95 or one percent of income
- In 2015, the fine will be the greater of $325 or two percent of income
- By 2016, it will be the greater of $695 or 2.5 percent of income

The fee for an uninsured individual under age 18 is one-half of the adult fee. There is a family cap on the dollar amount fine of $2.085.

Q: What happens to individuals who cannot afford coverage?
A: The new law expands Medicaid coverage to all individuals with incomes up to 133% of the federal poverty level (FPL), beginning in 2014. If an individual does not qualify for Medicaid but still can't afford coverage, they may be eligible for government subsidies to help pay for private insurance sold through the exchanges. Premium subsidies will be available for individuals and families with incomes between 133% and 400% of the FPL.

Q: When does free preventive care (care not subject to cost-sharing requirements) start, and will it affect my plan?

A: Beginning September 23, 2010, all new group health plans and new plans in the individual market must provide coverage for preventive services. Recommended prevention and vaccination services will be covered without any deductibles or copayments. Seniors enrolled in Medicare will also no longer have to pay for proven preventive services.

Q: What services are considered preventive that must be covered without deductibles or copays?
A: Group and individual health insurance plans will cover at no additional cost to policy holders:
(1) Evidence based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the US Preventive Services Task Force (USPSTF);
(2) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC with respect to the individual involved;

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA;
(4) With respect to women, additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by HRSA.

Q: I have a preexisting condition. How can I get coverage this year?

A: This year, if you have been uninsured for 6 months and have a preexisting condition, you will gain access to health insurance that was not previously available to you.

A new federal high-risk pool will provide insurance for Americans who are uninsured and have a preexisting condition. This program will provide temporary protection for people with preexisting conditions until 2014, when insurance companies can no longer deny you coverage based on your health.

Generation Y

Q: I'm 21 years old. How do I get onto my parent's plan?

A: Six months from the date of enactment (September, 2010), insurers will be required to permit children to stay on family policies until age 26. This applies to all plans in the individual market, new employer plans, and existing employer plans, unless the adult child has an offer of coverage through his or her employer. This requirement will take effect the next time the plan comes up for renewal. Adult children who are on their parents' plan now but who lose that coverage when they graduate from college will have the option of rejoining their parents' policy in the new plan year beginning 6 months after the date of enactment of the new law (September, 2010). Those whose parents work at self-insured companies will also be eligible if they do not have an offer of employer-sponsored insurance.

Both married and unmarried dependents qualify for this dependent coverage.

Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have an offer of coverage through their employer.

Q: I keep hearing the young and healthy will pay more to offset the costs of the old and sick. Is this true?
A: Yes – the new law will require most of the uninsured Americans between the ages of 18 and 34 to buy policies that will likely be more expensive than the major-medical coverage that might have been available prior to the new law. The legislation caps age-related price variation so the healthy 20-somethings will pay higher premiums and those in the higher age ranges will pay lower premiums than they would have under the old law.

Young adults in entry-level jobs with low wages whose earnings fall below the 400% of poverty line will receive some government subsidies. However, the subsidies are unlikely to take the full sting out of the higher premiums. The most generous subsidies are for poor families, not single young adults.

Q: What is the "young invincible" policy?

A: A catastrophic plan (sometimes called the "Young Invincible" policy) will be available to those up to age 30 or to those who are exempt from the mandate to purchase coverage. This qualifying policy (one that exempts its owner from fines for failure to carry health insurance) provides catastrophic coverage only. The coverage level is set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market.

Individuals Earning $200,000 or More, and Married Couples Filing Jointly Who Earn $250,000 or More (of Modified Adjusted Gross Income)

Q: I heard annuity distributions are subject to a new tax. Is this true?

A: ***Yes.*** A new 3.8 percent tax on high income taxpayers' unearned income, including annuity withdrawals, will take effect in 2013. Thus, for taxpayers with modified adjusted gross income in excess of $200,000 (individual) or $250,000 (married filing jointly), annuity distributions received in 2013 and later will be subject to the 3.8% tax.

Q: What other unearned income is subject to this new 3.8% tax?

A: Other unearned income subject to the 3.8% tax includes interest, dividends, rents, and royalties.

Q: What's the Medicare wage tax increase?

A: Effective 2013, the Medicare wage tax is increased by 0.9% for those earning over $200,000 (individual)/$250,000 (married filing jointly). These income levels are not indexed to inflation.

Q: Is my employer required to withhold the additional Medicare wage tax?

A: Yes, but unlike the general 1.45% on wages, this additional tax is on the combined wages of the employee and the employee's spouse, in the case of a joint return. The employer is only required to withhold on wages in excess of $200,000 for the year, even though the tax may apply to a portion of the employee's wages at or below $200,000, if the employee's spouse also has wages for the year, they are filing a joint return, and their total combined wages for the year exceed $250,000.

Q: Does the additional Medicare wage tax apply to self-employed?

A: Yes.

Seniors

Q: What are the Medicare Advantage changes?

A: The new law modifies Medicare Advantage (MA) plan rules as follows:

- Freezes MA payments in 2011. Beginning in 2012, MA benchmarks are reduced from 95% of Medicare spending in high cost areas to 115% of Medicare spending in low-cost areas. The benchmark reductions will be phased in over three, five or seven years, depending on the extent of the resulting payment reductions.
- Authorizes the Centers for Medicare and Medicaid Services (CMS) to adjust MA risk scores for observed differences in coding patterns relative to fee-for-service.

- Requires MA plans spend at least 85% of their revenue on medical costs or activities that improve quality of care.

Q: My prescription drug spending will push me into the donut hole this year. What relief will I get?
A: Seniors who hit the gap in Medicare prescription drug coverage known as the donut hole will be provided with a $250 rebate in 2010.

Beginning in 2011, seniors in the donut hole will receive a 50 percent discount on prescription drugs. In addition, the Medicare share of costs will increase so that the donut hole will be completely closed by 2020.

Q: When does my free preventive care start and what does it cover?
A: Effective January 1, 2011, proven preventive services will be free. In addition, Medicare will provide a new annual wellness visit that provides personalized prevention plan services, including a health risk assessment.

Q: Are there changes to Medigap plans?
A: The NAIC will create new model plans for benefit packages C and F that include nominal cost sharing. The new models C and F will be available in 2015.

Employer Roles & Requirements

Q: I own a small business—does this mean that I'll need to purchase insurance for my workers?
A: No. The new law does not require any business of any size to provide health insurance for its workers. However, it does impose assessments on employers that do not provide affordable health insurance coverage. Whether a small business will be subject to these assessments depends on the size of the business, and on whether any of its workers qualify for federal subsidies with which to purchase their own health insurance.

If your business employs fewer than 50 full-time (including full-time equivalents) workers, it will not face any penalties for not offering insurance. Small employers with fewer than 25 employees and average wages of less than $50,000 (per full-time and full-time equivalent worker) will qualify for a health coverage tax credit.

Businesses with 50 or more full-time (including full-time equivalents) employees that do not offer coverage will have to pay a fee of $2,000 per full-time employee if any of their workers qualify for the premium tax credit, a government subsidy used to purchase health insurance coverage through the exchange.

The employer's first 30 employees are not counted in calculating the assessment. Employees in the waiting period between date of hire and eligibility for the employer's health plan are not counted. The waiting period cannot exceed 90 days. Only full-time employees are counted for purposes of calculating the assessment, although "full-time equivalents" are used to determine whether the employer is subject to the rule. Full-time equivalents are determined by counting all part-time hours worked in a month, and then dividing by 120, to reach the number of "full-time equivalent" employees the employer

has. Measurements are done on a monthly basis. The employer responsibility rules take effect in 2014.

Q: Is the employer responsible for determining workers' eligibility for a premium tax credit?
A: No - eligibility for a premium tax credit (federal subsidy to pay for health insurance) is determined by the exchange, which notifies the employer (for purposes of assessments).

Q: How is eligibility for subsidies determined?
A: Eligibility for subsidies is based on "household income". If an employee's household income is between 133 percent and 400 percent of the federal poverty level, and is such that the employee's share of the cost of the health insurance (including dependent coverage) is greater than the prescribed percentage (a sliding scale based on income that tops out at 9.5 percent), then the employee qualifies for the federal subsidy.

Q: What is included in "household income"?
A: Household income includes income from ALL those in the household (i.e., children) who can be covered under the insurance policy (it isn't pegged to tax filing (e.g., kids file their own tax returns separately), and it doesn't include "mere roommates" (i.e., students sharing an apartment).

Q: Does "household income" include children's earnings?
A: Yes.

Q: How does an employer determine whether any of its workers qualify for a premium credit with which to buy health insurance (and thus triggers the employer assessments)?
A: There's no reliable way for an employer to know ahead of time whether any of its workers qualifies for a federal subsidy. The "exchange" is responsible for notifying the employer if any of its workers qualify for a federal subsidy. Premium credits (payable by the government to the insurance company) are available to families earning up to 400% of federal poverty.

An employer certainly can ask its workers for information on the worker's spouse's earnings, but there will surely be some workers who decline to share that information. There is nothing in the law that would compel a worker to tell his/her employer that information. Also note: other laws prohibit prospective employers from inquiring of job applicants about their family status.

Q: Are there other assessments on employers?
A: Yes. The law requires that to avoid an assessment, the employer-offered insurance must be "affordable." That means the worker cannot be required to pay more than 9.5 percent (and in some cases much less—as low as two percent) of his/her household income for insurance. If the employer's insurance plan is "not affordable, "the employer is subject to a $3,000 per affected full-time worker assessment. This rule also takes effect in 2014.

Q: Does "affordable insurance "include only individual coverage, or does it also include dependent coverage?

A: The cost of dependent coverage is included in calculating whether the employer-offered health insurance is "affordable."

Q: If a person on Medicare is an employee, does that person count in calculating assessments?
A: No.

Q: Can employers send their workers with preexisting conditions to the high-risk pool?
A: No – The temporary national high-risk pool beginning in 2010 is for individuals who cannot obtain individual coverage. The pool will end on January 1, 2014, when the exchanges are operational. Employers are prohibited from putting individuals in the high-risk pool.

Q: What is the small business tax credit and how do I know if I am eligible?
A: Effective January 1, 2010, tax credits are available to qualifying small businesses that offer health insurance to their employees. So if your business qualifies for a tax credit, you are eligible right now.

The tax credit is worth up to 35 percent of the premiums your business pays to cover its workers – 25 percent for nonprofit firms. In 2014, the value of the credit will increase to 50 percent – 35 percent for nonprofits.

Your business qualifies for the credit if you cover at least 50 percent of the cost of health care coverage for your workers, pay average annual wages below $50,000, and have less than the equivalent of 25 full-time workers (for example, a firm with fewer than 50 half-time workers would be eligible).

The size of the credit depends on your average wages and the number of employees you have. The full credit is available to firms with average wages below $25,000 and less than 10 full-time equivalent workers. It phases out gradually for firms with average wages between $25,000 and $50,000 and for firms with the equivalent of between 10 and 25 full-time workers.

Q: Is the credit payable in advance or refundable?
A; The credit is not payable in advance to the taxpayer nor is it refundable. The credit is only available to offset actual tax liability and is claimed on the employer's tax return.

Q: What if my small business doesn't offer insurance today, but I choose to start offering insurance this year. Will I be eligible for these tax credits?

A: Yes. The tax credit is designed to both support those small businesses that provide coverage today as well as those that newly offer such coverage.

Q: When will the tax credits for exchange coverage begins?

A: In 2014, tax credits are made available for exchange-based coverage; amount varies by income up to 400% of FPL.

Q: What is a SIMPLE Cafeteria Plan?
A: A new employee benefit cafeteria plan to be known as a Simple Cafeteria Plan eases the participation restrictions so that small businesses (100 or fewer employees) can provide tax-free benefits to their employees and it includes self-employed individuals as qualified employees. The SIMPLE cafeteria plan design will be available as of available 2011.

Q: What is the "Early Retiree Program"?
A: The new law creates a temporary reinsurance program (it expires on January 1, 2014) for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. The program reimburses employers 80% of claims between $15,000 and $90,000.

Q: Does the new law change the employer deductible subsidy under Medicare Part D?
A: Yes – in 2013 the law eliminates the tax deduction for employer subsidies of Medicare Part D (prescription drug) premiums.

Q: Do employers have new CLASS program responsibilities?

A: Yes - employers must automatically enroll their workers in the CLASS program, which is a federal long-term care/disability insurance program, unless the employee opts out. Details on how this will work will not be known until the implementing rules are released in regulations. These are expected soon, as the CLASS Act program takes effect by 2011.

Q: Do employers have to report the value of health benefits?

A: Yes – beginning 2011, employers are required to report the value of health benefits on W-2.

Q: How is the value of employer-sponsored health insurance determined?

A: To determine the value of employer-sponsored health insurance coverage, the employer calculates the applicable premiums for the taxable year for the employee under the rules for COBRA continuation coverage under section 4980B(f)(4) (and accompanying Treasury regulations), including the special rule for self-insured plans. The value that the employer is required to report is the portion of the aggregate premium.

Q: What is the employer's role in determining the high-value health insurance tax (nicknamed the"Cadillac" tax)?
A: The "Cadillac" tax is a 40% tax, payable by "the insurer" (the insurance company or the employer or plan administrator in the case of self insurance or other non-insurance company coverage, like flexible spending accounts), if the aggregate value of the employer-offered insurance exceeds $27,500 for dependent coverage or $10,200 for individual coverage. Stand alone dental and vision coverage is exempt from the aggregation rules. The employer is responsible for doing the aggregation calculations. (There are higher threshold amounts for those in high risk occupations, and adjustments will be permissible for employers with age and gender demographics that vary from national averages.)

Q: What are Free-Choice Vouchers?
A: Beginning in 2014, employers that offer basic insurance coverage must offer free-choice vouchers to their low-income employees, who can elect to purchase their health insurance through one of the exchanges created under the new law. The dollar value of the free-choice vouchers must be equal to what the employer would have paid to cover its low-wage employees under the most generous option in the employer's plan. Employers will get a tax deduction for the dollar value of the vouchers, and employees generally will pay no income taxes on the dollar value of the vouchers.

Q: Will Free-Choice Vouchers hurt employer plans?
A; Free-choice vouchers could potentially hurt an employer's insurance risk profile if too many young, healthy workers qualified for vouchers to buy insurance through newly created exchanges leaving the older, sicker workers on the employer plan.

Q: Do employers have to automatically enroll full-time employees in a health plan?
A: Employers with more than 200 full-time employees must automatically enroll full-time employees in their health plans (if they offer such plan). The automatic enrollment program must include adequate notice and opportunity for employees to opt out. Note: this is not a requirement to offer health insurance; it is a requirement only if the employer is offering health insurance.

Q: What responsibilities do employers have regarding notifying employees about the exchange?
A: Employers are required to provide to each employee at the time of hiring (or with respect to current employees, not later than March 1, 2013) written notice informing them of the existence of the exchange, including a description of the services provided by such exchange and the manner in which the employee may contact the exchange to request assistance.

Q: Do employers have new responsibilities regarding nursing mothers?
A: Employers shall provide a reasonable break time for an employee to express breast milk for one year after the employee's child's birth, and shall provide a private place for such purpose. This rule does not apply to employers with fewer than 50 employees, if such requirements would impose an undue hardship.

Long Term Care Insurance

Q: What is the CLASS Program?
A: The CLASS program is a voluntary, self-funded insurance program designed to provide a lifetime cash benefit that offers people with disabilities some protection against the costs of paying for long term services.

Q: Who can participate in the CLASS Program?
A: Working individuals are eligible for the program. When an individual's employer is participating in the program, premiums are paid through payroll deductions. Self-employed, or those whose employers do not choose to participate will still be able to join the CLASS program through a government payment mechanism.

Q: What are the procedures for allowing workers to participate in the CLASS Program?
A: The HHS Secretary, in coordination with the Secretary of the Treasury, will establish procedures allowing eligible individuals to automatically enroll employees in the CLASS program. They will also develop alternative enrollment procedures for individuals who are self-employed, have more than one employer, or whose employer does not elect to participate in the automatic enrollment process.

Q: Can workers with multiple employers enroll more than once in the CLASS Program?
A: No – the HHS Secretary, with the Secretary of Treasury will create an enrollment form for the CLASS program, and ensure that individuals are not automatically enrolled by more than one employer.

Q: When can an individual opt out of the CLASS Program?
A: An individual may elect to opt out at any time in such manner as the Secretaries shall prescribe.

Q: When is a participant eligible for CLASS benefits?
A: Once an individual has paid premiums for five years and has worked at least three of those five years, they are eligible to receive benefits when they need help with certain activities of daily living. Beneficiaries will receive a lifetime cash benefit—based on the degree of impairment. The cash benefit is expected to average $75/day or more than $27,000 per year to maintain independence at home or in the community and cover typical costs of home care services or adult day care. The benefits can also be used towards payment of assisted living and nursing home care costs.

Q: What will this do the private LTC market?
A: The insurance industry warned against enacting this new LTC program believing that the CLASS Act will create a false sense of security and may have the unintended consequence of delaying appropriate action by people who can and should plan ahead for their long-term care needs. However, some optimistic producers believe private LTC sales will be enhanced as the new law will bring the issue of LTC planning to the workplace and the private market has better products to offer.

Disease Prevention and Wellness

Q: Are there financial incentives for small employers to provide wellness programs?
A: Yes - the new law establishes a federal grant program in 2010 for small employers providing wellness programs

Q: Are there wellness plan incentives in the individual market?
A: The new law establishes a 10-state pilot program to apply HIPAA bona fide wellness program rules to the individual market. (The pilot program will operate between 2014 and 2017.)

Q: I note that one of the benefits that will be available in 2010 is a wellness benefit for all policies. Does that mean all policies including individual health insurance policies? And what must be included in the wellness benefit?
A: For all group and individual health plans, coverage of specific preventative services with no cost sharing is mandated this year. Group and individual health insurance plans will cover at no additional cost to policy holders:
(1) Evidence based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the US Preventive Services Task Force (USPSTF);
(2) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC with respect to the individual involved;
(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA;
(4) With respect to women, additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by HRSA.

There is also a Federal grant program for small employers providing wellness programs to their employees that will take effect on October 1, 2010.

Financing

Q: Are contributions to a Flexible Spending Account (FSA) limited?
A: Yes – beginning in 2013 there is a $2,500 cap on FSA contributions. FSA funds can be used only for medical expenses.

Q: Is the cap on FSAs indexed?
A: Yes

(This Q&A was a duplicate)

Q: Does the "Cadillac" tax require inclusion of FSA reimbursements?
A: Yes. The aggregate value of the health plan includes FSA reimbursements for medical expenses. It also includes reimbursements under health reimbursement arrangements (HRAs), employer contributions to a health savings account (HSA) and other supplementary health insurance. Stand-alone dental and vision coverage is not included in aggregating the value of coverage for Cadillac tax purposes. These rules take effect in 2013.

Q: What is the "tanning" tax?
A: Beginning in July 2010 a 10% tax on indoor UV tanning services will be imposed.

Q: How is comparative effectiveness research funded?

A: A new tax ($2 per enrollee) will be imposed on all private health insurance policies (including self-insured plans) to pay for comparative effectiveness research (effective for plan years beginning in 2012).

Q: What's the Medicare wage tax increase?
A: Effective 2013, the Medicare wage tax is increased by 0.9% for those earning $200,000 (individual)/$250,000 (married filing jointly), or more. These income levels are not indexed for inflation.

Q: How will taxes be increased to pay for this?
A: Taxes and assessments to pay for the new law are as follows:

<u>2010</u>

- 10% tax on indoor UV tanning (7/1/10)

<u>2011</u>

- Wealthier seniors (individuals with modified adjusted gross income of $85,000/individual or $170,000/married filing jointly or more begin paying higher Part D premiums. (Income amounts are not indexed for inflation in Parts B/D)
- Impose new annual tax (based on annual sales) on brand name pharmaceutical companies
- Penalties for nonqualified HSA and Archer MSA distributions double (to 20%)
- New tax ($2 per enrollee) on all private health insurance policies (including self-insured plans) to pay for comparative effectiveness research (plan years beginning FY12)

<u>2013</u>

- Increase Medicare wage tax by 0.9% and impose a new 3.8% tax on investment income including annuities for high income taxpayers (those earning $200,000 (individual)/$250,000 (married filing jointly) or more. No indexing is provided.
- Impose $2,500 annual cap on FSA contributions (indexed to CPI)
- Generally, establishes that medical expenses are deductible only to the extent they exceed 10 percent of adjusted gross income (up from 7.5 percent). There are temporary exceptions to this increase for older taxpayers.
- Eliminate of the deduction for employers' Part D retiree drug subsidy
- Impose 2.3% excise tax on medical devices
- $500,000 deduction cap on compensation paid to insurance company employees and officers

<u>2014</u>

- Individuals without government-approved coverage are subject to a fine of the greater of $95 or 1.0% of income. The fine phases up to the greater of $325 or 2.0 percent of income in 2015 and to $695 or 2.5 percent of income in 2016.

- Employers who fail to offer "affordable" coverage would pay a $3,000 assessment for each employee who receives a federal subsidy (premium credit) with which to buy health insurance through the exchange
- Employers that do not offer insurance must pay an assessment of $2,000 for every full-time employee—employers with fewer than 50 full-time (including full-time equivalent) employees are exempt from this assessment.
- Impose tax on nearly all private health insurance plans ($8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017, $14.3 billion in 2018, and indexed to medical cost growth thereafter); based upon firm's market share starting in 2013

2018

- Impose "Cadillac tax" on "high cost" plans-- 40% tax on the aggregated benefit value above $10,200 for individual coverage, and $27,500 for family coverage, annually.

Medical Malpractice

Q: Does the new law reform tort/medical malpractice law?
A: No, but it does authorize grants to states to test alternatives to civil tort litigation. It also requires the federal government to evaluate these alternatives' effectiveness.

Additional Resources:

New law (H.R. 3590) text
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf

Reconciliation bill (H.R. 4872) **http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872eh.txt.pdf**

Manager's amendment (H.R. 4872)
http://docs.house.gov/rules/hr4872/111_managers_hr4872.pdf

Summary prepared by Committees on Ways & Means, Energy & Commerce, and Education & Labor, March 23, 2010
http://docs.house.gov/energycommerce/SECTION_BY_SECTION.pdf

Summary of Prevention, Public Health & Workforce Provisions prepared by Healthy Americans http://healthyamericans.org/assets/files/Summary.pdf

Joint Committee on Taxation's description of the revenue provisions (160 pages)
http://www.jct.gov/publications.html?func=startdown&id=3673