



Overview of the Federal Healthcare Reform: What does it mean?

Questions and Answers From the Webinar

Q: Can you elaborate on the \$2000 annual fee per employee that employers will have to pay?

A: Beginning in 2014, for employers with greater than 50 employees who do not offer health insurance coverage at all to its employees, they must pay \$2,000 annually for each "full-time employee." A full-time employee is one that works 30 hours or more per week. When determining the number of full-time employees, employers may exclude the first 30 employees.

Q: If an individual decides to pay the penalty and not purchase insurance, can they still go to the Emergency room? Why would this change the people who currently decide to not have insurance?

A: Individuals without insurance may still go to the emergency room. The new legislation does not change EMTALA, so a hospital with an emergency room must still provide appropriate medical screening and stabilization or appropriate transfer for those with emergency medical conditions and follow additional EMTALA requirements. The goal of the legislation is to make the penalty for not purchasing insurance expensive the cost of insurance, making it more likely people will purchase insurance to avoid the penalty.

Q: What about dental?

A: The legislation includes various provisions that affect oral health. Some examples of this are: Insurance plans are required to include pediatric oral health services for children up to 21 years of age, the essential health benefits package must include oral care, the expansion of oral health prevention programs, the implementation of dental sealants, water fluoridation and preventive programs, and various funding affecting dental education.

Q: How will the Health Care Reform legislation effect Self Insured/MEWA plans?

A: Most of the provisions relating to insurance reform apply to self-insured plans, including the 40% excise tax on "Cadillac plans", \$2 per average covered lives tax for funding comparative effectiveness research. Provisions that don't apply include fee allocated by market share, which won't apply to self-funded plans whose fees from administration are \$5 million or less, standards for insurance overhead and public disclosure requirements requiring plans in the individual and small group market to spend 80 percent of premium dollars on clinical services and quality activities, and 85 percent for plans in the large group market.

Q: What is the thrust of the new trauma center program?

A: The law establishes a new trauma center program to strengthen emergency department and trauma center capacity. Also, funds research on emergency medicine, including pediatric emergency medical research, and develop demonstration programs to design, implement and evaluate innovative models for emergency care systems. Funding will begin in 2011.

Q: We thought dependent coverage until age 26 started in the plan year that starts six months after the signed law. For us that is plan year 2011. Is that not correct?

A: Yes, the Health Reform Law requires insurers that offer dependent coverage to allow uninsured children to remain on their parents' health insurance up until age 26. This is effective for plans years beginning on or after September 23, 2010. So if an insurance plan runs on a calendar plan year, it would not come into effect until January 1, 2011.

Q: What about physician ownership in ambulatory surgery centers? Will that be prohibited or will reimbursement be reduced for care in those facilities?

A: No additional prohibitions on ownership of ambulatory surgery centers. Law requires productivity adjustment to annual inflation updates beginning in 2011 which will reduce payment increases to ambulatory surgery centers thereafter.

Q: What is the projected number of uninsured by 2018 if the reform had not been enacted?

A: (1) 66.8 million - Source: Urban Institute, Brookings Tax Policy Center, September 2008; (2) 53 million (non-elderly) - Source: Director of CBO's July 2009 letter.

Q: Does the State Health exchange effectively translate into Medicaid, or will commercial payors enter this market?

A: It is the intent that exchanges will include private health insurance plans, but they must at least offer a not-for-profit plan and a plan that does not cover abortions. It remains unclear how states will implement these changes.

Q: When does the prevention and wellness provision for employers to give discounts for participation in wellness go into effect?

A: January 1, 2014. In addition, the law establishes a 10-state pilot program by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective.

Q: How does the legislation affect employee responsibilities for paying their portion of premiums provided by employer if they are out on leave (example: FMLA) and do not pay. Currently, an employer can cancel coverage if no payment is received and reinstate coverage without waiting period once they return. Will employers be unable to cancel coverage in those cases?

A: An employee may be penalized if he or she fails to maintain minimum essential coverage due to his or her failure to pay his or her portion of an employer-sponsored plan's premium while on leave. Whether or not the employee is penalized may depend on the period of time the employee is without minimum essential coverage, whether the employee can afford the premium (based on household income), and whether the employee is eligible for another exemption. With respect to employers, we believe that employers will continue to be able to cancel coverage in certain situations, but must maintain minimal or no waiting periods for reinstatement of coverage to ensure they will not be assessed penalties.