Healthcare Reform
Frequently Asked Questions

When will the healthcare reform law take effect?
The health insurance reform law adopted as part of the Patient Protection and Affordable Care Act (PPACA), and the subsequent reconciliation bill, will be phased in over 5 years. Many provisions will take effect in January 1, 2014. However, there are some protections that employers have already implemented and certain provisions that do not yet apply to the University’s grandfathered self-funded health plans.

- Lifetime limits are prohibited and annual limits are restricted (new 2011)
- Enrollees under 19 years of age cannot be denied coverage (no pre-existing condition exclusions allowed) (new 2011)
- Children up to age 26 may remain on a parent’s policy (new 2011)
- Medical loss ratio standards limit insurers’ overhead (Note: not applicable to self-funded plans)
- A standardized summary of benefits (SBC) must be used by all insurers, allowing for easier comparison of plans (new 2012)
- Reporting of the value of healthcare on the W-2 (W-2 issued in 2013)
- Pre-existing condition exclusions will be removed from all plans (new 2014)
- Enhanced appeal procedures are available to consumers (new 2014)
- New insurance company rate review transparency requirements are in place (new 2014)
- Preventive services must be covered at no cost. Some generic maintenance drugs are also provided at no cost (Note: does not apply to grandfathered plans)

Why does the law require me to purchase health insurance coverage?
The key goal of the healthcare reform law is to ensure that nobody can be denied coverage or be priced out of coverage due to a pre-existing health problem and this is referred to as the “individual mandate”. However, if you allow people to wait until they have a health problem to purchase insurance, then the market simply will not work effectively and premiums will escalate. There would be few choices available to consumers, and those choices would be expensive for everyone. So, the law requires everyone to have minimum coverage, thus creating a pool of both sick and healthy individuals.

Will my health insurance premiums continue to go up?
Unfortunately, the grim fact is that healthcare spending is likely to continue rising faster than general inflation well into the future, resulting in higher insurance premiums. While some individuals and families with health problems may see their premiums decrease under the new rules, for most Americans premiums will continue to increase from year to year. However, the new regulations are designed to prevent unreasonable and unexpected spikes in premiums and, over time, to slow the growth in overall healthcare spending.

In addition, the law adds new taxes and fees that will be passed on to individuals and employer sponsored plans through the premium cost of health insurance. These fees are to help pay for the following programs;

- **Patient-Centered Outcomes Research Institute Fee (PCORI),** to improve patient care and to help fund the Exchanges. The fee is $1 per covered person for 2013, $2 per covered person for 2014, and will be indexed for inflation for 2015 through 2019.
- **Transitional Reinsurance Assessment Fee,** which is to help fund the Exchanges will be at least $63 per covered person for 2014 and can be increased by the state. As of May 24, 2013, Colorado has not announced that they will add to this fee. The fee will be paid through 2016 and is expected to increase.
- **High-cost Health Insurance Tax, more commonly known as the Cadillac tax.** This is a 40% excise tax paid by plans with an annual premium exceeding $10,200 for an individual or $27,500 for a family. This tax does not go into effect until 2018.

It sounds like the University’s plan is grandfathered. What benefit changes can I expect?
The legislation includes the following mandates which all grandfathered group health plans will have to comply with effective with the first plan year starting on or after September 23, 2010:
- Provide coverage to dependent children until they turn age 26
- Eliminate lifetime aggregate dollar limits on “essential benefits”
- Eliminate annual dollar limits on “essential benefits”
- Eliminate pre-existing condition exclusion for enrollees up to age 19
- Prohibit the rescinding of coverage except in the case of fraud, intentional misrepresentation, or nonpayment of premiums

Starting in 2014, grandfathered health insurance plans must:
- Eliminate annual aggregate benefit limits
- Provide coverage of dependents to age 26 regardless of eligibility for other coverage
- Eliminate pre-existing condition limitations for adults
- Eliminate waiting periods of greater than 90 days

Will I be required to drop my current coverage?
No. CSU’s health plans (Green, Gold and POS) are grandfathered under the law and are considered “qualified coverage” that meets the mandate to offer health insurance to employees that begins January 2014. Employees and eligible dependents can be added to the policy without losing grandfathered status.

Is there a deadline for providing a Summary of Benefits and Coverage (SBC) to employees?
Yes. A separate SBC must be created and made available for each medical benefit option offered under the University’s self-funded group health plan for open enrollment periods beginning after September 23, 2012. The SBC provided by Anthem Blue Cross and Blue Shield for the University medical plans (Green, Gold and POS) is available on the Human Resources website at [http://www.hrs.colostate.edu/benefits/fap-insplans.html](http://www.hrs.colostate.edu/benefits/fap-insplans.html).

When can my 21-year-old be added to my plan?
The health reform law requires that insurers and employers that provide dependent coverage to children make that coverage available to adult children of enrollees up to their 26th birthday. This requirement became effective for “plan years” beginning September 23, 2010, so parents will be able to enroll a child in group coverage during the next open enrollment period.

When can I enroll my 10-year-old who has a pre-existing condition?
The law and subsequent regulations prohibit plans from denying coverage for children based on health status or excluding coverage of their pre-existing conditions if otherwise covered under the plan. This protection became effective after September 23, 2010. A child can be added to an existing plan under the enrollment rules of the plan.

What are “Exchanges”?
Exchanges are the central mechanisms created by the health reform bill to help individuals and small businesses purchase health insurance coverage. On October 1, 2013, an Exchange in every state will begin enrolling individuals and small businesses into qualified health plans. The Exchange, operated by the federal government or by the state, will provide information to consumers about their coverage options and what assistance is available to them. The Exchanges will also administer the new health insurance subsidies and facilitate enrollment in private health insurance, Medicaid, and the Children’s Health Insurance Program (CHIP). The federal law does not require anyone to purchase health insurance through the Exchange, though subsidies will only be available for plans sold through the Exchange, if eligible. If you would rather purchase health insurance through your employer, or an insurance agent or broker, you will be free to do so.

What is the Health Insurance Marketplace?
A Marketplace (formerly known as an “Exchange”) is an arrangement through which private and non-profit insurers offer small employers (up to 100 employees) and individuals the ability to purchase health insurance. The Act requires each state to set up a Marketplace for the purchase of health insurance coverage. Coverage can be purchased through the Marketplace starting in 2014. On October 1, 2013, a Marketplace in every state will begin enrolling individuals and small businesses into qualified health plans. Each Marketplace will offer four plan categories plus a catastrophic plan including:

**Bronze plan** – Essential health benefits covering 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($6,250 for individuals and $12,500 for families in 2013);
Silver plan – Essential health benefits covering 70% of the plan benefit costs, with HSA out-of-pocket limits;
Gold plan – Essential health benefits covering 80% of the plan benefit costs, with HSA out-of-pocket limits;
Platinum plan – Essential health benefits covering 90% of the plan benefit costs, with HSA out-of-pocket limits;
Catastrophic plan – Available to individuals up to age 30, or to those who are exempt from the mandate to purchase coverage. Provides catastrophic coverage only, with the coverage level set at the current HDHP levels except that preventive benefits and coverage for three primary care visits would be exempt from the deductible.

The University fully expects to continue to sponsor employee benefits as an integral piece of your total compensation. You are free to continue to participate in the benefits offered to you by Colorado State University.

What is the Employer Mandate?
The Employer Mandate has been delayed until January 1, 2015, however it will impact large employers like the University and have steep employer shared penalties for non-compliance

For example:

If the University offers coverage to full-time employees, will a penalty be assessed?
If the employer has a least 50 full-time employees and coverage is offered to at least 95% of the full-time employees, the University would be subject to a penalty starting in 2015, if:
1. A full-time employee’s contribution for employee-only coverage exceeds 9.5%* of the employee’s household income or the plan’s value is less than 60%; and
2. The employee’s household income is less than 400% of the federal poverty level; and
3. The employee waives your coverage and purchases coverage on an exchange with premium tax credits.

*The University’s self-funded medical plan provides Faculty/Admin Pros and other Non-Classified Staff the ‘Green’ plan employee only coverage option at zero employee cost.

How does the University know if an employee is full-time or a variable hour employee as defined under Healthcare Reform?
This is generally based on the employee’s hours worked, or, the amount of hours the employee is reasonably expected to work as of their hire date.

- **New employee reasonably expected to work full-time (i.e. 30 or more hours per week)**-If an employee is reasonably expected to work full-time when hired, and coverage is offered to the employee before the end of the employee’s initial 90 days of employment, the employer is not subject to the employer mandate payment for that employee, if the coverage is affordable and meets the minimum required value (University Green Plan employee coverage is $0).
- **New employee reasonably expected to work part-time (i.e. less than 30 hours per week)**-If an employee is reasonably expected to work part-time and the employee’s number of hours do not vary, the employer is not subject to the employer mandate penalty for that employee if you don’t offer them coverage.
- **New variable hour employees** – If based on the facts and circumstances at the date the employee begins working (the start date).

For purposes of the employer mandate penalties, the law permits an employer to use a “look-back measurement period/stability period” to determine which of your employees are considered full-time employees. You may use a standard measurement/stability period for ongoing employees, while using a different initial measurement/stability period for new variable and seasonal employees.

If an employee meets the 30 hours per week requirement over the measurement period, when is medical enrollment with the University effective?
For current employees, an “administrative period” is applied after the “measurement period” ends and before the associated “stability period” begins. This administrative period can’t reduce or lengthen the measurement period or the stability period; it can’t be longer than 90 days; and it must overlap with the prior stability period; so that, during the administrative period, continuous coverage is provided to ongoing employees until the new stability period begins.

Can I continue to participate in flexible spending accounts?
Yes, nothing in the PPACA would eliminate this account. However, the law reduced the annual participant contribution amount to $2,500 due to the loss of tax revenue for this pre-tax benefit program.