

# PacificSource FAQ: Healthcare Reform General Information

Updated December 30, 2010

## Background

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On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (the Affordable Care Act). On March 30, the president signed into law the Health Care and Education Reconciliation Act of 2010 (the "Reconciliation Act"), which amended the PPACA. These Acts, taken together, provide for several changes over a number of years ranging from within 60 days of the passage of the Acts to eight years later and beyond.

The following FAQ is intended to be a high-level overview. As regulations are released, new bills introduced, or other clarification provided, we will update these FAQs to keep you as informed as possible.<sup>1</sup>

## Information for Members

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**Q1: What changes are to be implemented in 2010?**

A1: Please see our [Summary of Changes - 2010](#).

**Q2: What changes will happen first?**

A2: Changes called for in the Affordable Care Act will not occur all at once. They will be **phased in** over the next decade. Here are some of the most significant changes you can expect, which will be effective for new health plans (both group and individual) and for existing health plans **as they renew after September 23, 2010**.

**Dependent age limit extension.** Dependents will be able to stay on their parents' health plan up to age 26. There will be a special enrollment opportunity for children under 26 who previously lost their coverage or were not eligible for coverage because of the age limit.

**Preventive care coverage.** Certain preventive services will not be subject to copayments, coinsurance, or deductibles. The services include those with a rating of A or B from the US Preventive Services Task Force; immunizations recommended by the CDC; and specific services for infants, children, adolescents, and women. You'll find a list of all recommended preventive care services online at:

<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>

**Pre-existing condition exclusions.** Exclusions for pre-existing conditions are eliminated for those under 19. The plan must immediately cover treatment for pre-existing conditions otherwise covered by the plan. With the new legislation, group plans can no longer require children to wait up to six months (12 months for Idaho) before the plans cover pre-existing conditions. On a related note, PacificSource will continue to offer child-only individual insurance policies. [Read the news release](#) for more information.

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<sup>1</sup> Please note that some aspects of the Acts deal with issues that are beyond insurance policies and benefit coverage provisions (e.g., tax provisions). Please consult your tax consultant for questions in this area, or other experts in other areas of the Acts that do not involve insurance policies.

**Lifetime maximum benefit limits.** Lifetime maximum dollar limits are eliminated on "essential benefits." While we are awaiting a definition of "essential benefits," we have decided to remove the overall lifetime maximum benefit limit from all PacificSource group and individual policies as they renew on or after September 23, 2010.

**Q3: What is the “grandfathered plan” concept, and how does it impact my policy?**

A3: Please see A16 under Information for Employers below.

**Q4: Can dependents up to the age of 26 be added back to an insurance policy now?**

A4: No, unless your policy already allows dependents up to age 26. The PPACA and Reconciliation Acts do not implement this change until plans renew on or after September 23, 2010. Prior to 2014, such dependents can stay on the plan regardless of whether or not they are eligible to enroll in an eligible employer-sponsored plan.

- Small groups (generally, under 51 employees) and individual plans: Please note that PacificSource will allow dependents on the plan as of April 30, 2010, to remain on the plan even though they are no longer students or otherwise fit within the definition of dependent on the policy, up to the age of 26.
- Large groups (generally, 51+ employees) may opt for “grandfathered” status, which allows them to decide whether to extend coverage in this same manner. Please contact our Membership Department at (541) 684-5583 or (866) 999-5583 if you have questions about whether you or your dependent is eligible to remain on coverage.

Please see our [FAQ: Early Extension of Dependent Eligibility](#) for more information.

**Q5: If I have group insurance of my own or through my spouse, and my parents add me on to their plan as a dependent, how will the two plans coordinate? [Added 12/30/10]**

A5: Our usual Coordination of Benefit (COB) policy applies. If you are covered under more than one group insurance plan, PacificSource will work with your other insurance carrier(s) to pay up to 100 percent of your covered expenses. We do this so you receive the maximum benefits available from all sources for the cost of your care. It is not expected that this will differ under healthcare reform, although that could change in the future.

- If you are a dependent under 26 and have coverage through both your employer and your parent’s group coverage, your own employer’s coverage is normally primary (pays first).
- If you are under 26 and covered under a spouse’s employer group coverage and your parent’s group coverage, the coverage that has been in effect longest is normally primary.

If you have a question about which coverage is primary, please refer to the Coordination of Benefits section of your Member Handbook, or contact PacificSource’s Coordination of Benefits team.

**Q6: How will PacificSource provide individual coverage to children under age 19 now that the reform law requires guaranteed issue for these children?**

A6: **In Oregon:** Consistent with the State of Oregon’s Open Enrollment Guidelines, we will offer children’s individual policy coverage in Oregon as follows:

- **During the state-prescribed open enrollment periods, we will offer coverage to all applicants under age 19.** This is true regardless of health status and applies to both child-only and family policies.

- **Outside of the open enrollment periods, we will accept all applicants under age 19 who meet the state’s qualifying event requirements.** This is true regardless of health status and applies to both child-only and family policies.
- **All applicants under age 19 who apply outside of the open enrollment periods and do not meet the qualifying event requirements will not be offered coverage.** This is true regardless of health status, and it applies to both child-only applications and children applying for enrollment along with parents. These applicants will be given the opportunity to update their enrollment applications and resubmit them for processing during the next state-prescribed open enrollment period:
  - For 2010, the open enrollment period runs from November 1 to December 31 allowing coverage effective January 1, 2011.
  - For 2011 and future years, there will be two open enrollment periods.

**In Idaho and Montana,** where there are no open enrollment periods, we will continue to accept applications for children’s individual policies at this time, and premium rates will vary, as allowed under state law.

**Q7: Should I cancel my individual or group plan now? Am I eligible for coverage provided by the government?**

A7: We have had people cancel their coverage already under the mistaken assumption that the Acts will provide them with free insurance or insurance provided by the government. That is not the case. While the Acts include provisions for setting up high-risk pools and an Exchange in 2014, there is no government insurance program for all individuals and employers at this time in Oregon, Idaho, Washington, or Montana (the states in which PacificSource Health Plans, or a subsidiary, does business).

**Q8: Is it true that you cannot cancel my coverage for any reason?**

A8: No, insurers can cancel coverage for non-payment, when an employer is no longer eligible for a plan (e.g., an employer drops its association membership, so is no longer eligible for insurance through the association), and for other circumstances just as they can today. However, the Acts do provide that plans cannot be rescinded (i.e.: deemed to be null and void as if the policy was never issued), unless fraud exists or an intentional misrepresentation of a material fact. Please note that PacificSource Health Plans has rarely found itself in situations where it needs to rescind coverage. In addition, in regards to our Individual plans, we only rescind the policy when egregious circumstances exist and only after a thorough review of the situation both internally and by our independent external panel. It is important for everyone to complete applications carefully and truthfully.

**Q9: Is the government going to cap premium increases?**

A9: No. Initially, the federal government will “review” unreasonable premium increases, although the term “unreasonable” has not yet been defined. The Acts do not give the government the authority to decline or reject a premium increase. In 2014, states and the Secretary of the United States’ Health & Human Services Department will “monitor” premium increases. Again, it is not clear what this means or the extent of the authority granted. PacificSource Health Plans carefully evaluates a number of factors before filing for a premium increase, including medical cost trends, new technology expense trends, the cost of newly mandated coverage, and other drivers of healthcare costs. We are very conscious of the high cost of medical care, which translates into

high insurance premiums; we work diligently to provide our members with the maximum benefit reimbursement possible and the best value for their health care premium dollars.

**Q10: Will my premiums increase or decrease as a result of the Acts?**

A10: Insurance premiums are likely to increase as a result of the passage of the Acts. Plans are required to offer richer coverage, expand access, and to increase risk; this generally results in increased premiums. PacificSource Health Plans is very aware that increasing premiums are a concern for individuals and employers alike; we share those concerns and, as noted above, work hard to keep premiums as low as possible while complying with all state and federal regulations.

**Q11: How will the new appeals requirements change current appeals rights?**

A11: It will depend on the regulations that are promulgated by HHS and DOL; however, all PacificSource Health Plans' policies currently include both an internal and external process, as provided for under state law.

**Q12: What are the Exchanges and when will they be available?**

A12: The Exchanges will be available in 2014. Each Exchange will consist of "qualified health plans," which will provide the essential benefits package, be certified by each Exchange through which it is offered, and will be offered by an insurer under certain criteria (e.g., properly licensed, specified plan designs ranges). Employers of small groups (defined in the Acts as 1-100 employees, although states may reduce it to 50 employees) may offer one or more small group plans to employees through the Exchanges. Only citizens and lawful residents may purchase coverage through the Exchanges. This is a very brief overview of the Exchanges and more clarification will emerge as regulations are promulgated.

## Information for Employers

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**Q13: What reform changes will be happening first?**

A13: Please see A2 above, under Information for Members.

**Q14: As an employer, am I eligible for a tax credit for providing health insurance for my employees?**

A14: There are tax credits available, but there are a number of specific criteria involved. This is an area where you should talk to your tax consultant and not your insurer. Please note that some aspects of the Acts deal with issues that are beyond insurance policies and benefit coverage provisions (e.g., tax provisions). PacificSource Health Plans is not in a position to provide tax advice for its members, employer groups or producers; please consult your tax consultant for questions in this area, or other experts in other areas of the Acts that do not involve insurance policies.

**Q15: Are insurers required to pay additional taxes as a result of the Acts?**

A15: Yes, the Acts have additional "fees" and taxes that apply to insurers. The Reconciliation Act pushed back some of these additional taxes until 2014; the taxes total several billion dollars annual (i.e.: \$8 billion in 2014; \$11.3 billion in 2015; \$11.3 billion in 2016; \$13.9 billion in 2017 and continuing to increase each year). Note that there are other taxes included in the Acts that affect a variety of areas (e.g., medical devices, hospitals, etc.).

**Q16: What is the "grandfathered plan" concept, and how does it impact my policy?**

A16: Certain provisions in the Acts do not apply to grandfathered plans. Grandfathered plans under the Acts are those policies that existed at the time the PPACA was passed – March 23, 2010. To provide members with the preventative care they need, while keeping employer options open and minimizing the administrative burden of health reform, we have decided the best course of action is to transition most of our customers to nongrandfathered plans.

- **For small groups and individual policies**, we will only offer nongrandfathered plans. In other words, these plans will be adjusted to comply with reform.
- **Large groups** will have the flexibility to keep their grandfathered plan. While fully insured large groups will be automatically moved to a nongrandfathered plan unless they tell us otherwise, we will follow up with self insured groups prior to renewal to confirm their intentions.

More information about grandfathered plans is available on our Web site. Please visit [PacificSource.com/healthcare-reform.aspx](http://PacificSource.com/healthcare-reform.aspx) and click the “Grandfathered plans” link on the right-hand side of your screen. We have also developed a [Grandfathered Plans FAQ](#).

**Q17: Do I have any responsibilities as an employer to notify employees of changes?**

A17: Several provisions of healthcare reform take effect for existing plans as they renew after September 23, 2010. Regulations recently issued by the HHS require plan sponsors (typically the employer, in the case of group plans) to notify covered employees of the following:

- Special enrollment opportunity related to the extension of dependent coverage to age 26
- Special enrollment opportunity related to the elimination of lifetime limits
- Pre-existing waiting period no longer applies to under age 19

We are sending a [letter](#) regarding this requirement to fully insured Oregon and Idaho group clients as they renew. With the letter we enclose a [sample member notice](#), which may be photocopied and distributed. There is also a PDF version of the notice on our Web site at <http://www.pacificsource.com/reform-notices/> for employers who prefer to notify their employees via e-mail.

**Q18: What are “essential benefits”?**

A18: According to the federal healthcare reform Web site (Healthcare.gov), essential benefits are “A set of healthcare service categories that must be covered by certain plans, starting in 2014. These include doctor office visits, hospitalizations, and prescriptions. Insurance policies must cover these benefits to be certified and offered in Exchanges, and all Medicaid State plans must cover these services by 2014. Starting with plan years or policy years that begin on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for these services and all plans, except grandfathered individual health insurance policies, must phase out annual dollar spending limits for these services by 2014.”

**Q19: Is it true that health plans are now prohibited from retro-terminating coverage?**  
**[answer updated 12/30/10]**

A19: Under healthcare reform, health plans are not permitted to rescind (or retro-terminate) coverage except in cases of fraud or intentional misrepresentation of a material fact. Our process for rescission of individual coverage already complies with these provisions of reform.

Group health coverage must also comply with the rescission of coverage provisions. Since the prohibition of retroactive termination does not apply in all cases, we anticipate there may be some initial confusion with the application of the regulatory requirements. Following are a few guidelines:

- The prohibition is *not* intended to apply for failure to pay the correct premium on time. (In other words, retroactive termination will still be allowed for failure to pay the correct premium on time.)
- The prohibition is *not* intended to apply when retroactive termination is attributed only to delays of normal terminations because of administrative processes (e.g. administrative delay in notifying an insurer that an employee terminated employment and is no longer eligible for coverage).
- The prohibition *would* likely apply if an employer continued to pay the premium for an employee whose hours were reduced below the eligibility requirement and attempted to retroactively terminate the employee's coverage to the point hours were reduced. In this scenario, the employee may unknowingly rely on the coverage for which premium was paid.
- The prohibition *would* likely apply if an employee inadvertently indicated an incorrect birth date of a dependent child and doing so caused coverage to continue beyond the dependent's normal termination date. Since the incorrect information was not an intentional misrepresentation, coverage could not be terminated retroactively.

If an employer terminates an employee's or dependent's coverage because of an intentional misrepresentation of material fact, the employer must give least 30 days advance notice to the employee or dependent before taking the action to retroactively terminate the coverage. This 30-day requirement is intended to allow the individual to appeal the employer's action.

Nothing prohibits termination of coverage prospectively. In the case of an hour reduction or dependent child who has exceeded the age limit, an employer may terminate their coverage going forward.

More information about rules regarding coverage rescissions is available on our Web site. Visit <http://www.pacificsource.com/healthcare-reform/patients-bill-of-rights.aspx>.

**Q20: What is the Early Retiree Reinsurance Program and how can I apply?**

A20: The Early Retiree Reinsurance Program (ERRP) provides reimbursement to participating employment-based plans for a portion of the costs of health benefits for early retirees and early retirees' spouses, surviving spouses, and dependents. PacificSource is working proactively with our eligible employer groups to provide assistance and resources related to the program. You can find information on our [ERRP Web page](#). The U.S. Department of Health and Human Services has also developed an extensive Web site ([errp.gov](http://errp.gov)) dedicated to the program.

**Q21: How do the new nondiscrimination rules apply to my policy?**

A21: Insured group health plans are required to satisfy nondiscrimination rules as of the first day of their plan year on or after September 23, 2010. The new rules prohibit discrimination with regard to eligibility and health benefits in a way that would favor highly compensated individuals. Providing different benefits to or excluding eligibility to some categories of employees on the basis of age, years of service, or compensation is not permissible under the new law. The Department of Labor has suggested violators could face fines of up to \$100 a day for each employee discriminated against.

We are recommending employer groups either offer coverage to all employees that meet their health plan's hourly requirement and probationary waiting period **or** that they conduct nondiscrimination testing according to provisions of IRS Code 105(5) to confirm their plan complies with the provisions of Public Health Service Act section 2716 as amended by Patient Protection and Affordable Care Act section 1001(5). Treating employees differently in any way, whether in the plan document or in operation, raises red flags that should be checked with counsel—many discrimination problems are not obvious to the untrained eye. If you have concerns about whether or not you are in compliance, you should contact your attorney or CPA for assistance.

**Key Employees:** While discrimination tests encompass several variables preventing PacificSource from determining whether or not a group is discriminatory in favor of highly compensated employees in many cases, we are taking the position that waiving the probationary period on key employees is discriminatory. While we have made exceptions to waive the probationary period for new key employees of large employer groups in the past, PacificSource will no longer make any exceptions on key employees as employer groups renew on or after September 23, 2010.

**Q22: Does the healthcare reform law impact self-funded plans?**

A22: Yes. Many of the changes are to the Public Health Services Act, which applies to insurance issuers and governmental plans. In addition, many of these changes are also made applicable to employer-sponsored plans, including self-funded plans, because PPACA amended ERISA and the Internal Revenue Code (Section 1562(e) of PPACA).