



FAQs – H.B. 1 Health Care Reform Provisions: Cost to Businesses August 3, 2009

Under Ohio's recently enacted state budget (Am. Sub. H.B. 1), new requirements for insurance companies and businesses could help more than 100,000 now uninsured adults obtain coverage. The first page of this document is a summary of the changes. The following pages are answers to frequently asked health care reform questions received by the Ohio Department of Insurance. Anyone with questions about health insurance should call the Department's consumer hotline at 1-800-686-1526 and visit www.insurance.ohio.gov for information.

Under the new law:

- **Continuation of Coverage for Unmarried Adult Children:** Insurers, health insuring corporations and public employee benefit plans must offer parents with employer-sponsored health insurance the opportunity to purchase coverage for their children up to age 28.
 - Group insurance policies and health insuring corporation contracts issued or renewed and plans established or modified on or after July 1, 2010, must provide for this new benefit.
 - A total of 20,000 estimated additional Ohioans will have access to health insurance.
- **Section 125 (Cafeteria) Plans:** Employers with 10 or more employees must offer uninsured employees the opportunity to purchase coverage with pre-tax dollars, saving about 40 percent off the cost of premiums by reducing the income taxes employees pay.
 - Although many Ohio businesses currently offer Section 125 plans, this requirement will begin to be phased in for some employers starting on January 1, 2011.
 - A total of 37,000 estimated additional Ohioans will have access to health insurance.
- **Open Enrollment Program:** Insurers will be limited in how much they can charge people with diabetes, cancer and other pre-existing or chronic conditions who purchase **individual** health policies through open enrollment. Following a phased-in approach, the cap will eventually be 1 1/2 times the lowest rate charged to a person of similar age and gender. This change is eventually expected to reduce open enrollment premiums by at least 50 percent. The cap applies only to the open enrollment coverage purchased in the individual health-insurance market, including non-employer groups. The changes to the Open Enrollment program do not apply to employer group plans.
 - These new rate limitations will affect policies issued or renewed on or after January 1, 2010.
 - Quotas for the number of individuals each insurance company will be required to offer coverage to will be phased in over several years, resulting in an eventual total of 52,000 estimated additional Ohioans able to purchase health insurance through open enrollment.
- **State Continuation Coverage:** Also referred to as Ohio's "mini-COBRA" program, state continuation coverage was permanently extended from 6 to 12 months so that employees of small businesses (less than 20 employees) who lose their jobs can maintain health insurance coverage for themselves and their families at their own cost. This change became effective for policies and contracts issued, delivered or renewed on or after April 1, 2009.

Accredited by the National Association of Insurance Commissioners (NAIC)

Consumer Hotline: 1-800-686-1526

Fraud Hotline: 1-800-686-1527

OSHIP Hotline: 1-800-686-1578

TDD Line: (614) 644-3745

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- **The Health Care Coverage and Quality Council:** A group representing diverse health insurance and health care constituencies, has been formed to advise the Governor and General Assembly on issues related to Ohio's health care system. The Council will work to encourage and advance strategies throughout the public and private sectors that contain cost, enhance quality, and improve health.

The Department of Insurance has created the following FAQs to help Ohio businesses understand how these changes to Ohio law may impact them:

Continuation of Coverage for Unmarried Adult Children

Q: What has changed?

A: Insurers and public employee benefit plans must offer parents with employer-sponsored health insurance the opportunity to purchase coverage for their children up to age 28.

Q: When is the effective date?

A: Insurance policies issued or renewed and plans established or modified on or after July 1, 2010, must provide for this new benefit.

Q: Will employers be required to share the increased cost of insurance for unmarried children up to age 28?

A: No. The employer could share in the additional cost of the premium or it could be the sole responsibility of the covered parent. Businesses are not required to pay for the continued coverage to age 28, but a business can pay for the coverage at its discretion.

Q: Why was coverage continued for unmarried older children up to age 28?

A: Younger adults have one of the highest uninsured rates, often because they are just entering the job market and insurance is either unavailable or unaffordable. Offering this option can provide coverage to this group at no cost to an employer, and can serve as a transition to subsequent coverage.

Q: What type of policies will the new continuation coverage apply to?

A: It applies to all group policies of sickness and accident coverage issued by insurance companies along with group coverage provided by MEWAs, public employee benefit plans and Health Insuring Corporations (HICS), also referred to as Health Maintenance Organizations (HMOs).

Q: Must an employer who does not currently offer coverage to dependents offer coverage to unmarried adult children as a result of this change in the law?

A: No, an employer who does not currently offer coverage to dependents is not required to do so as a result of this continuation of coverage law.

Q: How will the child's coverage be continued?

A: Once the child has reached the limiting age for dependent children in the policy, upon the request of the insured, the insurer, the health insuring corporation (or public employee benefit plan) shall offer to cover any unmarried child until the child attains the age of 28.

Q: What children will be eligible for continued coverage?

A: To receive benefits up to the age of 28, the unmarried child must be: (1) the natural child, stepchild, or adopted child of the employee; (2) a resident of this state or a full-time student at an accredited public or private institution of higher education; (3), not employed by an employer that offers any health benefit plan under which the child is eligible for coverage, and (4) not eligible for coverage under Medicaid or Medicare.

Q. Can the insurer apply a pre-existing condition exclusion period to an eligible child who has had a break in continuous coverage?

A. Yes. The terms of coverage for the child who has previously reached the maximum age are the same as the terms of coverage for any other person covered under the policy. Limits on pre-existing condition exclusions apply to older age children the same as they apply to any other insured.

Q. Will a child be allowed to terminate individual coverage in order to receive coverage under a parent's coverage?

A. Yes. As long as the child otherwise meets the eligibility criteria outlined above.

Q. Will a child who previously reached the maximum age for coverage under the policy and elected COBRA continuation coverage be eligible for continued coverage under the parent's policy after July 1, 2010, when these changes become effective?

A. Yes. As long as the child meets the eligibility criteria stated above.

Q. Must the child have been continuously covered under the parent's policy in order to be eligible for continued coverage after reaching the limiting age for coverage under the policy?

A. No. The child need not have been continuously covered under the parent's policy. The child must meet the eligibility criteria.

Q: If the adult child does not meet the income and support limits to be classified as a dependent under federal tax law, what are the tax implications to the parent of the employer offering this coverage?

A: For purposes of state tax law, the older adult child will be treated as a dependent even if they don't meet the income and support limitations under federal law and the benefit will not be included in the parent's adjusted gross income under state tax laws. Consult your tax advisor to determine the federal tax implications.

Section 125 (Cafeteria) Plans

Q: What has changed?

A: Employers with 10 or more employees must offer uninsured employees the opportunity to purchase coverage with pre-tax dollars, saving about 40 percent off the cost of premiums by reducing the income taxes employees pay.

Q: When will this requirement become effective?

A: The requirement will be phased-in based on employer size. When fully implemented, all employers who employ 10 or more employees must adopt and maintain a cafeteria plan that allows the employer's employees to pay for health insurance coverage by a salary reduction arrangement as permitted under Section 125 of the Internal Revenue Code.

The Department of Insurance will need to work with the Internal Revenue Service and the Department of Labor to develop rules to implement the Section 125 plan requirement in accordance with federal law. Prior to adopting rules and implementing this new requirement placed upon employers, the Department must receive approval from the appropriate federal agencies.

Employers with more than 500 employees must comply with the requirement by no later than January 1, 2011, or six months after the superintendent of insurance adopts rules to implement and enforce this requirement, whichever is later. Employers that employ 150 to 500 employees must meet the requirement by no later than July 1, 2011, or 12 months after the superintendent adopts rules, whichever is later. Employers that employ 10 to 149 employees must be in compliance by January 1, 2012, or 18 months after the superintendent adopts rules.

Q: Will all employers be required to offer Section 125 plans?

A: No. This requirement will not apply to businesses with less than 10 employees.

Q: What is an “employer” and who is an “employee” under this law?

A: An “employer” is any person who has one or more employees; this includes an agent of an employer, the state or any agency or instrumentality of the state, and any municipal corporation, county, township, school district, or other political subdivision or any agency or instrumentality of those.

An “employee” is an individual employed for consideration who works twenty-five or more hours per week, or who renders any other standard of service generally accepted by custom or specified by contract as full-time employment; however, a public employee employed by a township or municipal corporation is an individual hired with the expectation that the employee will work more than one thousand five hundred hours in any year unless full time employment is defined differently in an applicable collective bargaining agreement.

Q: Will companies have any flexibility in complying with this requirement?

A: Yes. Employers can comply with this requirement by offering a Section 125 plan to workers, offering health coverage, reimbursing for health insurance coverage, or providing employees with opportunities to pay for health insurance with pre-tax dollars through other salary reduction arrangements.

Q: How can the Department of Insurance be a resource to businesses and consumers implementing and considering these plans?

A: There will be minimal cost to business to set up and maintain the withholding mechanism for Section 125 Plans. The Department of Insurance will educate, assist, and conduct outreach to employers to simplify administrative processes for businesses with respect to creating and maintaining cafeteria plans, including, but not limited to, providing employers with model cafeteria plan documents and technical assistance with creating and maintaining cafeteria plans that conform to state and federal law. The Department will also educate, assist, and conduct outreach to employees with respect to finding, selecting, and purchasing a health insurance plan to be paid for through their employer's cafeteria plan.

Q: How many people do you anticipate this will impact?

A: A total of 37,000 estimated additional Ohioans will have access to health insurance.

Open Enrollment Program

Q: What has changed?

A: Insurers will be limited in how much they can charge people with diabetes, cancer and other pre-existing or chronic conditions who purchase individual health policies through open enrollment. Following a phased-in approach, the cap will eventually be 1 1/2 times the lowest rate charged to a person of similar age and gender. This change is eventually expected to reduce open enrollment premiums by at least 50 percent. The cap applies only to the open enrollment coverage purchased in the individual health-insurance market, including nonemployer groups, but does not apply to employer group plans.

Q: When is the effective date?

A: These new rate limitations affect policies issued or renewed on or after January 1, 2010.

Q: Does the new open enrollment law change Ohio group insurance plans?

A: No. This law change will only affect the individual insurance market, not group plans. Some individual coverage has been made available through nonemployer groups, such as associations or other entities, but is still individual coverage.

Mini – COBRA (State) Extension

Q: What were the permanent changes to Ohio’s Mini-COBRA?

A: The new law extends state continuation coverage (Ohio’s “mini-COBRA” program) from 6 to 12 months permanently so that employees of small businesses who lose their jobs can maintain health insurance coverage for themselves and their families at their own cost. In addition, entitlement to unemployment compensation is no longer required. To be eligible for mini-COBRA, employees must be involuntarily terminated, other than for gross misconduct. In addition, the continuation coverage must include prescription drug coverage if it is included in the group coverage.

Q: When is the effective date?

A: The changes became effective for policies and contracts issued, delivered or renewed on or after April 1, 2009.

Q: What size businesses are affected by this change?

A: State Mini-Cobra, the state continuation coverage law, applies to small businesses with less than 20 full-time employees as counted under the COBRA rules.

Q: Why was the Mini-COBRA timeframe extended?

A: The timeframe for eligibility under Ohio's "mini-COBRA" law had temporarily been changed from 6 to 12 months in early 2009 to allow Ohioans to take full advantage of federal stimulus premium assistance funds. The revised law makes the change permanent.

Q: Do small employers in Ohio have to notify employees at the time they are involuntarily terminated of their right to continuation of coverage?

A: Yes, Ohio law requires small employers and non-ERISA public and private employer self-insurance plans to notify the employee of the right to continuation of coverage at the time the employee is notified of the termination of employment. Public self-funded plans with 20 or more employees are subject to federal COBRA continuation requirements.

For further information on COBRA or Mini-COBRA see
www.insurance.ohio.gov/Consumer/Pages/Cobra.aspx.

Federal Health Care Reform

Q: How will the reforms being discussed at the federal level affect these changes?

A: The Department is tracking federal reform proposals as they develop, but specific impacts cannot be determined until legislation is enacted. The reform proposals will allow for implementation to occur over several years, while the state reforms are taking affect more immediately to assist those without insurance. Also, we anticipate that the states will be very involved as federal reform activities move from planning to implementation, and Ohio's initiatives will position us to transition efficiently.

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