



# Health Reform Update for Employer Sponsored Health Plans

## Agenda

- Employer compliance requirements in 2010 and 2011
- Grandfathered Plans
- 2014 Employer Mandate

## ○ Legislation

### ➤ The “Affordable Care Act”

- Includes the Patient Protection and Affordable Care Act as amended by the Health Care and Education Affordability Reconciliation Act of 2010

## ○ Regulations

### ➤ HHS Office of Consumer Information and Insurance Oversight at [www.hhs.gov/ociio](http://www.hhs.gov/ociio)

- Regulations issued through August 2010
  - Dependents to age 26
  - Early retiree reinsurance
  - Grandfathered plans
  - “Patient Protections”
  - Pre-existing condition limitations
  - Preventive care
  - Appeal requirements

- Children covered to age 26
- Pre-existing limitations
- Lifetime and annual maximum limits
- Preventive care coverage requirements
- New appeals process requirements
- Section 105 nondiscrimination rules
- FSA, HSA, HRA changes
- Tax change for dependent coverage
- New W-2 reporting
- Tax Credit for Small Employers
- Early Retiree Reinsurance Program

 Requirements effective on plan years beginning after

<b>All Plans (Including Grandfathered Plans)</b>	<b>New Plans Only (Not applicable to Grandfathered Plans)</b>
Children covered to age 26	Section 105 nondiscrimination rules apply to fully-insured plans
No pre-existing condition limitations for children under 19	No cost sharing for certain preventive care services
No lifetime plan limits, restrictions on annual limits	New appeals process
	<b>“Patient Protections”</b> <ul style="list-style-type: none"> <li>• Allow direct access to pediatricians and OB/GYN</li> <li>• Out-of network emergency coverage requirements</li> </ul>

## ○ Children covered to age 26

- Adult children eligible regardless of tax dependent status or full-time student status
  - Married children eligible, plan does not need to cover spouse or dependent of employees child
  - Note: For grandfathered plans, child must not be eligible for coverage under another employer's group health plan
- Plan enrollment rules (i.e. open enrollment, late enrollment and status change) still apply

## ○ Children covered to age 26

- Special enrollment required
  - Employers must offer a special enrollment opportunity to children made eligible due to the rule
  - Must treat as a HIPAA special enrollment
    - i.e. even if employee is not currently enrolled, employer would need to offer employee and adult child an enrollment opportunity
- Premiums
  - May not charge a higher premium for older dependents
- Notice
  - Employer must notify employees of new adult child eligibility
    - May include in benefit communication materials

## Pre-ex limitations

- Plans may not impose pre-existing limitations on children under 19
  - Does not require an employer group plan to provide dependent coverage – it governs how the plan pays claims if it offers coverage to dependents
  - Pre-existing limitations not allowed for all individuals in 2014

## Plan maximum limits

- No lifetime dollar limits on essential health benefits
- Plans can have restricted annual limits no lower than:
  - \$750,000 for plan years beginning after September 23, 2010
  - \$1.25 million plan years beginning after September 23, 2011
  - \$2 million plan years beginning after September 23, 2012
  - No annual limits for essential health benefits permitted beginning in 2014
- Limits on certain services
  - Plan can still include # of days, # of services, and other similar limits
  - Questions remain regarding \$ limits on particular services

2010/2011 (Does not apply to grandfathered plans)

## ○ Preventive care coverage requirements

- Not applicable to grandfathered plans
- Plans must cover certain preventive care with no cost sharing (i.e. deductibles or copays)
  - Includes immunizations, annual check-ups, healthy child visits, breast cancer screenings and other services determined by U.S. Preventive Task Force.
- A general description of covered services:
  - <http://www.healthcare.gov/law/about/provisions/services/lists.html>
- A more comprehensive list of services:
  - <http://www.healthcare.gov/center/regulations/prevention/recommendations.html>

## Claims Appeals Process

- Expanded internal appeals process requirements
- New external appeals process to claims disputes
  - External appeal will be state or federally run
- Fully-insured plans
  - Appeal process will be the responsibility of the carrier
- Self-funded plans
  - Administration of appeal likely will be handled by TPA
  - Plan documents will need to be updated

2010/2011 (Does not apply to grandfathered plans)

## Section 105 (h) nondiscrimination rules

- Will apply to fully-insured plans effective on first plan year after 9/23/10
- Tests to determine if plans discriminate in favor of highly compensated individuals
- Highly compensated employee
  - One of five highest paid officers
  - Shareholder owning more than 5%
  - One of highest 25% paid of all employees

## Section 105(h) nondiscrimination rules

### ➤ Quick check

- If an employer offers the same benefits to all full-time employees with the same eligibility and employer contributions, there will be no problem with the 105(h) rules.
- If an employer clearly provides better benefits, eligibility or contributions to a group of highly compensated employees, the plan will likely violate the 105(h) rules.
- If an employer offers different benefits, eligibility or contributions based on legitimate classes of employees (i.e. salary vs. hourly, locations, etc.) the plan may pass the 105(h) rules and should be analyzed.

## Grandfathered plans

- Any group health plan in effect on 3/23/2010
  - New employees and dependents can be added to grandfathered plans
- Rules issued June 14th, 2010
  - Employers offering multiple benefit options (i.e. giving employees a choice between a high deductible plan and a traditional PPO plan) will need to consider the grandfathered status of each benefit option separately
    - Employer may find that changes will cause one option to lose grandfathered status but not the other

## Reasons plans will lose grandfathered status

- A significant cut or reduction in benefits for specific conditions
  - Eliminate “all or substantially all benefits to diagnose or treat a particular condition”
- Raising coinsurance that is based on a percentage
  - Plans may not raise % charged for coinsurance when coverage is expressed as a percentage
- Reduce annual limits

## Reasons plans will lose grandfathered status

### ➤ Reducing employer contributions

- Employer may not decrease the percent of premiums the employer pays by more than 5% from contribution level on March 23rd, 2010
- Example:
  - On March 23, 2010, employer contributes a flat \$300 to an enrollee with single coverage with a total premium of \$500
    - »  $\$300 = 60\%$  of \$500
  - Plan's rate increases to \$600 the following plan year
  - Employer must contribute at least \$330 to retain grandfathered status
    - »  $\$330 = 55\%$  of \$600

## Reasons plans will lose grandfathered status

- Significantly raising deductibles or fixed copayment charges
  - New deductibles and copayments will be compared to those in effect on March 23, 2010
  - To retain grandfathered status, plans can increase deductibles and copays by no more than a fixed percentage (or \$5, whichever is greater)
  - Medical inflation since March 23, 2010 plus 15%

Grandfathered plan deductible change example:

<b>Plan Deductible on March 23, 2010</b>	<b>\$1000</b>
<b>January 1, 2011</b>	
Medical CPI-U between March 23, 2010 and January 1, 2011	4%
Maximum deductible on 1/1/2011 = 19% above March 23, 2010 level (4% Medical CPI + 15%)	<b>\$1,190</b>
<b>January 1, 2012</b>	
Medical CPI-U between March 23, 2010 and January 1, 2012	10%
Maximum deductible on 1/1/2012 = 25% above March 23, 2010 level (10% Medical CPI + 15%)	<b>\$1,250</b>

## Grandfathered plans

### ➤ Notice requirement

- Plans which maintain grandfathered status must include notice in plan materials
- Model notice released with regulations



# Grandfathered Plans

...this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. **Being a grandfathered health plan means that your plan may not include certain consumer protections of the ACA that apply to other plans**, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans **must comply with certain other consumer protections** in the ACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which **protections** apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator ...

## Other 2010/2011 Changes

- New W-2 reporting
  - Applicable for tax year 2011, employer must report aggregate cost of health coverage on W-2
  - Does not effect tax status of benefits
- Federal tax no longer applies to older children coverage
  - Effective March 30, 2010 coverage for child who has not reached age 27 by the end of a tax year is not taxable to employee
- Over-the-counter (OTC) drugs not an eligible expense for FSA, HSA and HRA
- Effective 1/1/2011 - HSA penalty for withdrawal for non-medical expenses increased from 10% to 20%

## ❶ Tax credit for small employers

- Up to a 35% credit for beginning with tax years 2011 for employers with up to 25 FTEs

## ❷ Early retiree reinsurance program

- Employers providing early retiree coverage to former employees age 55-65

## 2014 Summary

- State based insurance exchanges
- Subsidies for low and middle income individuals
- Employer mandate or “Play or Pay”

- Subsidies for individuals purchasing health insurance through the exchange
  - Premium tax credits & cost sharing reduction for individuals purchasing coverage in an exchange
  - Available to individuals with income up to 400% of Federal Poverty Level (FPL)
    - 2010 = \$43,320 for individual, \$88,200 family of four
  - Not available to individuals offered qualifying employer provided coverage at “affordable cost”
    - Affordable is defined as employee premium no more than 9.5% of the employee’s household income

## ○ Employer Mandate or “Free Rider Penalty”

- Applies to employers with 50 or more employees
- Full-time employees defined as 30 hours/week
- Employers not required to offer health insurance but will pay a penalty if certain conditions are met
- Penalty applies if an employee opts out of employer plans and purchases coverage and receives a subsidy or cost sharing reduction through an exchange

- Employers who offer coverage to all full-time employees
  - Penalty = \$3,000/yr (\$250/mo.) for each employee who purchases subsidized coverage through an exchange
- Employers who do not offer coverage to all full-time employees
  - If at least one employee purchases subsidized coverage through the exchange
  - Penalty = \$2,000/yr (\$166.67/mo) multiplied by the total number of FTEs (not counting first 30 EEs)

## Example 1 - Employers who offer coverage to all full-time employees

- 100 employees
  - Employee mo. Contribution S=\$150 F=\$400
- 5 employees qualify for subsidy and purchase coverage through an exchange
  - 2 FT single employees earning \$18,000/yr
    - \$1500 mo income ÷ \$150 premium = 10% of income
  - 3 FT employees with families earning \$42,000/yr
    - \$3,500 mo income ÷ \$400 premium = 11.4% of income
- Employer penalty = \$1,250/mo

## Example 2 - Employers who do not offer coverage to all full-time employees

- 100 employees
- If at least 1 employee qualifies for subsidy and purchases coverage through an exchange
- Employer penalty  $70 \times \$166.67 = \$11,666.90/\text{mo}$

## ⊗ Employer Mandate or “Play or Pay” Plan Design Considerations...

- Adjust employer contribution to minimize penalty
- Eligibility rules (i.e. 30 hours or more)
- Number of employees working full-time vs. part-time
- Offer low cost plan option

