Health Care Reform
For Employer-Sponsored Health Plans

October 2010 Update

Benefits, Payroll, and
Risk Management Consulting

Legislation & Regulations Update

Legislation

- The "Affordable Care Act"
  - Includes the Patient Protection and Affordable Care Act (3/23/10) as amended by the Health Care and Education Affordability Reconciliation Act of 2010 (3/30/10)

Regulations

- HHS Office of Consumer Information and Insurance Oversight at www.hhs.gov/ociio
  - Regulations issued through September 2010
    - Dependents to age 26
    - Early retiree reinsurance
    - Grandfathered plans
    - "Patient protections"
    - Pre-existing condition limitations
    - Lifetime and annual limits
    - Appeal requirements
    - Preventive care coverage

Legislation & Regulations Update

- Regulations and/or guidance issued
  - Applies to all plans including grandfathered plans
    - Children covered to age 26
    - Pre-existing limitations
    - Lifetime and annual maximum limits
  - Does not apply to grandfathered plans
    - Patient protections
      - Emergency coverage and physician access
    - Preventive care coverage requirements
    - New appeals process requirements
- Expect regulations and/or guidance soon
  - Section 105(h) non-discrimination rules
    - Does not apply to grandfathered plans

Reasons Plans 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 dollar plan limits
- Reducing employer contributions
  - May not decrease the percent of premiums the employer pays by more than 5% from contribution level on 3/23/2010

Reasons Plans Lose Grandfathered Status

- Significantly raising deductibles, copayments or maximum out-of-pocket
  - Deductibles, copayment or Max OOP can be no more than 15% + medical inflation (or $5 if greater) above that in effect 3/23/10

Plan Deductible on March 23, 2010	$1000
January 1, 2011	
Medical CPI-U between March 23, 2010 and January 1, 2011	0.3%
Maximum deductible on 1/1/2011 = 15.3% above March 23, 2010 level (0.3% Medical CPI + 15%)	**$1,153**
January 1, 2012	
Estimate of Medical CPI-U between March 23, 2010 and January 1, 2012	5%
Maximum deductible on 1/1/2012 = 20% above March 23, 2010 level (5% Medical CPI + 15%)	**$1,200**

Grandfathered vs. Non-grandfathered

All Plans (Including Grandfathered Plans)	New Plans Only (Not applicable to Grandfathered Plans)
Children covered to age 26	Section 105(h) 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
	"Patient protections" ▪ Allow direct access to pediatricians and OB/GYN ▪ Out-of network emergency coverage requirements

Grandfathered Plans - Notice Requirement

- Plans which maintain grandfathered status must include notice in plan materials
- Model notice released with regulations
- Notice should be distributed for plans renewing after 3/23/10

Grandfathered Plans – Model Notice

…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 …

Children Covered to Age 26

- Effective first plan year after 9/23/2010 adult children eligible until they reach age 26
  - Married children eligible; however, plan does not need to cover a child's spouse or dependents
    - Note: For grandfathered plans, child must not be eligible for coverage under another employer's group health plan
- Plans affected
  - Yes – medical plan, HRA
  - No – stand alone dental and vision plan, HSA
  - Not required but… – Section 125 health FSA not required but reimbursements would be allowed under changes to tax code

Children Covered to Age 26

- Premiums
  - Employer may not charge a higher premium for dependents based on age
- Special enrollment required
  - Employers must offer a special enrollment period of at least 30 days
  - Must treat as a HIPAA special enrollment
    - i.e. even if employee is not currently enrolled, employer would need to offer employee and newly-eligible adult child an enrollment opportunity
- Issues with early adoption of adult child coverage
  - Many insurance companies offered some form of coverage for adult children prior to required effective date
  - Employer may still be required to offer special enrollment period and notice on effective date if early adoption did not meet all of the requirements

Children Covered to Age 26 Notice Requirement

- Employer must notify employees of new adult child eligibility
  - May include in benefit communication materials
- Model language included in regulations
  www.dol.gov/ebsa/healthreform

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the first plan year beginning on or after September 23, 2010.] For more information contact the [insert plan administrator or issuer] at [insert contact information].

Prohibition on Rescissions

- Plan must not retroactively rescind coverage except in the case of fraud or an intentional misrepresentation
- Retroactive termination due to failure to pay premium is not a rescission
- Impact on employer enrollment procedures
  - Example in regulations – employee move from FT to PT but employer continues to cover by mistake for three months. Employer may not retroactively terminate coverage once discovered
  - Possible COBRA problem
    - COBRA QB fails to pay premium but employer continues to pay insurance company
    - Insurance company may refuse to retroactively terminate coverage when employer discovers mistake

Pre-existing Condition Limitations

- Plans may not impose pre-existing condition limitations on children under 19
  - Effective first plan year after 9/23/10
  - Applies to grandfathered plans
  - 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 condition limitations not allowed for all individuals beginning in 2014

Plan Maximum Limits

- Effective first plan year after 9/23/1010 - No lifetime dollar limits allowed on essential health benefits
- Plans may have annual limits no lower than:
  - $750,000 for plan years beginning after September 23, 2010
  - $1.25 million for plan years beginning after September 23, 2011
  - $2 million for plan years beginning after September 23, 2012
  - No annual limits for essential health benefits 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
- Mini-med plans can apply to HHS for exception

Plan Maximum Limits

- Enrollment opportunity
  - Individual still eligible for coverage who have exceed existing lifetime or annual maximums must be given opportunity to re-enroll
- Notice requirement
  - Notice to individuals who have exhausted their lifetime maximum www.dol.gov/ebsa/healthreform

The lifetime limit on the dollar value of benefits under [Insert name of group health plan or health insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator or issuer] at [insert contact information].

Preventive Care Coverage Requirements

- Effective for plan years beginning on or after 9/23/2010 group health plans must provide certain preventive care services without cost-sharing (e.g., copayment, coinsurance or deductibles)
- The rules do not apply to grandfathered plans
- Plans may still impose cost sharing on out-of-network preventive services

Required Preventive Services

- Evidence-based preventive services
  - Rated "A" or "B" by the U.S. Preventive Services Task Force
    - Includes breast and colon cancer screenings, screenings for vitamin deficiencies during pregnancy, screenings for diabetes, high cholesterol and high blood pressure screening and tobacco cessation counseling
- Routine immunizations
  - As recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
    - Includes routine childhood immunizations and periodic tetanus shots for adults

Required Preventive Services *(cont'd)*

- Evidence-informed preventive care and screenings for infants, children and adolescents
  - Recommended by the Health Resources & Services Administration (HRSA)
    - Includes regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations and screening, and counseling to address obesity
- A general description of covered services

  www.healthcare.gov/law/about/provisions/services/lists.html
- A more comprehensive list of services:

  www.healthcare.gov/center/regulations/prevention/recommendations.html

Preventive Care

- Other requirements and issues
  - If the list is updated, changes will be effective for plan years beginning one year after the date of the change
  - Questions remain regarding when certain services are considered preventive vs. diagnostic or treatment
- Cost impact
  - Obviously dependent on current plan preventive benefits
  - HHS overall estimates
    - 0.6% (about $4) increase in additional paid benefits per person per year
    - Premium increases of approximately 1.0 % - 1.5% on average for enrollees in non-grandfathered plans

Claims Appeals Process and External Review

- Expanded internal appeals process requirements
  - Build on existing Department of Labor claims rules and regulations
  - Now applies to non-ERISA plans
- New external review process
  - External review will be to a state for most fully-insured plans and federally-run for self-funded plans or fully-insured plans in states which do not implement the necessary procedures
- Fully-insured plans
  - Appeal process will continue to be principally the responsibility of the carrier
- Self-funded plans
  - Administration of appeal likely will be handled by TPA – employers should review administrators ability to handle new appeals rules

Patient Protection Provisions

- Effective first plan year after 9/23/2010
  - Do not apply to grandfathered plan
- Choice of health care professionals
  - Plans that require designation of a primary care provider must permit:
    - Participants to designate any participating provider (in the network) who agrees to treat them
    - Participants to designate pediatricians as a child's primary care provider
  - Plans may not require an authorization or referral for OB/GYN services
  - Requirements apply only to in-network providers only

Patient Protection Provisions

- Emergency services
  - Plans may not require pre-authorization for emergency care
  - Must cover emergency services at out-of network providers
  - Plans may not impose any administrative requirement for out-of-network emergency services more restrictive than the requirements that apply to in-network
  - May not impose copayment or coinsurance cost-sharing for out-of-network emergency services greater than for in-network

Non-Discrimination Rules

Section 105(h) nondiscrimination rules

- Health plans may not discriminate in favor of highly compensated employees
  - Already applies to self-funded plans - will now apply to fully-insured, non-grandfathered plans effective on first plan year after 9/23/10
- Highly compensated employee (HCE)
  - One of five highest paid officers
  - Shareholder owning more than 5%
  - One of highest 25% paid of all employees
- Penalty
  - Self-funded plans – value of benefit received by HCE treated as taxable income
  - Fully-insured plans – not clear yet, but could be up to $100 per day per HCE

Non-Discrimination Rules

- Quick check
  - Prior to doing a detailed analysis, employers can often evaluate if they have possible issues with 105(h) rules
    - If an employer offers the same benefits to all full-time employees with same eligibility and employer contributions, unlikely there could be a 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 but should be analyzed

Non-Discrimination Rules

- Common contribution strategy for fully-insured plans
  - Example 1 - Employer pay 100% of premiums for owners and executive and 75% for other employees.
    - Clearly violates 105(h) rules - what should the employer do?
      - Adjust HCE contribution to equal other employees
      - Compensate HCE in other ways through taxable income
  - Example 2 - Employees located in Minnesota and Ohio
    - Minnesota plan is $500 deductible plan with 25% employee contribution, Ohio plan is $1000 deductible plan with 25% employee contribution
    - Benefit classification based on location is included in 105(h) regulations as an example of a classification based on a bona fide business purpose.
      - May be allowed under 105(h) rules

- New W-2 reporting
  - Optional for tax year 2011, employer must report aggregate cost of health coverage on W-2
  - Will be required for tax year 2012
  - Does not affect tax status of benefit
- Tax change for dependent coverage
  - Effective March 30, 2010, coverage for older dependents is not taxable to the employee
    - Old tax rules apply to coverage for children until 3/29/2010
    - Applies to any child who has not reached age 27 by the end of a tax year
    - Affects health plan, Section 125 health FSA, HRA
      - Does not apply to health savings account

- FSA, HSA, HRA changes
  - Over-the-counter (OTC) drugs not an eligible expense for FSA, HSA, HRA
    - Effective 1/1/2011
    - Insulin, OTC that are prescribed by MD, and OTC medical supplies are still eligible
  - HSA penalty for withdrawal for non-medical expenses increased from 10% to 20%
    - Effective 1/1/2011

Tax credit for small employers

- Up to a 35% credit for tax years 2010-13, 50% for plans purchased through exchange beginning in 2014
  - Full credit for employers with 10 or fewer full-time equivalent employees and average annual wages of less than $25,000
  - Partial credit for employers with up to 25 full-time equivalent employees and average annual wages up to $50,000
  - Employer must pay at least 50% of premiums
  - Owners, 2% S-corp owners, any owner of more than five percent of businesses are not considered employees
    - Wages or hours of owners and partners are not counted in determining FTEs or average annual wages
  - Tax exempt organizations eligible for partial credit (up to 25%)
- IRS website
  - http://www.irs.gov/newsroom/article/0,,id=223666,00.html

- Early retiree reinsurance program
  - Applies to employers already providing early retiree coverage (age 55-65)
  - Federal government to reimburse plans 80% of claim costs between $15,000 - $90,000 per year
    - Payments will need to be used to lower participant costs
      - HHS to issue regulations on use of payments
  - Employers will have to submit an application to HHS
  - Program scheduled to launch June 2010
  - Program ceases by 1/1/2014 or when $5B funding is exhausted

- New statement of benefits and coverage form
  - Must be distributed by 3/23/2012
  - HHS must issue regulations by 3/23/2011
  - Must meet certain requirements
    - No more than 4 pages
    - No fonts smaller than 12 points
    - Must include examples
    - Will be uniform areas that must be addressed
- 60-day advanced notice rule
  - Once new notice rule is in effect changes to plan will need to be communicated to employees at least 60 days in advance of the change

- Section 125 flexible spending account
  - Employee annual contributions capped at $2,500
    - Indexed to inflation beginning on 2014
- Employee notice requirement
  - Beginning March 2013
  - Employers must provide notice to all employees
    - Exchange details
    - Premium tax credits and cost reductions that may be available to employee

Summary

- State-based insurance exchanges
- Subsides for low and middle income individuals
- Employer mandate or “Play or Pay”
- Free-choice vouchers
- Employer health coverage reporting requirements
- Limit on waiting periods
- Wellness plan changes

- State- or federal-based health insurance exchanges
  - Coverage for individuals and employers up to 100 employees
  - Carriers selling plans through the exchange must offer standardized plan options
- Most importantly to employer-sponsored plan
  - Exchange will administer subsidies and cost-sharing reductions for eligible individuals and regulate penalties for employers

- 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
  - Penalty applies if an employee opts out of employer plan and purchases coverage and receives a subsidy or cost-sharing reduction through an exchange
- "Minimum Essential Coverage" vs. "Essential Health Benefits"
  - Essential Health Benefits
    - Defines what a plan offered through the exchange must cover
    - Must include coverage in a variety of categories
  - Minimum Essential Coverage
    - Minimum threshold for a plan employer must offer to meet mandate
    - To avoid penalty, employer must offer minimum essential coverage where plan pays at least 60% of the total costs incurred by members

- 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: Single=$150 and Family=$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 x $166.67 = $11,666.90/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

Free choice voucher

- Employers must offer free choice vouchers to qualified employees
  - Employee contribution between 8% - 9.5% of household income
  - Income not greater than 400% of FPL
- Amount of voucher equals amount employer would have paid for coverage
- Employee can apply the voucher to the cost of exchange-provided coverage

Reporting requirements

- Employers with more than 50 employees
  - Applies to employers with less than 50 employees where the employee's share of the cost of coverage exceeds 8% of the employee's wages
- Must file annual report including:
  - If employer offers full-time employees minimum essential coverage
  - Name of each employee and dependent covered
  - Number of full-time employees
  - Length of any waiting period and the monthly premium of lowest cost option

"The Cadillac Tax"

- 40% excise tax on cost of health benefits over $10,200 annually for individuals and $27,500 for other than individual coverage
  - Adjusted for age and gender demographics of the group
  - Limits may be adjusted if health care inflation rate exceed expected level between now and 2018
  - HRA, HSA and FSA employer contributions included
  - Cost of separate dental and vision coverage excluded