



Howard W. Phillips & Co.

Health Care Reform

Health Plans Overview

Topics

- Status of health care reform
- Grandfathered plans
- Timeline for compliance

Health Care Reform – What is It?

- Patient Protection and Affordable Care Act (PPACA) – signed on March 23, 2010
- Health Care and Education Reconciliation Act (Reconciliation Act) – signed on March 30, 2010
- The health care reform law makes sweeping changes to our nation's health care system

Health Care Reform – What's Next

- **Action in Congress**

- Republicans control House
- Democrats have majority in Senate
- Attempts to repeal or revise the law
 - Form 1099 reporting requirement repealed
 - Free choice voucher provision repealed

- **Court Cases**

- Courts split on constitutionality
- Supreme Court will take up the issue in 2012

Health Care Reform – Which Plans Must Comply?

- **New plan rules generally apply to group health plan coverage**
- **Exceptions**
 - Excepted benefits (some health FSAs, dental, vision, etc.)
 - Retiree-only plans
 - Group health plans covering fewer than 2 employees

GRANDFATHERED PLANS

Grandfathered Plans

- **Grandfathered Plans**
 - A group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of the health care reform legislation
- **Certain health care reform provisions don't apply to grandfathered plans, even if coverage is later renewed**
 - New employees can still enroll
 - Family members of current enrollees can still join
- **Regulations provide guidance on changes that could take a plan out of “grandfathered” status**
 - **Plans will have to analyze changes at each renewal**

Grandfathered Plans - Which Rules Don't Apply?

- Patient Protections
- Nondiscrimination rules for fully-insured plans
- New appeals process
- Quality of care reporting
- Insurance premium restrictions
- Guaranteed issue and renewal of coverage
- Nondiscrimination based on health status/in health care
- Comprehensive health insurance coverage
- Limits on cost-sharing
- Coverage for clinical trials

Grandfathered Plans - Which Rules Apply?

- **Health Insurance Changes – Prohibitions on:**
 - Lifetime and annual limits
 - Pre-existing condition exclusions
 - Rescissions
 - Excessive waiting periods
- **Required coverage of adult children up to age 26**
- **Summary of benefits and coverage**
- **Reporting medical loss ratio**

Grandfathered Plan Regulations

- **Permitted Changes**

- Cost adjustments consistent with medical inflation
- Adding new benefits
- Modest adjustments to existing benefits
- Voluntarily adopting new consumer protections under the health care reform law
- Changes to comply with state or federal laws

Grandfathered Plan Regulations

- **Prohibited Changes**

- Significantly reducing benefits or contributions
- Significantly raising co-payment charges or deductibles
- Raising co-insurance charges
- Adding or tightening annual limits
- Changing insurance companies (not TPA) - **Changing insurers is now permitted!**

- **Special Rule for Insured Collectively Bargained Plans**

- **Additional Requirements**

- Disclose grandfathered status
- Status can be revoked if try to avoid compliance

TIMELINE OF CHANGES

Health Care Reform - Effective Upon Enactment

- **Small Employer Tax Credit**
 - For small employers that provide health coverage to employees through qualifying arrangement
 - Fewer than 25 full-time equivalent (FTE) employees
 - Average annual wages of less than \$50,000
- **Amount of credit is based on premiums paid and depends on employees and wages**
 - Maximum credit is 35 percent of premiums paid
 - Phased out if more than 10 FTEs and more than \$25,000 in average annual wages
- **IRS Notices 2010-44 and 2010-82**

Health Care Reform - Effective Upon Enactment

- **Automatic Enrollment for Large Employers**
 - Effective on date of enactment?
 - Yes, but need regulations so compliance delayed
 - **Regulations to be issued by 2014**
- **Large employer = more than 200 full-time employees**
- **Adequate notice and opt-out required**
- **Other questions to be addressed in regulations**

Effective in 2010

- **High-Risk Pool Program**

- Available for individuals with pre-existing conditions and no creditable coverage for 6 months
- Cannot have employees drop coverage to join high-risk pool
- 27 states are running the high-risk pool on their own, while HHS is running the pool in the remaining 23 states and the District of Columbia

- **Early Retiree Reinsurance Program**

- Temporary program to reimburse costs of providing coverage for retirees 55 and older who are not eligible for Medicare
- Pays 80 percent of eligible claims
- Application and certification requirements apply
 - **Application deadline was May 5, 2011**
 - **HHS will not accept reimbursement requests for claims incurred after Dec. 31, 2011**

**Effective for Plan Years
Beginning on or after
Sept. 23, 2010**

Age 26 Coverage Rule

- **Coverage must be offered to adult children to age 26**
 - Applies to plans that cover dependent children
 - Includes grandfathered plans, unless child is eligible for employer coverage (before 2014)
- **Children to be covered**
 - Married and unmarried children
 - Not spouses or children of covered adult children
 - Interim final rules give more information
- **Federal tax exclusion applies to coverage**
- **State mandates above this level continue to apply**

Age 26 Coverage – Interim Final Coverage

- **Definition of dependent restricted**
 - Can only be defined by relationship
 - Other factors (financial dependence, residency, student status, employment, eligibility for other coverage) generally can't be used as basis for denial
- **Qualified dependents must be:**
 - Offered same coverage as similarly-situated individuals
 - Given the same rates for coverage
 - Provided with a 30-day special enrollment opportunity and notice

Lifetime and Annual Limits

- **No lifetime limits on essential benefits**
- **Restricted annual limits on essential benefits**
 - Allowed for plan years beginning before Jan. 1, 2014
- **Essential benefits generally include:**
 - Ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehab services, lab services, wellness and disease management, pediatric care
- **Some regulations issued, waiting on others**
- **Rules apply to non-grandfathered and grandfathered plans**

Lifetime and Annual Limits

- **Lifetime Limits**

- Notice and special enrollment required for individuals who reached lifetime limit

- **Restricted Annual Limits**

- After Sept. 23, 2010: \$750,000
- After Sept. 23, 2011: \$1.25 million
- After Sept. 23, 2012 (before Jan. 1, 2014): \$2 million

- **Waivers available for annual limit requirements**

- Designed to help mini-med plans
- **Sept. 22, 2011 – Deadline for waiver application**

Annual Limit Waivers

- **Plans could apply for waiver of annual limit minimum if access to or cost of benefits would be significantly affected by limit**
- **Plan or policy must have existed before Sept. 23, 2010**
 - Exceptions for certain mandated or group policies
- **Waiver applies until plan years beginning on or after Jan. 1, 2014 – when all annual limits on essential health benefits are prohibited**
- **If plan obtained a waiver, must notify participants annually and provide annual updates to HHS**

Access to Coverage

- **No rescission of coverage**
 - Applies to group and individual coverage
 - Exception for fraud or intentional material misrepresentation
 - Individual must be given prior notice of cancellation
- **No pre-existing condition exclusions or limitations for children under age 19**
 - This prohibition will apply to everyone in 2014
- **Apply to non-grandfathered and grandfathered plans**

Patient Protections

- **Apply to non-grandfathered plans only**
- **Limits on preauthorization and cost-sharing**
 - No cost-sharing for some preventive care (including well-child care) and immunizations
 - No preauthorization or increased out-of-network cost-sharing for emergency services
 - No preauthorization or referral for ob/gyn care
 - New preventive care requirements for women (including no cost sharing for contraceptives) are effective for plan years beginning on or after Aug. 1, 2012.
- **Patients can choose any available participating primary care provider (or pediatrician)**

Nondiscrimination Rules for Fully-Insured Plans

- **Nondiscrimination Requirements**
 - Apply to non-grandfathered fully-insured plans
 - Plan cannot discriminate in favor of highly-compensated employees
 - Eligibility test
 - Benefits Test
- **HCE:**
 - Five highest paid officers, more than 10 percent shareholder, or highest paid 25 percent of all employees
- **Effective date delayed for regulations**

Appeals Process Changes

- **New rules for non-grandfathered plans**
- **Plans must have an effective internal appeals process:**
 - Include rescissions as denials
 - Provide a full and fair review and avoid conflicts of interest
 - Follow new notice standards
 - Continue coverage until appeal is resolved
- **Grace period until Jan. 1, 2012, for some rules**
- **Plans must meet minimum requirements for external review (state or federal)**

Effective in 2011

- **Employer Reporting**

- Employers will be required to report the aggregate value of employer-sponsored health coverage on employees' Form W-2
- Optional for 2011 tax year; mandatory for later years
- **For small employers – optional for 2012 tax year and beyond**

- **Simple Cafeteria Plans for Small Businesses**

- Small employers with 100 or fewer employees during one of the last 2 years
- Will be treated as meeting nondiscrimination rules
- Contribution, eligibility and participation requirements apply
- Effective in 2011

Effective in 2011

- **Increased Tax on HSAs**

- HSA distributions not used for medical expenses previously subject to tax of 10 percent
- Tax amount increased to 20 percent if funds not used for medical expenses

- **No Reimbursement for OTC Medicine or Drugs without a Prescription**

- Reimbursement only allowed for medicine or drugs with a prescription (or insulin)
- Health FSAs, HRAs, HSAs and Archer MSAs
- Applies to expenses incurred after Dec. 31, 2010

Effective in 2012

- **Summary of Benefits and Coverage**
 - Applies to non-grandfathered and grandfathered plans
 - Additional disclosure requirement
 - Simple and concise explanation of benefits
 - Template and guidance available
 - Instructions
 - Sample language
 - Uniform glossary of terms
 - **Compliance Deadline:**
 - Open enrollment periods beginning on or after **Sept. 23, 2012**
 - Plan years beginning on or after **Sept. 23, 2012** for other enrollees
 - Issuers must provide to plans effective **Sept. 23, 2012**

Effective in 2012

- **Summary of Benefits and Coverage**

- Disclosure requirements

- Must be provided by issuer to GHP when a policy is renewed or reissued, upon request and at other specific times
 - GHP must provide to participants and beneficiaries at certain times, such as annually at renewal and upon request

- Material modifications not in connection with renewal must be provided at least 60 days BEFORE effective date

Effective in 2013

- **Health FSA Limits: \$2,500 per year**
 - Currently no limit on salary reductions, although many employers impose limit
 - Limit is \$2,500 for 2013; indexed for CPI after that
 - Does not apply to dependent care FSAs
- **Medicare Part D Subsidy Deduction Eliminated**
 - Employers that provide retiree prescription drug coverage could deduct subsidy amount
 - That part of deduction is eliminated in 2013

Effective in 2013

- **New Notification Requirements for Employers**
 - Must notify new employees regarding health care coverage
 - At time of hiring
- **Notice must include information about 2014 changes:**
 - Existence of health benefit exchange
 - Potential eligibility for subsidy under exchange if employer's share of benefit cost is less than 60 percent
 - Risk of losing employer contribution if employee buys coverage through an exchange

2014 Changes

Individual Responsibility

- **Jan. 1, 2014:** Individuals must enroll in coverage or pay a penalty
- **Penalty amount:** Greater of \$ amount or a % of income
 - 2014 = \$95 or 1%
 - 2015 = \$325 or 2%
 - 2016 = \$695 or 2.5%
 - Family penalty capped at 300% of the adult flat dollar penalty or “bronze” level premium
- **Subject of court cases – unconstitutional?**

Health Insurance Exchanges

- **States will receive funding to establish health insurance exchanges**
- **Individuals and small employers can purchase coverage through an exchange (Qualified Health Plans)**
 - In 2017, states can allow employers of any size to purchase coverage through exchange
- **Individuals can be eligible for tax credits**
 - Limits on income and government program eligibility
 - Employer plan is unaffordable or not of minimum value

Employer Responsibility

- Large employers subject to “Pay or Play” rule
- Applies to employers with 50 or more full-time equivalent employees in prior calendar year
- Penalties apply if:
 - Employer does not provide coverage and any FT employee gets subsidized coverage through exchange OR
 - Employer does provide coverage and any FT employee still gets subsidized coverage through exchange

Employer Penalty Amounts

- **Employers that do not offer coverage:**
 - \$2,000 per full-time employee
 - Excludes first 30 employees
- **Employers that offer coverage:**
 - \$3,000 for each employee that receives subsidized coverage through an exchange
 - Capped at \$2,000 per full-time employee (excluding first 30 employees)

Health Insurance Vouchers

- **Voucher program repealed**
- **Vouchers were to be available to “Qualified Employees”**
 - Household income not more than 400 percent of federal poverty level
 - Required plan contribution between 8 and 9.8 percent of income
- **Qualified employees were to use vouchers to buy coverage through exchange**
- **Employers that offer coverage (and make a contribution) were to provide vouchers**
 - Voucher would have been for amount employer would have contributed to plan

Employer Reporting

- **Employers will have to report certain information to the government**
 - Whether employer offers health coverage to full-time employees and dependents
 - Whether the plan imposes a waiting period
 - Lowest-cost option in each enrollment category
 - Employer's share of cost of benefits
 - Names and number of employees receiving health coverage

2014 - A Big Year for Health Care Reform

- **No pre-existing condition exclusions or limitations**
 - Applies to everyone and all plans
- **Wellness program changes**
- **Limits on out-of-pocket expenses and cost-sharing**
- **No waiting periods over 90 days**
- **Coverage of clinical trial participation**
- **Guaranteed issue and renewal**

2018 – Cadillac Plan Tax

- **40 percent excise tax on high-cost health plans**
- **Based on value of employer-provided health coverage over certain limits**
 - \$10,200 for single coverage
 - \$27,500 for family coverage
- **To be paid by coverage providers**
 - Fully insured plans = health insurer
 - HSA/Archer MSA = employer
 - Self-insured plans/FSAs = plan administrator
- **More guidance expected**

THANK YOU