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Spring Seminar: Strategic HR – *March 18, 2011*

Health Care Reform

2010-2011 and Beyond

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Health Care Reform 2010

- How the law affects employers and health plans
- Grandfathered plans
- Health care reform changes that are effective:
  - What has happened so far
  - Changes as of today
  - 2011 and beyond
- Taxes and Penalties

Small Employer Tax Credit

- Amount of credit
  - Up to 35 percent of premium costs paid in 2010 (25 percent for tax-exempt employers)
  - On Jan. 1, 2014, increases to 50 percent (35 percent for tax-exempt employers)
- Depends on employees and wages
  - The credit phases out gradually for:
    - Employers with average wages between $25,000 and $50,000 and
    - Employers with the equivalent of between 10 and 25 full-time workers

Coverage of Children

- Plans that cover dependent children must cover them up to age 26
- No grandfathering-all plans must comply
  - Except - Grandfathered plans may exclude children under age 26 if *eligible* for their own employer-sponsored coverage.
  - Exception ends January 1, 2014

Coverage of Children

- Generally effective first plan year beginning after September 23, 2010
- Employers may elect to extend coverage before the deadline
  - Many insurers agreed to limited effective date of June 1, 2010
  - Children who would lose coverage due to age after May 30, 2010

Coverage of Children

- Permitted Exclusions
  - Children/spouses of children are not covered
  - Limited scope plans provided under a separate insurance policy dental/vision
    - Participants must elect coverage and
    - Pay additional premium for coverage

Coverage of Children

- Plans May Not
  - Charge more for coverage of adult dependent children than for similarly situated dependents
  - Offer different benefit packages
  - Exclude children on the basis of:
    - Student status
    - Financial dependency
    - Residency
    - Marital Status

Coverage of Children

- Coverage under both Parents Plans
- Parent & Child with same employer
- Health FSAs not Subject
  - not the only group health plan of employer
  - No "employer" contributions; or
    Employer contribution not greater than $500

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Coverage of Children

- Enrolling:
  - Plans must offer a 30-day enrollment opportunity and provide written notice regarding enrollment rights
  - Children covered under COBRA must be given the opportunity to enroll in a non-COBRA plan
  - Even children never enrolled in plan must have the opportunity to enroll
- Model Notice –
  - http://www.dol.gov/ebsa/dependentsmodelnotice.doc

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Grandfathered Plans

Grandfathered Plans

- Insured or self-insured group health plan offered that was in existence on March 23, 2010
- New family members
- New participants
- Added to assure individuals that they can keep the coverage they had on date of enactment

Grandfathered Plans

- Loss of Grandfathered Plan Status
  - A group health plan will lose grandfathered status if any of the following events occur:

Grandfathered Plans

- ***Elimination of Benefits*** – All, or substantially all, benefits to diagnose or treat a particular condition are eliminated

- ***Increase in Percentage Cost-Sharing Requirements*** – Percentage cost-sharing requirements (e.g. coinsurance) are increased to any extent after March 23, 2010

Grandfathered Plans

- ***Increase in Copayment Fixed Amount Cost-Sharing Requirements*** – Fixed amount copayments are increased more than the greater of medical inflation (from March 23, 2010) plus 15 percentage points, or $5 (as increased by medical inflation)

Grandfathered Plans

- ***Increase in Non-Copayment Fixed Amount Cost-Sharing Requirements*** – Fixed amount cost sharing requirements other than copayments (e.g. deductibles) are increased more than medical inflation (from March 23, 2010) plus 15 percentage points

Grandfathered Plans

- ***Decrease in Employer Contribution Rates*** – Employer contributions toward the cost of any tier of coverage for any class of similarly situated individuals are decreased by more than 5 percentage points below the contribution rate (the percentage of employer contributions towards the total cost of coverage) for the coverage period that includes March 23, 2010

Grandfathered Plans

- ***Changes in Annual Limits*** – Annual limits are changed as of March 23, 2010, as follows:
  - No overall annual or lifetime limit – limits cannot be added
  - Lifetime dollar limit, but no annual dollar limit - cannot adopt an annual dollar limit lower than the lifetime limit on March 23, 2010
  - Overall annual dollar limit – cannot decrease the annual limit

Grandfathered Plans

- ***Transfers of Employees*** – Employees are transferred into plan from another plan in which they were covered on March 23, 2010
  – (i) the plan from which they transferred would lose grandfathered plan status if it were amended to be the same as the plan into which they transferred, and
  – (ii) there is no bona fide employment-based reason to transfer the employees

Grandfathered Plans

- ***Issuance of New Insurance Policy***
- Prior to November 15, 2010
  – On or After November 15, 2010
    - NOT LOSE STATUS –
    - Effective date of new policy
    - No retroactive effect
    - Provide new insurer with terms of prior policy

Grandfathered Plans

- ***Mergers, Acquisitions, and Other Business Restructurings*** – There is a merger, acquisition or similar business restructuring the principal purpose of which is to cover new individuals under a grandfathered health plan

Grandfathered Plans

- ***Other Changes – No Loss of Status***
  - Premiums
  - Comply with Federal or State legal requirements
  - Voluntarily comply with the Health Care Reform
  - Third-Party Administrators
  - Changes to Structure?

Grandfathered Plans

- ***Disclosure Requirements***
  - Materials provided to participants and beneficiaries must state that plan believes it is grandfathered
  - Model Language available

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Grandfathered Plans

- ***Exempted From:***
  - Preventive care benefits, without cost sharing
  - Compliance with the non-discrimination requirements of Section 105(h) (insured plans)
  - External review in benefit claims and appeals process
  - Emergency and OB/GYN services be provided without the need for prior authorization or referral

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Grandfathered Plans

- ***Exempted From (con't):***
  – Auto-enrollment for eligible employees
  – Submit to HHS and plan participants whether the benefits under the plan
    - Improve health outcomes
    - Implement activities to prevent hospital readmission
    - Implement activities to improve patient safety and reduce medical errors, and
    - Implement wellness and health promotion activities

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Grandfathered Plans

- ***Exempted From (con't):***
  – Self-insured plans not required to comply with "cost sharing" restrictions
  – Insured plans not required to disclose claim payment policies and practices, financial information, enrollment and denials, claim denials and rating practices

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Grandfathered Plans

- ***Grandfathered plans <u>will be subject</u> to:***
  - Restriction on imposing waiting period for coverage to not more than 90 days (effective 1/1/2014)
  - Restriction on imposing annual and lifetime limits on essential health benefits (effective for first plan year after 9/23/2010)
  - Limitation on circumstances under which employer sponsored group health plan can terminate or cancel coverage (effective for first plan year after 9/23/10)

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Grandfathered Plans

- ***Grandfathered plans <u>will be subject</u> to (con't):***
  - For plan years beginning after 9/23/2010, plan must allow continued coverage of adult children up to age 26 unless they are eligible for coverage under another employer sponsored plan
  - Beginning in 2014, plan must allow continued coverage of adult children up to age 26 <u>regardless</u> of whether or not they are eligible for other non-parent employer sponsored coverage

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Grandfathered Plans

- ***Grandfathered plans <u>will be subject</u> to (con't):***
  - Effective for the first plan year beginning after 9/23/2010, employer sponsored plans are prohibited from excluding anyone under age 19 due to pre-existing condition
  - Effective after 1/1/2014, prohibition extends to all other individuals, regardless of age

Cafeteria Plans

Cafeteria Plans/FSAs

- Medication Reimbursed Only if:
  - Medicine or drug requires a prescription
  - It is available without a prescription (an over-the-counter medicine) and the individual obtains a prescription, or
  - It is insulin

Cafeteria Plans/FSAs

- Prescription
  - Written or electronic order
  - A medicine or drug
  - Meets the legal requirements of a prescription
  - Issued by an individual who is legally authorized to issue a prescription
  - State law applies

Cafeteria Plans/FSAs

- 2010 run-out payments – OK
- Grace Period payments – NO
- Also applies to HRAs and HSAs
- Amend plans by June 30, 2011

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Cafeteria Plans/FSAs

- "Benny Cards" affected
  - Enforcement after January 15, 2011
- Rules for use of Benny Cards
  - Present prescription to the pharmacist,
  - Dispensed according to pharmacy's rules, and
  - Prescription number must be assigned
  - Pharmacy retains records
  - Records available to employer

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Cafeteria Plans/FSAs

- "Benny Cards" affected
  - Enforcement after January 15, 2011
- OTC Meds must be substantiated
  - A customer receipt issued by a pharmacy
  - Date and amount of the purchase
  - Rx number satisfies the substantiation requirements for over-the-counter medicines or drugs
  - Receipt without an Rx number and a copy of the related prescription

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Cafeteria Plans/FSAs

- FSA contributions limited to $2,500
  - Effective January 1, 2013
  - Adjusted for CPI beginning in 2014
- Limited to employees deferrals
- Does not apply to HRA or dependent care FSA (current limit is $5,000)

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Cafeteria Plans/FSAs

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Simple Cafeteria Plans

- Nondiscrimination requirement of section 125(b)
- 25% concentration test
- nondiscrimination requirements of 79(d), 105(h), and 129(d)
  - group life
  - self-insured or medical reimbursement plan,
  - dependent care assistance benefits

Simple Cafeteria Plans

- "Small Employers"
  - 100 or fewer employees
  - During either of the two preceding years
  - Until have 200 employees
- Rate of contribution for HCE or Key employee cannot exceed that of any other employee

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Simple Cafeteria Plans

- Employer Contributions
  - Uniform % of comp (not less than 2%); or
  - Not less than lesser of
    - 6% of comp; or
    - 2 times the salary reduction of each employee

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Simple Cafeteria Plans

- "Small Employers"
  - 100 or fewer employees
  - During either of the two preceding years
  - Until have 200 employees
- Employer contributions
  - Uniform % of comp (not less than 2%); or

Simple Cafeteria Plans

- Employees
  - 1,000 hours in prior plan year
  - Can exclude
    - Not 21 by plan year end
    - Less than 1 year of service anytime during plan year
    - Collectively bargained employees
    - Non-resident aliens working outside of US /non-US income
  - No Partners, Sole Props or S Corp

Procedural Provisions

Uniform Health Plan Summary

- Implement within 24 months of enactment
- 60-days advance notice of any *material modifications*
- $1,000 fine per participant
  - Willful failure to notice of *material modification*

Uniform Health Plan Summary

- Not greater than 4 pages – 12pt font
- Issue annually
- In addition to usual Summary Plan Description
- Presented in culturally and linguistically appropriate manner

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Appeals Process

- Denial includes rescission of coverage
- Urgent Care Claims – 24 hours vs. 72 hours
- Full and Fair Review
  - Provide new or additional evidence relied upon or generated

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Appeals Process

- Eliminate Conflicts of Interest
  - Independent and impartial reviewers
  - No employment decisions based on likelihood to deny appeals
- Deemed exhaustion of internal appeals process
- Continued coverage during process

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Appeals Process

- Model Notice of Adverse Benefit Determinations
- Model Notice of Final External Review Decision
- Model Notice of Final Internal Adverse Benefit Determination

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Rescission

- Rescission is prohibited except in case of fraud or intentional misrepresentation of material fact
  - Cancellation or discontinuance of coverage that has retroactive effect
- Not Rescission if:
  - Prospective effect
  - Attributable to non-payment of premiums
  - Coverage may not be terminated without 30 day prior notice

Non-Discrimination in Favor of Highly Compensated

- Section 105(h)
- Currently applies only to self-insured plans
- No discrimination in favor of HCIs
  - Eligibility to participate
  - Benefits provided
- Eligibility to participate
  - 70% of all
  - 70% of all are eligible and 80% participate
  - Fair cross section

Reinsurance of Certain Early Retirees

- Early Retiree Reinsurance Program
  - Reimburse employers for a portion of their early retiree health program costs
  - $5 billion limit

Miscellaneous 2011 Provisions

- Excise tax for Non-Medical distributions from HSAs increased from 10% to 20%
- W-2 Reporting required regarding value of coverage offered in 2011 and later
  - To show employees the value of their health care benefits so they can be more informed consumers
  - Delayed until 2012

Insurance Market Reforms

No Limits on Benefits

- No lifetime or annual limits on value of essential benefits
- *Restrictive* annual limits on essential benefits until 2014
  - What is restrictive? HHS to rule
- Can limit non-essential benefits
  - Annual limits
  - Day or visit limits

Emergency Services

- Emergency room services must be covered
  - Without prior authorization
  - Whether or not provider in network
  - Copays / coinsurance must be same for out-of-network as in-network

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Emergency Services

- Emergency Medical Condition
  - Placing the health of the individual in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part
- Appears to apply to grandfathered and non-grandfathered plans after September 23, 2010

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High Risk Pools

- Protection against "dumping"
- If encouraged by insurer or employer to dis-enroll, HHS will impose sanctions
  - Reimburse high risk pool for such employee's claims
- Did employer or insurer
  - Provide financial incentive to dis-enroll

Preventive Services

- Full coverage (no co-pays, etc.) for certain preventive care – includes:
  - Evidence based services recommended by U.S. Preventative Task Force
  - Well infant, child and adolescent care/screenings supported by the Health Resources and Services Administration
  - Immunizations recommended by CDC

Preventive Services

- Preventive Services for Women:
  - As recommended by Health Resources and Services Administration
  - For breast cancer screenings, mammography and prevention – US Preventive Services Task Force – other than 2009

Preventive Services

- Preventive Services:
  - Immunizations
  - Blood pressure, diabetes and cholesterol screening
  - Cancer screening
  - Adolescent depression screening
  - Lead and autism testing
  - Counseling, screening and vaccines for health pregnancies
  - Counseling related to tobacco cessation, losing weight, eating better, treating depression, and reducing alcohol use

New Taxes to Fund HRC

- Medical Industry
  - Rx Industry estimated to pay $27 Billion starting in 2011.
  - Medical Device Manufacturers 2.3% excise tax on sales estimated at $20 Billion starting 2013
  - Insurers to pay tax premiums estimated at $94.6 Billion starting in 2014
- More Taxes…
  - Medicare Payroll tax .9% on high earning individuals
  - 3.8% tax on passive income (interest/dividends/annuities/rental income)

Employer Penalties 2014

- Large Employer
  - F/T Employees In Exchange – subsidy/credit
- Provide Health Insurance
- No – 1/12 x $2,000 x (#F/T – 30)
- Yes – Lesser Of:
  - 1/12 x $2,000 x (#FT ees minus 30); or
  - 1/12 x $3,000 x #FT ees w/credit/subsidy in exchange

Employer Penalties 2014

- Large Employer
  - 50 or more full-time equivalent
    - Those who work at least 30 hours per week
    - Pro-rate those who work less than 30 hours per week
    - Exclude Seasonal workers – up to 120 days

Additional Taxes in 2018

- High Cost Plan Excise Tax – also known as the Cadillac Tax
  - 40% excise tax on excess benefit of high dollar employer health plan
  - Annual limit on individual coverage for calculating tax is $10,200 for individual coverage; and $27,500 for coverage other than individual
  - Responsibility for the tax will be on the “coverage provider” which can be the insurer, the employer, or a third party administrator