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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    - Form 1099 reporting requirement repealed
    - Free choice voucher provision repealed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 chose 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