Health Care Reform: Where are we now?

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GROUP

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With more than 14 years of experience in employee benefits and a strong record of achievement, Lisa is responsible for the overall growth, retention, profitability, best practices, and strategic direction of the firm's $20 million employee benefits operation spanning 12 offices throughout the Midwest. Lisa was named one of the "50 Women to Watch" in the July 30, 2007 issue of *Business Insurance and was honored with the 2007 20 Under 40 Leadership Award. Most recently, Lisa was honored with the 2009 Leadership Toledo Distinguished Community Leader Award.*

An accomplished speaker, Lisa has presented to numerous local and national organizations including Financial Executives International (FEI), the Society for Human Resource Management (SHRM), Worldwide Employee Benefits Network (WEB), American Institute of CPAs (AICPA) and the Association for Corporate Growth (ACG).

Lisa is a member of several industry associations including SHRM, WEB, the Council of Insurance Agents & Brokers (CIAB), National Association of Health Underwriters (NAHU), International Foundation of Employee Benefits (IFEBP), and others.

Lisa is a Magna cum Laude graduate of Hanover College with post-graduate work from Indiana University and has received further education through the various professional organizations including a certification in Global Benefits Management from IFEBP.

What we'll cover

- Current Environment
- PPACA Timeline
- Maintaining Grandfathered Status
- Essential Health Benefits
- Minimum Medical Loss Ratio (MLR)
- What's required for 2012
- A Look Down the Road: 2013 – 2018

Health Care Reform – Current Environment

Action in Congress

- Republicans control House
- Democrats maintain majority in Senate
- Attempts to repeal or revise the law
- Form 1099 reporting requirement and free choice voucher program repealed

Health Care Reform – Current Environment

Court Cases

- District courts split on constitutionality
- Challenges based on Commerce Clause authority
- Supreme Court given the go-ahead to decide

HHS Suspends Implementation of CLASS Act

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EMPLOYEE BENEFITS PRACTICE

2010
- Small Business Tax Credit for ERs to buy health insurance
- Accounting impact of change in Medicare retiree drug subsidy tax treatment
- Early retiree med reinsurance
- Medicare Rx "donut hole" beneficiary rebate
- Break time/private room for nursing mothers (>50 ees)

2011
- Dep coverage to age 26 (GF plans may limit to children w/o access to other ER coverage, other than parent's coverage.)*
- No LT $ Limits on Essential Benefits*/Restricted Ann. $ Limits, phased amts until 2014*
- No pre-ex for enrollees up to age 19*
- No rescissions*
- No FSA/HRA/HSA for OTC (non-prescribed)
- Add'l standards for new or non-GF health plans:
  - Mandatory preventive in-network – no cost share
  - Internal Claims & Appeals/External Review
  - Non-discrimination provisions for insured plans***
- HSA non-qualified distribution penalty increased to 20%
- Income based Medicare Pt. D premiums
- Insurers subject to MLR rules

2012
- ERs to distribute uniform benefit summaries to participants
- ERs to provide 60d advance notice of material modifications
- Form W-2 reporting for health coverage (for 2012 W-2s)
- Group Health Plan fees begin
- Auto-enrollment of FTEs (>200 ees) ***

2013
- $2,500 contribution cap on Health FSA
- ER to notify EE about Exchanges
- Higher Medicare payroll tax on wages exceeding $200K ind./$250K couples
- New tax on net investment income for taxpayers w/incomes >$200K ind./$250K couples
- Change in Medicare retiree Rx subsidy tax treatment takes effect

2014
- Exchanges
- Ind. Coverage Mandate
- Financial Assistance for Exchange coverage for lower-income individuals
- Medicaid Expansion
- HIPAA wellness limit inc.
- ER shared responsibility
- Add'l reporting & disclosure requirements

- Dep coverage age 26 – all**
- No ann. $ limits**
- No pre-ex limitations**
- Max. 90 day waiting period**
- Add'l new standards for new & non-GF plans
  - Cost-sharing & deductible limits
- Health insurance industry fees begin

2018
- 40% excise tax on "Cadillac" plans
  - $10,200 single / $27,500 family

***Applies to all plans (inc. GF) ≥ 9/23/2010**
****Applies to all plans, inc. GF ≥1/01/2014**
***** Delayed until regs issued/date TBD**

ADDITIONAL REGULATIONS UNDER AFFORDABLE HEALTH CHOICES ACT

HEALTH INSURANCE PLAN

FEDERAL QUALIFICATIONS OF GATEWAY BENEFIT PLANS
- Marketing
- Provider access
- Standards for plan comparability
- Benefit plan information
- Quality improvement
- Appeal process
- National accreditation
- Availability of essential benefits

NEW FEDERAL INSURANCE REGULATION[1]
- Guarantee renewal
- Rating
- Pre-existing conditions
- Non-discrimination/health status
- Provide incentives to improve quality care
- Fraud and abuse
- Reporting
- Non-discrimination/salary
- Guarantee issue
- Minimum loss ratio & reporting
- Dependent coverage until age 25
- Coverage for preventive care
- No annual/lifetime limits

CURRENT FEDERAL INSURANCE REGULATION[1]
- ERISA – Self-funded employer-sponsored coverage
- HIPAA
- [illegible]
- Antitrust
- COBRA
- Benefit mandates

HEALTH & HUMAN SERVICES
- [illegible] (HIAC)
- Gateway Web site
- [illegible]
- [illegible] Gateway [illegible]
- [illegible]
- [illegible]
- Employer responsibility payments
- Small business tax credits
- Essential benefits
- Standards and reimbursement rates for community health insurance options

STATE ADVISORY COUNCIL
- [illegible] policy for community health insurance option

PARTICIPATING STATES WITHIN FEDERAL PARAMETERS AND WITH FEDERAL GRANTS[4]
- Expenditure Reporting
- Federal Gateway if state rejected
- Federal Gateway fallback
- HHS determines threshold for employer size in Gateway

GATEWAY
- Facilitates purchase for qualified individuals & groups
- Offers "qualified" benefit plans
- Assist in enrollment in CHIP, Medicaid
- Risk-adjusted premium rates, but not on self-funded employer-sponsored coverage
- Purchasing health insurance plans
- Certifies qualified health plans
- Consumer complaint process
- Requires compliance with new provider contracting regulations
- Community health insurance option

ESTABLISHING STATES WITHIN FEDERAL PARAMETERS AND WITH FEDERAL GRANTS[4]
- Expenditure reporting
- State determines threshold for employer size in Gateway

NAVIGATOR
- Public or private non-profit entity
- Consumer education & information
- Enrollment assistance

FEDERAL/STATE COLLABORATION ON GUIDELINES

EMPLOYERS
- [illegible] Gateway

NON-GATEWAY MARKET
- Offers "qualified" benefit plans
- Offers "non-qualified" benefit plans [illegible]

CURRENT STATE INSURANCE REGULATION[3]
- Guarantee renewal
- Rating
- Pre-existing conditions
- Non-discrimination/health status
- Quality improvement & reporting
- Fraud and abuse
- External review
- Guarantee renewal
- Benefit mandates
- Solvency & financial management
- Market conduct
- Prompt pay
- Fraud and abuse
- Appeals and grievances
- Privacy/confidentiality
- Non-discrimination/genetic
- Licensure
- Antitrust
- Benefit plan material/information
- Consumer protections

PRESERVED STATE INSURANCE REGULATION[2]
- Benefit mandates
- Market conduct
- Consumer protections

[1]Does not apply to existing coverage.
[2]Unclear under bill as to the extent of state enforcement and federal preemption.
[3]See attached chart for an explanation of current insurance regulations.
[4]Proposal allows for states as (establishing) federal/non (participating) and multiple Gateways per state.

Grandfathered Status

"Grandfathered" Plans: Which rules don't apply?

- Patient protections (PCP designation and free preventive)
- 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

Maintaining "Grandfathered" Status

CAN

- Change premiums
- Change provider network
- Change administrators (self-funded)
- Change Rx formulary
- Add new employees/enrollees
- Enroll new dependents
- Make changes to comply w/law
- Change carriers (for insured plans as of 11/15/10)

(Each Benefit Package Considered Separately)

Maintaining "Grandfathered" Status

CANNOT

- Corporate mergers/sale to avoid compliance
- Eliminate all benefits to diagnose or treat a particular condition
- New or decreased annual limits
- Increase percentage (%) coinsurance charges
- Require EEs to switch plans
  - e.g., Employer offering multiple plans

Maintaining "Grandfathered" Status

CANNOT

- Increase fixed amount cost-sharing (i.e. copays, deductibles, out-of-pocket maximums) "significantly" (greater of $5 or medical inflation + 15%)
  - Retail / Mail Order Prescription Drug Copays
  - Medical Inflation + 15%
- Decrease employer contribution percentage by more than 5%
  - Definition of employer contribution percentage
  - Calculation issues with SF plans

Maintaining “Grandfathered” Status

MUST

- Provide notice
  - must state in **all** plan materials whether it “believes” it is grandfathered
- Maintenance and availability of records

Essential Health Benefits

Essential Health Benefits

- PPACA coverage requirements
  - No lifetime maximums
  - Restricted annual limits until 2014 (phase-out)
  - Non-grandfathered, small (≤100) plans must cover in 2014
- "Essential Health Benefits" not clearly defined
  - Ten broad categories
- IOM released their report October 6
  - Balance coverage with affordability

Minimum Medical Loss Ratios

MLR

Minimum Medical Loss Ratios

MLR rules

- Insurers must spend 80-85% of premiums on medical care and quality improvement (not admin costs) or give rebates
- Effective January 1, 2011
- Does **NOT** apply to self-insured health plans

HHS issued final rule

- Adopted NAIC recommendations
- Outlines items counted as medical care/health care quality improvement (and items that are not)
- Provides rules for rebates

MLR Rebates

- Issuer must provide proportionate rebate to each enrollee if MLR requirements not met (and notice)
- Due by August 1st after reporting year
- Issuer can arrange with group health plans to distribute rebates to enrollees
- Methods of payment
  - Premium credit
  - Lump sum check
  - Reimbursement to account used to pay premium

What's Required for 2012?

Form W-2 Reporting of Health Care Costs

- Compliance begins January 1, 2012
  - i.e. Forms that will be issued in January 2013
- Small Employer Exception
  - If <250 W-2s in the prior year
- All plan costs must be reported on a calendar year basis, regardless of the employer's plan year

Form W-2 Reporting: Aggregate Cost of Health Coverage

Includes

- Entire cost of coverage
  - includes employee contributions
  - Cost of coverage = COBRA premiums (less 2% administrative fee)
- Cost of coverage of the employee and any dependents
  - including any portion of the cost that is includible in an employee's gross income

Does Not Include

- HIPAA "Excepted Benefits" (accident, disability, worker's comp, etc.)
- Long Term Care
- Non-Integrated Dental / Vision Plans
- Cancer, Fixed Indemnity Plans
- Archer MSA, Employer HSA contributions, HRA or EE contributions to FSA

Form W-2 Reporting of Health Care Costs

- Reportable costs under a plan for a year must reflect any increases and decreases in the cost for the year
- If an employee begins, changes, or terminates coverage during the year, the reported costs must reflect the actual periods of coverage
- Where plans utilize composite rates, it is acceptable to report based on those composite rates provided this method is applied to all types of coverage offered under the plan.

Form W-2 Reporting of Health Care Costs

- Terminated Employees: Can use a “reasonable method” for including the value
  - Not required to report if employee terminated and requested W-2 prior to end of the year in which termination occurs
- The employer is NOT required to use the same method for every plan, but must use the same method with respect to a plan for every employee receiving coverage under that plan

Uniform Summary of Coverage (SBC)

- Applies to grandfathered and non-grandfathered plans
- Additional disclosure requirement
  - Does not replace any other required disclosures or documents (e.g., SPDs)
- Simple and concise explanation of benefits
- Proposed standards issued August 17, 2011, comment period ended last week

Uniform Summary of Coverage (SBC)

- Plans must start using by March 23, 2012
- Proposed template and guidance available
  - Instructions
  - Sample language
  - Uniform glossary of terms

SBC: To Whom & Penalties

- Must be provided:
  - To applicants (at the time of application)
  - To enrollees (upon enrollment and re-enrollment)
- May be provided in paper or electronic form
  - If electronic, must satisfy DOL rules on electronic disclosure
- Penalties
  - $1,000 for each willful failure to provide
  - $100 per day per individual excise tax

SBC: Standards

Appearance

- Cannot be larger than 4 double-sided pages
- 12-point or larger font
- May be color or black and white

Language

- Easily understood language
- “Culturally and linguistically appropriate manner” – interpretive services and written translations upon request.

SBC: Providing to GHPs

- Issuers must provide SBC to GHPs:
  - Upon application
  - Upon request for info about the health coverage
  - Before the first day of coverage (if there have been changes to the SBC)
  - When a policy is renewed or reissued
  - Upon request

SBC: Providing to Participants & Beneficiaries

- Plans must provide SBC to Ps and Bs
- For each benefit package offered or which they are eligible
- Annually at renewal
- With enrollment application materials (or within 30 days of new plan year if automatic renewal)
- Before the first day of coverage (if there have been changes to the SBC)
- Within 7 days of request for enrollment pursuant to a special enrollment period
- Upon request

Updating the SBC

- Material modifications **not** in connection with renewal must be described in a summary of material modifications (SMM) or an updated SBC
- Material Modification
  - Enhancement of covered benefits or services
  - Material reduction in covered benefits or services
  - More stringent requirements for receipt of benefits
- Must be provided at least 60 days **BEFORE** modification becomes effective

Women's Health Preventive Care

- General Requirements
  - Applies first plan year ≥ September 23, 2010
  - Does **not** apply to GF plans
  - No cost-sharing in-network (may vary if preventive service is provided during an office visit)
  - Applies to "A" or "B" services from the US Preventive Services Task Force: www.HealthCare.gov/center/regulations/prevention.html

Women's Health Preventive Care

- Effective Plan Years beginning ≥ August 1, 2012, additional guidelines cover the following health services:
  - Well-woman visits
  - Gestational diabetes screening
  - Human papillomavirus (HPV) DNA testing for women age 30 and older
  - Sexually transmitted infection (STI) counseling
  - Human immunodeficiency virus (HIV) screening and counseling
  - FDA-approved contraception methods and contraceptive counseling
  - Breastfeeding support, supplies and counseling
  - Domestic violence screening and counseling

Comparative Effectiveness Research (CER) Fees

- Applies to health insurance issuers and sponsors of self-insured health plans
- Effective plan years ending ≥ 9/30/2012, and
- Payable following the end of the plan year
  - Calendar year plans beginning 1/1/12, payable after 12/31/12
- Sunsets after 2019

Comparative Effectiveness Research (CER) Fees

- Fee is equal to $1 multiplied by the average number of lives covered under the plan
- Effective plan years ending ≥ 9/30/2013, fee is increased to $2 per covered life
- Effective plan years ending ≥ 9/30/2014, fee is indexed based on any increase in the projected per capita amount of National Health Expenditures, as published by HHS
- No fees payable for plan years ending ≥ 9/30/19

What you need to do for 2012

Form W-2 Reporting of Health Care Costs	• Gross costs using rules similar to COBRA *including* employee contributions (exc. 2% admin. fee) • Reporting requirement begins with 2012 Forms (i.e. Forms issued January 2013) • Small Employer Exception
Uniform Benefit Summary & 60 day Advance Notice of Material Modifications	• Called Summary of Benefits & Coverage (SBC) • Must begin providing **no later than March 23, 2012** • Four pages, double-sided, 12-pt. font summary • Provided at 1) time of application, 2) prior to enrollment or reenrollment, 3) at time of policy issuance or certificate delivery • Can be provided in paper or electronic form • Template provided as of August 17th issuance of proposed regulations (60 day comment period began)
Expanded Women's Preventive Care Services	• August 2011 HHS expanded Women's Preventive Services • Effective for non-GF plan years ≥ 8/1/2012 • No cost sharing
Comparative Effectiveness Research Fee on GHPs	• Annual fee of $1 per enrollee, plans ≥ 9/30/2012, increased thereafter • Sunsets after 2019

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A look down the road: 2013

Topic	Details
Health FSA Cap $2,500	• In 2013 and future years, indexed to reflect CPI increases
Exchange Notice	• Beginning March 2013, inform EEs about health insurance exchange
Elimination of Deduction for Medicare Part D Subsidy	• Tax deduction for Rx costs (including costs attributable to subsidy) will be eliminated beginning 2013
Increased Threshold for Medical Expense Deductions	• Income threshold for claiming itemized deductions for health expenses increases from 7.5% to 10% • Individuals over 65 able to claims deduction over 7.5% through 2016
Additional Hospital Insurance Tax for High Wage Workers	• Increases tax rate by 0.9% on wages over $200,000 for an individual ($250,000 for married couples filing jointly) • Tax is expanded to include 3.8% tax on net investment income for high wage workers

A look down the road: 2014

Individual Coverage Mandate	• Obtain insurance or pay penalty (up to a cap) • Penalties increase annually • Exemptions available if individual cannot obtain affordable coverage
Employer Coverage Requirements	• ERs ≥ 50 ees must offer coverage or pay penalty up to $2,000/year/FTE (exc. first 30 FTEs) if FTE receives gov't subsidy • ERs who offer coverage, but FTEs receive tax credits, fined of $3,000 for each FTE receiving tax credit (up to aggregate of $2,000 per FTE) • ERs must report to gov't on health coverage they provide
Establishment of Health Insurance Exchanges	• Established by each state • Individuals & small ERs (<100 FTEs) may shop through Exchange

Additional Health Insurance Reforms for 2014 & beyond

- Guaranteed Issue & Renewability (non-GF plans)
- Pre-Existing Condition Exclusions eliminated
- Insurance Premium Restrictions (non-GF plans)
- Nondiscrimination Based on Health Status (non-GF plans)
- Annual Limits Removed
- Excessive Waiting Periods Removed
- Coverage for Clinical Trials (non-GF plans)
- Comprehensive Benefits Coverage
- Limits on Cost-Sharing (non-GF plans)
- Wellness program incentive maximum increases from 20% to 30%
- Individual Health Care Tax Credits
- Small Business Tax Credit
- Health Insurance Provider Fee

2018

- Cadillac Tax on "high cost" employer-sponsored health insurance.

Please note:

These slides are intended to provide only a general overview of selected issues related to the health care reform regulations. They do not provide a complete analysis. The information in the outline is for general use only and is not intended to provide specific advice or recommendations, legal or otherwise, for any individual or organization. The information provided herein is not intended to be and should not be construed as a legal opinion or advice. You need to consult with your own attorney or other adviser relating to your specific circumstances or those of any organization that you advise.

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QUESTIONS?

Questions after today?

Contact your Hylant Group representative or e-mail questions to:

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