Health Care Reform

A Summary of the Law and Analysis of the Impact

Compiled by The Employee Benefit Service Center.

On March 30, 2010, President Obama signed into law the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152), which makes notable changes to several areas of the Patient Protection and Affordable Care Act (PPACA). This material is intended to offer guidance on some significant changes affecting employers and their health plans.

The PPACA includes a provision addressing ''grandfathered health plans,'' that is intended to delay many of its provisions from applying to plans in which an individual was enrolled on the date of enactment of the PPACA, or March 23, 2010. The Reconciliation Act limits this rule by making many of the PPACA provisions apply to grandfathered health plans. These provisions include:

1) Plans may not apply a waiting period in excess of 90 days.
2) Plans are prohibited from establishing lifetime maximums or unreasonable annual maximums on essential health benefits.
3) Plans are prohibited, from rescinding coverage for individuals enrolled in the plan, except in the case of fraud.
4) Plans may not impose any preexisting condition exclusion.
5) Plans offering dependent coverage for children must continue providing that coverage for adult children up through age 26.

The various effective dates and details of these changes are explained below. Please note that several federal agencies are required to issue additional guidance and regulations on the PPACA provisions, so if you feel confused, you're not alone. As more clarification is issued, The Employee Benefit Service Center will provide follow up communications to you.

The reality is that 160 million Americans currently get coverage through their employer, and this is unlikely to change because the federal budget depends on it. This is just the beginning - regulatory guidance and potential legislation will undoubtedly be on the table in the months and years to come.

EFFECTIVE JUNE 21, 2010

I) Adults with pre-existing conditions

Adults with pre-existing conditions will be eligible to join a temporary national high-risk pool, which will be superseded by the health care exchange in 2014.

Next Steps

1) For employer plans, no immediate action needs to be taken.
2) Simply be aware that individuals with pre-existing conditions have the ability to enroll in these high-risk pools until 2014 (i.e., the date when you can no longer apply pre-existing exclusions to adults).

II) Temporary Reinsurance Program for Early Retirees

Establishes a temporary reinsurance program to provide 80% reimbursement to participating employer plans for claims over $15,000 and under $90,000 of early retirees (and to eligible spouses, surviving spouses, and dependents of such retirees).

A) Early retiree is defined as an individual who is age 55-64 but is not eligible for coverage under Medicare and who is not an active employee in the plan.
B) Applies to group health benefit plans that provide coverage to early retirees and that are maintained by one or more current or former employers (including any state or local government or political subdivision),employee organizations, multiemployer plans, or a committee or board appointed to administer such plan.

To get reimbursed, a Plan must do the following:

1) implement Programs and Procedures to generate cost-savings with respect to participants with chronic and high-cost conditions;
2) Provide documentation of the actual cost of medical claims involved;
3) Be certified by the Secretary of Health & Human Services;
4) Submit an application for participation in the program in the manner specified by the Secretary.

If the Secretary determines that a plan has submitted a valid claim for reimbursement, the Secretary may reimburse the plan for 80% of the portion of the costs attributable to such claim that exceeds $15,000 (subject to certain limits: the claim must not be less than $15,000 or greater than $90,000). In determining the claim amount, the plan must take into account any negotiated discounts, subsidies, rebates, etc. obtained by the plan with respect to the claim. The costs paid by the early retiree or the retiree's spouse or dependent in the form of deductibles, copayments or coinsurance must be included in the amounts paid by the plan for purposes of determining the amount of the claim.

Any reimbursement received by the plan must be used to lower costs for the plan (i.e., used to reduce premiums, copayments, deductibles, coinsurance or other out-of-pocket costs for participants). The payments may not be used as general revenues for the sponsoring employer. Reimbursements will not be included in the employer's gross income.

Next Steps

1) Reevaluate current retiree medical plan to determine whether currently eligible for reimbursement and possible design changes.
2) Apply to HHS for claim reimbursement, and if applicable, communicate any plan changes to members.

III) There will be an annual Flat Fee of $2.3 billion dollars on the pharmaceutical manufacturing sector.

EFFECTIVE FIRST PLAN YEAR AFTER SEPTEMBER 23, 2010

I) Dependent Children Coverage to Age 26

Group health plans that provide dependent coverage for children shall continue to make such coverage available for an adult child until the child turns age 26.

A) Applies to newly established plans and grandfathered plans (i.e., plans that were in existence as of the date of enactment, or March 23, 2010). For plan years beginning before 2014, a grandfathered plan is not required to offer coverage to dependents through age 26 if the dependent is eligible to enroll in his or her own employer-sponsored plan.

B) Example: Under the new law, a 25 year old is eligible to be covered under both parents' employer plans. The 25 year old then gets a job and is now eligible for coverage under his own employer's plan. The parents' plans are not required to offer coverage to the 25 year old if the plan was in place before 2014.

C) The Secretary is required to promulgate regulations to define dependents to which such coverage shall be made available in the next couple of months.

Question: Can you charge participants additional amounts to cover these dependents (above what is charged for a normal dependent)? The legislation is unclear. The intent is that coverage would be offered under the same terms as it would be for other dependents. Hopefully the regulations will clarify this point.

Next Steps

1) Update administrative and payroll systems and procedures.
2) Communicate plan design changes before and during 2011 open enrollment.
3) Update SPDs, Plan Documents and HIPAA Certificates.

II) No annual lifetime limits

Group health plans may not establish lifetime maximums on the dollar value of benefits for any participant or beneficiary, OR establish unreasonable annual maximums on the dollar value of benefits.

A) Effective for plan years beginning on or after September 23, 2010. For calendar-year plans, the effective date is January 1, 2011.
B) Applies to newly established plans and grandfathered plans.

Question: What is an ''unreasonable annual maximum"? This is defined by reference to the HSA section of the Internal Revenue Code. Generally, a restriction or exclusion of benefits is reasonable only if significant other benefits remain available under the plan in addition to the benefits subject to the restriction or exclusion. A lifetime limit on benefits designed to circumvent the maximum annual out-of-pocket amount defined in the Code is not reasonable. Presumably, plans would not be permitted to exceed the annual out-of-pocket expenses for HSA-compatible high deductible health plans. However, the regulation writers are asking for feedback on this issue.

Next Steps

1) Communicate plan design changes before and during 2011 open enrollment.
2) Update SPDs, Plan Documents and HIPAA Certificates.

III) Children with pre-existing conditions

Prohibits group plans denial or rate adjustments for children who have pre-existing conditions.

A) Effective for plan years beginning on or after September 23, 2010.
B) Applies to newly established plans and grandfathered plans

Next Steps

1) Communicate plan design changes before and during 2011 open enrollment.
2) Update SPDs, Plan Documents and HIPAA Certificates.

IV) Reporting of Quality of Care

The Secretary of HHS is required to develop reporting requirements for group health plans with respect to plan benefits and health care provider reimbursement structures that:

A) Improve health outcomes through implementation of quality reporting case management, care coordination, disease management, etc.
B) Implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge;
C) Implement activities to improve patient safety and reduce medical errors; and
D) Implement health and wellness promotion activities.

The plan will be required to submit an annual report to the Secretary on whether its benefits meet the elements specified above. Effective date is September 23, 2010 for newly established plans only. Plans already in existence as of March 23, 2010 will not immediately have to comply. The Secretary is required to issue additional regulations before the compliance date explaining these reporting requirements in greater detail.

V) Prohibition on Denying Coverage for the Sick

A group health plan may not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan. There is an exception when the enrollee has engaged in fraud or intentional misrepresentation.

This provision appears to be designed for fully insured individual plans. How the regulation writers will apply this to self-funded plans and interpret the meaning of "fraud'' is unclear.

A) Effective for plan years beginning on or after September 23, 2010. For calendar year plans, the effective date is January 1, 2011.
B) Applies to newly established plans and grandfathered plans.
C) Need for the Secretary to issue additional clarification on whether and to what extent this prohibition applies to self-funded plans.

VI) Plans may not set eligibility rules based on health status, medical condition, claims-experience, receipt of healthcare, medical history, genetic information, or evidence of insurability.

A) Effective for plan years beginning on or after September 23, 2010. For calendar year plans, the effective date is January 1, 2011.
B) Applies to newly established plans and grandfathered plans.

C) Need for the Secretary to issue additional clarification on whether and to what extent this prohibition applies to self-funded plans.

VII) Certification through State Insurance Exchange

Effective September 23, 2010 for newly established plans. Plans already in existence as of March 23, 2010 will not have to immediately comply. Additional guidance is needed from the Secretary. Plans must provide to the Secretary of HHS and the State insurance Commissioner the following information:

A) Claims payment policies and procedures;
B) Periodic financial disclosures;
C) Data on enrollment and disenrollment;
D) The number of denied claims;
E) Rating practices;
F) information on cost-sharing and payments with respect to any out-of-network coverage;
G) Information on participant rights, and;
H) Other information as determined by the Secretary.

VIII) Internal and External Appeals Process

Group health plans are required to implement an internal claims appeal process and an external review process. This requirement is effective September 23, 2010 for newly established plans. Plans already in existence as of March 23, 2010 will not have to immediately comply.

A) For internal appeals, the plan shall, at a minimum:
   1) Have in effect an internal claims appeal process;
   2) Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health assistance; and,
   3) Allow an enrollee to review his or her file, present evidence and testimony, and to receive continued coverage pending the outcome of the appeals process.

B) For external appeals, a self-insured plan that is not subject to State insurance regulation must implement an effective external review process that meets minimum standards established by the Secretary through guidance that is similar to the applicable State external review process.

Note: Claims appeal processes are in place at this time for plans. We need more guidance from the Secretary on how this may change those processes.

IX) Preventive Care

Requires qualified health plans to provide coverage without cost- sharing for preventive services that have been rated ''A'' or ''B'' by the U.S. Preventive Services Task Force (includes immunizations, mammograms, and other preventive care services for infants, children, adolescents, and women). This requirement is effective September 23, 2010 for newly established plans. Plans already in existence as of March 23, 2010 will not immediately have to comply. Need to wait for additional guidance from the U.S. Preventive Services Task Force and the Secretary of HHS regarding what preventive services are affected.

EFFECTIVE JANUARY 1, 2011

I) Grants for Wellness Programs

The Secretary will provide grants for up to five years to small employers that establish wellness programs. The Secretary needs to issue additional guidance to begin planning for this section of the law.

II) Costs for Over-The Counter Drugs

The law excludes the cost for over-the-counter drugs not prescribed by a doctor from being reimbursed through a Flexible Spending Account or Health Reimbursement Account and from being reimbursed on a tax-free basis through a Health Savings Account. This section applies to newly established plans and to grandfathered plans.

III) Health Savings Account Distributions

When a person with a Health Savings Account takes a distribution for non-qualified expenses, the penalty is changed from 10% to 20%. This applies to newly established and grandfathered plans.

IV) Department of Labor 5500 Analysis

To determine if self-funded plans offered less costly coverage, the Secretary of Labor is required to prepare an annual aggregate report using data collected from 550 forms that will provide the following information on self-funded health plans:

A) Plan type;
B) Number of participants;
C) Benefits offered;

D) Funding arrangements;
E) Benefit arrangements.

The report must provide data on plan assets, liabilities, contributions, investments and expenses and applies to newly established plans and grandfathered plans

V) Annual Flat fee of $2 billion dollars on medical device manufacturers (through year 2017, and $3 billion dollars annually thereafter).

EFFECTIVE 2012

I) Uniform Explanation of Coverage

The law requires group plans to provide a summary of benefits and a coverage explanation that meets specified criteria to all enrollees when they apply for coverage, when they enroll or reenroll in coverage, and when the policy is delivered.

A) The new summary must be sent out by March 23, 2012;
B) This applies to newly established and grandfathered plans;
C) This does not replace the ERISA Summary Plan Description requirements;
D) The summary must be four pages or less in length and be at least 12 point type;
E) The summary must be in a culturally and linguistically appropriate manner and utilize terminology understandable by the average plan enrollee. The summary must include uniform definitions of insurance terms, medical terms, a description of the coverage including cost-sharing, exclusions, renewability and a statement on whether the plan is "minimum essential coverage".
F) Within twelve months of enactment, before March 23, 2011, the Secretary is required to develop standards for the summary of benefits.

II) Notice of Material Modifications

If a plan makes "material modification" to the terms of the plan or coverage that is not reflected in the most recently provided summary of benefits, the plan must notify participants no later than 60 days prior to the date on which such modification will become effective. This rule applies to newly formed plans and to grandfathered plans.

EFFECTIVE 2013

Contributions to Medical Reimbursement FSAs are limited to $2,500, indexed by inflation.

Currently there is no cap and it is set by the employer.

EFFECTIVE 2014

I) Prohibition on Pre-Existing Conditions

Group health plans prohibited from discriminating against or charging higher rates for adults based on preexisting medical conditions.

A) Effective for plan years beginning after January 1, 2014;
B) This applies to newly established and grandfathered plans.

II) Annual Lifetime Maximums

Group health plans are now prohibited from establishing annual spending caps (as distinguished from simply establishing reasonable spending maximums as described above).

III) Employer Mandate and Automatic Enrollment

Employers that have more than 50 employees which offer coverage but have at least one full-time employee receiving a premium tax credit from the state will pay the lesser of $3,000 for each employee receiving a premium tax credit or $2,000 for each full-time employee.

Employers with more than 200 employees are required to automatically enroll employees in a health insurance plan offered by the employer.

IV) Limiting Deductibles

Limits deductibles for health plans in the group market to $2,000 for individuals and $4,000 for families, unless employer contributions are offered which off-set deductible amounts above these limits.

The term ''group market'' means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of

themselves and their dependents through a group health plan maintained by a large employer (an average of at least 101 employees during a plan year) or by a small employer (an employer who employs at least I but not more than 100 employees during a plan year).

V) No Excess Waiting Periods

When a person is newly enrolled onto a plan, the waiting period for coverage is limited to 90 days. This is effective for plan years beginning after January 1, 2014 and applies to newly established plans and grandfathered plans.

VI) Universal Coverage

Everyone must carry health insurance or face a fine, subject to certain narrow exceptions.

VII) Wellness Programs

Allows employers to offer rewards of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards (in some circumstances, the reward may be increased up to 50% of the cost of coverage).

VIII) Medicaid Eligibility

The law expands Medicaid eligibility to individuals with income up to 133% of the federal poverty level, including adults who do not have dependent children.

IX) Tax Credits to Small Businesses

The law offers tax credits to small businesses that offer health benefits and have fewer than 25 employees.

X) Clinical Trials

If a group health plan provides coverage to an individual who is eligible to participate in an ''approved clinical trial,'' the plan may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with trial participation.

The term ''approved clinical trial'' means a Phase 1, Phase 11, Phase III, or

Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease and is either federally funded or is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

This is effective for plan years beginning after January 1, 2014 for newly established plans. Plans in existence as of March 23, 2010 will not have to immediately comply.

XI) Emergency Services

If a group health plan covers benefits for emergency service in a hospital, the plan must cover these services without the need for any prior authorization, regardless of whether the health care provider is a participating provider, and at the same cost-sharing rules that apply to in-network services.

Effective for plan years beginning on or after January 1, 2014 for newly established plans. Plans already in existence as of March 23, 2010 will not immediately have to comply.

XII) Pediatric Care

If a plan requires a primary care provider designation for a child, a physician who specializes in pediatrics may be selected if the physician participates in the network of the plan.

Effective for plan years beginning on or after January 1, 2014 for newly established plans. Plans already in existence as of March 23, 2010 will not immediately have to comply.

XIII) OB/GYNs

The law prohibits authorization or referral for obstetrical or gynecological care provided by in-network health care providers who specialize in obstetrics or gynecology.

This is effective for plan years beginning on or after January 1, 2014 for newly established plans. Plans already in existence as of March 23, 2010 will not immediately have to comply.

EFFECTIVE 2018

I) All existing insurance plans must cover approved preventive care and checkups without a copayment.

II) A new 40% excise tax will be imposed on high cost (''Cadillac'') plans, including self-insured plans. The tax is based upon the cost of coverage in excess of $27,500 family coverage and $10,200 individual coverage.