



Compliance Guide June 2, 2010

Federal Health Care Reform for Self-funded Employers

This *Guide* provides an overview of the key provisions of federal health care reform which are likely to affect **Health Plans, Inc.'s** self-funded employer health benefit plans. Since the legislation is voluminous and complex, with regulations needed to interpret Congressional intent, the information included in this *Guide* is based upon our current knowledge and understanding. We will also issue a series of Compliance *Bulletins* and/or *Alerts* as the provisions of the law take effect and as governing regulations are published.

- Use this *Guide* as a quick reference for the overall provisions and timeline for federal health care reform.
- Use the Federal Health Care Reform *Bulletins* and *Alerts* that **Health Plans** will issue periodically for more detail about recommended and required actions for employers and about the steps we will take to help you keep your plan in compliance.

The Compliance Bulletin, Federal Health Care Reform—Number 1 accompanies this Guide and addresses recently released regulations on:

- Tax treatment of coverage for children under age 27
- Extension of coverage for adult children
- Early Retiree Reinsurance Program

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This Guide is intended to provide a summary of our understanding of significant developments which may affect our clients' plans. It should not be construed as specific legal advice or legal opinion. The contents are for general informational purposes only and are not a substitute for the advice of legal counsel.

I. THE LEGISLATION AND OVERVIEW

The Patient Protection and Affordable Care Act (PPACA) was passed by the Senate on December 24, 2009 and signed into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 which provided amendments to PPACA was passed by the House on March 23, 2010 and signed into law on March 30, 2010.

These Acts, collectively referred to as the "Affordable Care Act" or the "Act", form the basis of the federal health care reform legislation. Health care reform includes six main provisions which phase in over the next eight years:

- 1) Immediate Reforms
- 2) Insurance and Group Health Plan Mandates
- 3) Individual Mandate
- 4) Employer Mandates
- 5) Insurance Exchanges
- 6) Tax Provisions

Each of these six provisions is discussed below. The effective dates for the reforms vary – some are effective immediately, some take effect for plan years that begin on or after September 23, 2010, and some take effect between 2012 and 2018. Turn to the Quick Chronologic Reference Chart on page 9 for an overview of the timeline.

If you are an employer subject to or familiar with Massachusetts Health Care Reform, you will find that significant portions of the federal reforms are based upon Massachusetts state reforms in place since 2007, with employers, individuals, and the government all playing a part. It is expected that further guidance from federal and/or state regulators will be issued to reconcile the new federal requirements with existing Massachusetts law.

II. IMMEDIATE REFORMS

A. Tax Treatment of Coverage for Children under Age 27

Effective for Plan years beginning on or after September 23, 2010, group health plans and insurers that offer coverage to dependent children must make the coverage available to adult children until they reach age 26. (See Section III C below for information on this provision.) Effective **March 30, 2010**, the cost of coverage for an employee's child who is under age 27 no longer needs to be reported as imputed income to the employee. The IRS recently issued guidance regarding the tax treatment of health coverage and reimbursements for these older children.

Please see the *Compliance Bulletin*, *Federal Health Care Reform—Number 1 that* accompanies this *Guide* for details of the IRS guidance on tax treatment of coverage and benefits for adult dependents under age 27.

B. Retiree Reinsurance Program

The U.S. Department of Health and Human Services (HHS) will establish a temporary reinsurance program intended to help employers provide coverage to early retirees (ages 55-64) who are not yet eligible for Medicare. The program reimburses employers 80% of costs between \$15,000 and \$90,000 that are paid for each retiree, and will run until January 1, 2014 (or until the \$5 billion in appropriations for the program is exhausted). To be eligible, employers must apply to participate and must implement programs and procedures to generate cost savings with respect to participants with chronic and high-cost conditions. Any reimbursements received must be used to lower plan costs. HHS recently released regulations establishing the program effective June 1, 2010.

Please see the *Compliance Bulletin*, *Federal Health Care Reform—Number 1 that* accompanies this *Guide* for details about the Retiree Reinsurance Program.

III. INSURANCE AND GROUP HEALTH PLAN MANDATES

A. Overview

The insurance and group health plan mandate reforms of the Act were added to the HIPAA portability subparts of ERISA and the Internal Revenue Code. This means that liability for failing to comply with the reforms mirrors the liability for violating HIPAA portability under ERISA and the Code:

- Participants may file suit for specific performance under ERISA to require the employer to change plan benefits to comply
- Employers may be assessed up to a \$100 per day per participant as the penalty under the Code for non-compliance

The reforms do not apply to the following benefit plans:

- HIPAA "excepted benefits" such as stand alone dental and vision plans, or health flexible spending accounts
- Stand-alone retiree plans (although further clarification is needed on the application of the reforms to such retiree plans)

B. Grandfathered Plans

1. "Grandfathered" vs. "New" Plans

To understand which of the insurance and group health plan mandates apply to your self-funded health benefit plan, it must be determined whether your plan is a "grandfathered" or "new" plan. New plans are subject to all of the insurance reforms and coverage mandates. Grandfathered plans may have delayed effective dates or total exemption from certain insurance reforms and coverage mandates. However, grandfathering does not protect a plan from certain other reforms, including the Employer Mandates (see Section V below) and the Tax Provisions (see Section VII below).

To be a grandfathered plan, the plan must have been in effect on March 23, 2010 (the date of the Act's enactment). The law generally allows a grandfathered plan to continue its normal operations without losing grandfathered status. New enrollees may enroll in the plan and current participants may reenroll or change coverage to add dependents. What is not yet known is the extent to which changes such as amendments to plan design or cost-sharing will impact grandfather status. Regulations providing guidance on the meaning and intent of "grandfathering" are expected soon.

2. Collectively Bargained Plans

Special rules apply for grandfathered collectively bargained plans in effect on March 23, 2010. The Act provides that with respect to health coverage maintained under a collective bargaining agreement ratified before March 23, 2010, the insurance reforms and coverage mandates will not apply until the date on which the last CBA relating to coverage terminates. When the CBA terminates, the plan will then be subject to the new rules; however it is not clear whether the plan can then assume grandfathered status and whether the grandfathering may only apply to fully-insured but not self-funded collectively bargained plans. In addition, it is not clear whether a collectively bargained plan may adopt some of the new rules without having to comply with all. The upcoming regulations should address these unanswered questions.

3. Application to Self-Funded Plans

Subject to further regulatory clarification, Health Plans assumes that our clients' plans (with the exception of collectively bargained plans which may be subject to special rules as noted above) will be considered to be grandfathered plans.

The insurance and group health plan reforms which apply to grandfathered plans are outlined below. We have also included some basic information regarding the reforms which do not apply to grandfathered plans since, depending upon regulatory clarification, your plan could potentially be subject to the reforms applicable to "new" plans at some point in the future. While the provisions described in this *Guide* also apply to fully insured plans, we have not addressed the reforms which are applicable *only* to fully-insured plans.

C. Changes Effective on the First Plan Year on and after September 23, 2010

(for calendar year plans this means January 1, 2011)

1. Reforms Which Apply to Grandfathered Plans

a) Extension of Coverage for Adult Children

Plans that provide dependent coverage for children must extend coverage for children to age 26. For plan years beginning <u>before</u> January 1, 2014, grandfathered plans must extend coverage unless the adult child is eligible to enroll in another employer-sponsored health plan. Beginning with plan years that start on or <u>after</u> January 1, 2014, all adult children under age 26 must be permitted to enroll, regardless of the availability of other coverage. The IRS, DOL and HHS recently released regulations governing the extension of coverage for children.

Please see the *Compliance Bulletin Federal Health Care Reform—Number 1* that accompanies this *Guide* which outlines the details of the recently issued regulations.

b) Elimination of Preexisting Conditions Exclusions for Enrollees under Age 19

Plans are prohibited from applying any preexisting conditions exclusions to all "enrollees" under age 19. An "enrollee" can be a young employee or an employee's or spouse's dependent child.

c) Restricted Annual Limits

Plans are allowed to apply only "restricted annual limits" on "essential health benefits." HHS will need to define the meaning of "restricted annual limits"; however it appears this may mean that no annual dollar limit may apply to many benefits. HHS must also define "essential health benefits"; however the law specifies that they must include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventive & wellness services and chronic disease management
- · Pediatric services, including oral and vision care

Plans may allow annual limits on "non-essential" benefits.

d) No Lifetime Limits

Plans are prohibited from placing lifetime dollar limits on "essential health benefits" (see above for description of essential health benefits). Plans may allow lifetime limits on "non-essential" benefits.

e) Prohibition on Rescissions

Plans are prohibited from revoking a participant's coverage except in cases of fraud or intentional misrepresentation of a material fact as prohibited by the terms of the plan or coverage.

2. Reforms Which Do Not Apply to Grandfathered Plans

Grandfathered plans are not subject to the following reforms. If your plan loses grandfathered status, it may be subject to some or all of these reforms. The soon to be released regulations should clarify this.

a) Coverage of Preventive Services

Coverage for certain preventive services without any cost sharing, including deductibles.

b) Enhanced Appeals Process

Establishment of an internal claims appeals process that includes a requirement for claimants to continue to receive coverage during the appeals process.

Establishment of an external review process that meets certain requirements established by HHS for self-funded plans and by state law for fully-insured plans.

c) Choice of Primary Care Physician

Participants must be permitted to designate any participating primary care physician, including a pediatrician for a child's PCP and a gynecologist or obstetrician without referral for females.

d) Emergency Services

Emergency services must be provided without preauthorization and covered as in-network services.

D. Changes Effective March 2012

1. Reforms Which Apply to Grandfathered Plans

a) Standardized Benefit Summaries

Plans must provide benefit summaries and coverage explanations that conform to HHS standards. HHS must develop the standards by March 23, 2011 and Plans must provide compliant summaries **by March 23, 2012**. The summaries will be limited to four pages with print no smaller than 12 point font. These requirements are in addition to ERISA SPD requirements.

b) Advance Notice of Plan Changes

Plans must provide participants with 60-days advance notice of plan changes.

c) Administrative Simplification Provisions

Plans will be subject to new HIPAA Administrative Simplification Provisions with **varying effective dates beginning in 2012** and extending through 2016. HHS will adopt the final rule for unique health plan identifiers and electronic funds transfer standards. HHS will also adopt operating rules for standard transactions. Plans must certify compliance to HHS.

2. Reforms Which Do Not Apply to Grandfathered Plans

a) Reporting Requirements Regarding Coverage and Benefit Structures

Plans must report to HHS on incentives for case management, care coordination, chronic disease management, and activities to prevent hospital readmission. HHS must develop the reporting standards by March 23, 2012.

E. Changes Effective on the First Plan Year on or after January 1, 2014

1. Reforms Which Apply to Grandfathered Plans

a) No Annual Limits on Essential Health Benefits (similar to Mass Minimum Creditable Coverage requirements)

Plans may not apply annual limits on any essential health benefits. See Section III (C)(1)(c) for a list of "essential health benefits."

- b) Elimination of Preexisting Conditions Exclusions for all Enrollees Plans may not apply preexisting conditions exclusions to <u>any</u> enrollee.
- c) Waiting Periods Limited to 90 Days (similar to requirements under Mass Fair Share Contribution rules) Plans may not require waiting periods in excess of 90 days.

2. Reforms Which Do Not Apply to Grandfathered Plans

a) HIPAA Wellness Incentives

HIPAA Non-Discrimination and Wellness rules remain essentially the same as currently exist, but the maximum premium reduction allowed for wellness programs that require satisfaction of a standard related to a health factor will increase from 20% to 30%.

- b) Maximum Out-of-Pocket Limits Limitations on Deductibles, Coinsurance and Copayments allowed under a Plan.
- c) Coverage of Routine Costs for Clinical Trials Requirements to cover routine costs of individuals participating in certain clinical trials.

IV. INDIVIDUAL MANDATE

(Similar to Mass Individual Mandate)

Effective January 1, 2014, all adults will be required to obtain and maintain "minimum essential coverage" for themselves and dependent children. Minimum essential coverage is coverage under an employer plan, government plan, or other plans specifically designated by HHS. Minimum essential coverage is not the same as "essential health benefits" described in Section III above; there are no specified benefits or coverage levels for minimum essential coverage. If individuals do not obtain the required coverage, they must pay an excise tax penalty of \$95 for 2014 with increasing penalty amounts each year thereafter. The Act provides for exemptions from the penalty if coverage is "unaffordable" (as defined in the Act), and also provides a tax credit for individuals with household incomes between 100-400% of the federal poverty level.

V. EMPLOYER MANDATES

A. Automatic Enrollment

The effective date for this provision is currently unknown and will be established in future regulations. Employers with 200 or more employees must automatically enroll new full-time employees (subject to any waiting period) and continue the enrollment of current employees. Employees must be given notice of the automatic enrollment and the opportunity to opt out of the plan.

B. Notice of Availability of Insurance Exchanges

Effective March 1, 2013, employers must notify current employees (and future employees on the date of hire) of the:

- Existence of an Insurance Exchange (see Section VI below regarding Exchanges);
- Potential eligibility for a subsidy under an Exchange; and
- Loss of the employer contribution to any employer sponsored health benefit plan if an employee purchases insurance through an Exchange.

C. Play or Pay Mandate

Effective January 1, 2014, "Large Employers" with at least 50 full time equivalent employees are subject to the following "play or pay" mandates:

1. Failure to Offer Coverage (similar to Mass Fair Share Contribution)

Large Employers that do <u>not</u> offer "minimum essential coverage" (i.e. coverage under an employer sponsored health benefit plan) to full-time employees must pay a penalty if at least one full-time employee receives a federal subsidy to purchase coverage through an Exchange. The amount of the penalty is \$2,000 per year for every full-time employee (in excess of 30 employees), regardless of how many employees receive a federal subsidy. This amount is prorated by month for the period during which at least one employee receives the subsidy.

2. Insufficient Coverage (similar to Mass Free Rider Surcharge)

Large Employers that offer coverage under an employer sponsored health benefit plan to full-time employees that is deemed "unaffordable" (as defined in the Act), must pay a penalty if at least one full-time employee receives a federal subsidy to purchase coverage through an Exchange. The amount of the penalty is \$3,000 per year for each full time employee (in excess of 30 employees) who receives a subsidy, prorated by month for the period during which the employee receives the subsidy. However, the penalty will not exceed the penalty the employer would have paid had it not offered a health plan (i.e., the failure to offer coverage penalty noted above).

D. Free Choice Vouchers

Effective January 1, 2014, employers who offer coverage under an employer sponsored health benefit plan and contribute any portion of the cost must provide "qualified employees" with a voucher toward the purchase of a health plan through an Exchange. Qualified employees are those who decline to participate in the employer's plan and meet certain income and contribution threshold requirements as set forth in the Act (i.e., the employee is deemed not able to afford the employer's coverage). The voucher must equal the dollar amount of the employer's contribution for the highest cost plan offered.

E. Reporting Obligations

(Similar to Mass HIRD Requirements)

Effective January 1, 2014, Large Employers will be subject to increased reporting obligations and must provide a certification to the IRS including:

- Whether the plan offers "minimum essential coverage" to full time employees and dependents
- The total number of full-time employees and their names, address and tax ID number
- The time period each full-time employee was covered under the plan
- Waiting period information
- Employer contribution information

The certification will be used to enforce the individual mandate. Employers must also provide a written statement to each employee including the information the employer provided to the IRS as noted above.

VI. INSURANCE EXCHANGES

(Similar to Mass Health Connector)

The Act requires states to have Health Insurance Exchanges established and operational **by January 1, 2014**. If a state does not comply, HHS is required to establish and operate an Exchange. The purpose of the Exchanges is to facilitate access to the purchase of "qualified health plans" that provide "essential health benefits." The "qualified health plans" must meet state and federal certification procedures with four levels of coverage offered: bronze, silver, gold, and platinum. The "essential health benefits" provided under the Exchange plans must provide the levels of benefits described above under Section III.

Until 2017, only individuals and small employers with 100 or fewer employees generally are permitted to participate in an Exchange. However, for years before 2016, a state may further limit "small employers" to those with 50 or fewer employees. Beginning in 2017, states may allow employers of any size to offer coverage through an Exchange.

Employers may permit employees to pay for Exchange coverage with pre-tax dollars through the employer's cafeteria plan, with some restrictions.

VII. TAX PROVISIONS

A. W-2 Reporting

Beginning with the 2011 calendar year, employers must report the "value" (i.e., the COBRA cost) of employerprovided health coverage on each employee's W-2. The first W-2 affected will be the W-2 for 2011, to be issued to employees no later than January 31, 2012.

B. Over-the Counter Drugs for FSA, HRA and HSA Plans

Effective January 1, 2011, over the counter (OTC) expenses for medicines or drugs, other than insulin, are not eligible for reimbursement as a medical expense under a Flexible Spending Account Plan (FSA), Health Reimbursement Arrangement (HRA), or Health Care Savings Account (HSA) without a doctor's prescription. In order for drugs that are available without a prescription to be reimbursed, a doctor must prescribe the drug. This new rule applies to expenses <u>incurred</u> under an FSA or HRA on or after January 1, 2011, and for <u>distributions made</u> from an HSA on or after January 1, 2011.

C. Comparative Effectiveness Fee

Effective for plan years ending after September 30, 2012, plans will be charged a fee to fund comparative effectiveness research. The fee is based on the average number of covered lives per year. For plans years ending before October 1, 2013, the fee is \$1 times the average number of covered lives; for plan years ending on and after October 1, 2013, the fee increases to \$2 times the average number of covered lives.

D. FSA Limits

Effective January 1, 2013, employee contributions to a health care FSA will be limited to \$2,500.

E. Elimination of Tax Deduction for Retiree Drug Subsidy

Employers that participate in the Retiree Drug Subsidy Program are entitled to a federal subsidy to offset the cost of providing coverage to retirees that is equivalent to Medicare Part D coverage. Currently, employers are not taxed on this subsidy; however **effective January 1, 2013**, the Act eliminates the tax deduction for the subsidy.

F. "Cadillac" Plan Tax

Effective January 1, 2018, Plans will be required to pay a nondeductible excise tax of 40% for employee health benefit coverage valued above \$10,200/individual and \$27,500/family per year. Adjustments to these thresholds apply to multiemployer plans, retirees, and high-risk professions. Stand alone dental and vision benefits are not counted as taxable benefits for purpose of this provision.

VIII. QUICK CHRONOLOGIC REFERENCE CHART

The following chart outlines the key dates for the provisions of the Act which affect grandfathered plans, including the related individual mandate and insurance exchanges. Only provisions which apply to grandfathered plans are included in this chart.

DATE	PROVISION
March 23, 2010	\Rightarrow Plans in Effect are Considered Grandfathered Plans
March 30, 2010	\Rightarrow Change in Definition of Dependent for Purposes of Tax Free Health Coverage
June 1, 2010	\Rightarrow Retiree Reinsurance Program
Effective Date Currently Unknown; Will Be Established in Future Regulations	\Rightarrow Automatic Enrollment
First Plan Year on or after September 23, 2010	 ⇒ Extension of Coverage for Adult Children to Age 26 ⇒ Elimination of Preexisting Conditions Exclusions for Enrollees Under Age 19 ⇒ Restricted Annual Limits ⇒ No Lifetime Limits ⇒ Prohibition on Rescissions (Cancellations) of Coverage
January 1, 2011	⇒ Over-the Counter Drugs for FSA, HRA and HSA Plans Not Reimbursable Expenses
Beginning with the 2011 calendar year	\Rightarrow W-2 Reporting on Value of Health Benefits
Effective in 2012	 ⇒ Standardized Benefit Summaries (by March 23, 2012) ⇒ Administrative Simplification Provisions (varying effective dates beginning in 2012)
Plan Years Ending after September 30, 2012	\Rightarrow Comparative Effectiveness Fee Based on Average Covered Lives
January 1, 2013	 ⇒ \$2,500 Health Care FSA Contribution Limit ⇒ Elimination of Tax Deduction for Retiree Drug Subsidy
March 1, 2013	\Rightarrow Notice of Availability of Insurance Exchanges
January 1, 2014	 ⇒ Individual Mandate ⇒ Employer Pay or Play Mandates ⇒ Free Choice Vouchers ⇒ IRS Reporting Obligations ⇒ Insurance Exchanges
First Plan Year on or after January 1, 2014	 ⇒ No Annual Limits on Essential Health Benefits ⇒ Elimination of Preexisting Conditions Exclusions for all Enrollees ⇒ Waiting Periods Limited to 90 Days
January 1, 2018	⇒ Cadillac Plan Tax

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