

# Implementing the New Health Reform Law: What Governmental Employers Need to Know (The "Immediate" Changes)

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# Outline of Presentation

***This presentation focuses on the most immediate actions required by employers that sponsor or administer group health plans***

- First Round of Coverage Reforms (Plan Years beginning on or after September 23, 2010)
- First Round of Disclosure Requirements (beginning in 2011 and 2012)
- New limitations on FSAs/HRAs/HSAs (2011 and 2013)
- Changes on the Horizon (2014 and beyond)



# Threshold Issue: What is a Group Health Plan?

- Coverage mandates apply to “group health plans”
- Group health plan (GHP) is any plan, fund or program established or maintained by an employer or by an employee organization, or by both, for the purpose of providing medical care to employees or their dependents directly or through insurance or reimbursement.
  - Self and fully insured major medical
  - VEBA's (defined contribution or unallocated)
  - Health reimbursement accounts (HRAs)
  - Retiree only plans (?)



# Threshold Issue: What is a Group Health Plan?

- Group Health Plan does not generally include:
  - Health savings accounts and health flexible spending accounts
  - Limited scope dental and vision in a standalone plan or not integral part of medical plan
  - Long-term, nursing home, home health, or community based care in a standalone plan or not integral part of medical plan
  - Accident only, disability, liability, workers compensation, automobile medical payment, credit-only insurance, on-site medical clinics
  - Coverage for a specified disease or illness, hospital indemnity or other fixed indemnity if under separate policy and no coordination with group health plan
  - Medical supplemental health if separate policy



# Threshold Issue: Grandfathered Plan Status

## ■ *What Is a Grandfathered Plan?*

- All group health plans in existence on March 23, 2010 are “grandfathered health plans” under the Act
- Plans that maintain grandfathered status are exempt from several of the new coverage reform mandates
  - General rule: grandfathered status can continue indefinitely (subject to regulation)
  - Union plans: grandfathered status ends on the date the last agreement relating to the coverage terminates



# Threshold Issue: Grandfathered Plan Status

- ***How can a group health plan (non-union) maintain grandfathered status?***
  - Plan won't lose grandfathered status if:
    - The plan enrolls new employees and their families
    - The plan enrolls "family members" of existing participants
    - The plan is amended to comply with the adult child coverage mandate (even if amended for early compliance)
  - Plan ***could potentially*** lose grandfathered status if:
    - The plan is amended (required/discretionary)?
    - The plan enrolls existing employees not currently enrolled?
    - The plan enrolls a domestic partner of an existing participant?
    - The plan changes service providers?
- **REGULATIONS ARE EXPECTED AT ANY TIME**



## **First group of new coverage mandates, effective for plan years beginning on or after September 23, 2010**

<b>New Coverage Mandate</b>	<b>Applicable to Grandfathered Plans?</b>
Adult child coverage	Yes
No lifetime or annual dollar limits	Yes
No pre-existing conditions	Yes
First dollar preventive health care coverage	No
Internal and external appeals process	No
Mandated patient protections	No
Non-discrimination rules extended to insured plans	No
No discrimination based on health status	No



# Coverage Reforms: Extension of Dependent Coverage (*All Plans*)

## ■ *What's the New Rule?*

- Group health plans that provide dependent coverage of children must “continue to make such coverage available” for an adult child until the child turns 26 years of age
  - If plan does not cover dependent children, this mandate does not apply
  - Coverage must be extended regardless of marital or student status, but not to the adult child’s spouses/dependents
  - “Dependent” for purposes of this extended coverage is not tied to Internal Revenue Code Section 152, but is defined in guidance by the Secretary of HHS
- For plan years beginning before January 1, 2014, this rule applies to Grandfathered Plans only if the adult child is not eligible to enroll in any other employer health plan ***other than*** the group health plan of a parent (adult child’s spouse’s plan would count as “other” employer health plan)



# Coverage Reforms: Extension of Dependent Coverage (*cont.*)

- ***Interim Final Rule Clarifies Several Points:***
  - No restrictions on child eligibility based on parental support, residency, or similar restrictions (for children under age 26)
  - Making adult child amendment will ***not*** compromise grandfathered plan status
  - ***No*** higher premiums or other coverage differences may be applied to adult children under age 26
    - A premium rate structure that charges additional premiums for additional dependents regardless of age is still permitted (e.g., self-only, self-plus-one, self-plus-two, self-plus-three-or-more).
  - Provides a transition rule to permit 30-day special enrollment opportunity (and notice of opportunity) for adult children under age 26 who either: (1) previously aged-out of the plan, or (2) were denied (or were never eligible) for coverage due to age
    - Enrollment opportunity provided no later than first plan year after 9/23/10
    - All benefit packages for similarly situated individuals must be offered



# Coverage Reforms: Extension of Dependent Coverage (*cont.*)

- ***Tax Treatment of Coverage Provided to Adult Children***
  - Coverage provided to children who as of the end of the year have not turned age 27 will not result in imputed income to the employee, effective March 30, 2010
    - For this purpose, “child” is defined to include the employee’s son, daughter, stepson, stepdaughter, legally adopted child or eligible foster child
  - ***Employers can take advantage of this change now*** to the extent that their plan covers children who are not tax dependents under Internal Revenue Code Section 152
  - Also applies to HRA and FSA reimbursements made for medical expenses incurred by adult children on or after March 30, 2010, but the tax change did not carry through to HSAs, leaving question on impact to HSA/HDHP
  - Employers can permit pre-tax elections for adult child coverage and FSA reimbursements through a cafeteria plan in 2010 if they amend their cafeteria plans by the end of 2010



# Coverage Reforms: No Lifetime or Annual Dollar Limits (*All Plans*)

## ■ *What's the New Rule?*

- Effective for plan years beginning on or after 9/23/2010, group health plans may not establish any lifetime limits or annual limits on the dollar value of benefits for any participant or beneficiary
  - Group health plans may still place lifetime or annual limits on specific covered benefits that are not “essential health benefits.”
  - For plan years prior to 2014, the Secretary may permit a group health plan to place “restricted” annual (but not lifetime) limits on essential health benefits, as defined by the Secretary.
  - It appears that a group health plan is still permitted to place other limitations on benefits, such as limits on days of treatment or number of visits.
- Need to discuss the affect of this provision with the plan's stop-loss carriers to see how/if they are changing the liability they will take on
- What about participants who have already exceeded limits?



# Coverage Reforms: No Pre-Existing Condition Exclusions for Children (*All Plans*)

## ■ *What's the New Rule?*

- Group health plans may not impose any pre-existing condition exclusions for ***enrollees younger than age 19***, effective for plan years beginning on or after 9/23/2010
- Group health plans may not impose any pre-existing condition exclusions on ***any enrollee***, effective for plan years beginning on or after 1/1/2014
  - Will this result in repeal of requirements to provide HIPAA Certificates of Creditable Coverage?
  - HHS will set up temporary high-risk pool effective June 23, 2010, through 2014 to cover people who are excluded from coverage between 2010 and 2014
  - Interaction with adult coverage mandate – will some employers choose to comply with the 2014 requirement early to not impose pre-existing condition exclusions on children 19-26?



# Coverage Reforms: Mandated Coverage of Preventive Health Services (*Non-Grandfathered Plans only*)

## ■ *What's the Rule?*

- Group health plans must provide first dollar coverage, without any cost-sharing requirements (e.g., deductibles, co-pays, co-insurance, etc.) for:
  - preventive care services recommended by the U.S. Preventive Services Task Force,
  - immunizations recommended by the Centers for Disease Control and Prevention, and
  - preventive care for children and women supported by the Health Resources and Services Administration.
- At least one year period between the time a recommendation is made and the plan year when it must be covered by a group health plan with no cost-sharing requirements
- Uncertain how this rule coordinates with the requirements relating to preventive care that apply to HSAs/HDHPs



# Coverage Reforms: Mandated Claims Appeal Processes (*Non-Grandfathered Plans only*)

## ■ ***Internal Appeals Process***

- Group health plans are required to have an internal appeals process for appeals of coverage determinations
  - Initially similar to ERISA claims rules
  - Must provide notice to participants of appeals process
  - Must allow participants to review their file, present evidence and testimony, and receive continued coverage pending outcome of appeal
- Governmental plans are not subject to ERISA so will need to review current internal appeals process

## ■ ***External Appeals Process***

- Group health plans are required to have an external review process
  - Many fully-insured plans must meet State external review standards that satisfy NAIC model act
  - Other fully insured plans and self-insured plans must meet similar minimum standards set by Secretary of HHS



# Coverage Reforms: Mandated Patient Protections (*Non-Grandfathered Plans only*)


## ■ *What's the Rule?*

- Participants may designate a participating primary care provider of their choice for themselves and their children from physicians available in the network
- If a group health plan covers hospital emergency department services, it must do so without requiring prior authorization regardless of whether the provider is a participating provider and with same requirements and costs imposed on in-network participating providers
- If a group health plan covers OB/GYN care, participants are required to have access to such care without referral or authorization



# Coverage Reforms: Extension of Nondiscrimination Rules (*Non-Grandfathered Plans only*)

- ***Current Application of Nondiscrimination Rules***
  - Apply to self-insured group health plans
  - Essentially prohibits such plans from discriminating in favor of highly compensated employees with respect to eligibility and benefits
  - These rules have always been applicable to governmental plans
- ***Extension of Application of Nondiscrimination Rules***
  - Effective for plan years beginning on or after 9/23/2010, the nondiscrimination rules will also apply to non-grandfathered fully-insured group health plans
  - Could impact fully-insured plans for executives and highly-placed public officials
  - Treasury expected to issue new regulations under Section 105(h), but Secretary of HHS is responsible for regulations under PHSA - expect new emphasis on compliance



# Coverage Reforms: Health Status Nondiscrimination (*Non-Grandfathered Plans Only*)

- **Prohibition on Discrimination Based on Health Status**
  - GHPs may not establish rules for eligibility (including continued eligibility) to enroll based on health status related factors such as health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability
  - Codification of ERISA, IRC and PHSA regulations that already prevent discrimination in eligibility on the basis of health status since 1996 passage of HIPAA



# New Reporting/Disclosure Requirements

Effective Date	Disclosure Requirements	Applicable to Grandfathered Plans?
Plan years beginning on or after September 23, 2010	Report to Secretary of HHS and public on transparency in coverage	No
Reporting for calendar year January 1, 2011	Form W-2 Reporting	Yes
March 23, 2012	Uniform Benefit Summary	Yes
March 23, 2012 (or later per regulations)	Annual report to participants and Secretary of HHS on quality of care	No
March 1, 2013	Notice of coverage options to employees	Yes
January 1, 2014	Reporting information to IRS and to employees on minimum essential coverage and employer penalties	Yes
January 1, 2014	Reporting information to IRS and to employees on terms of coverage offered by employer	Yes



# New Disclosure Requirements: Form W-2 Reporting

## ■ *What's the New Reporting Requirement?*

- Employers are required to report on employees' Form W-2 the aggregate cost of employer sponsored health coverage
  - The “aggregate cost” will generally be the cost calculated for COBRA purposes and includes **both** employee **and** employer contributions
  - Not clear whether dental/vision are reported if stand-alone
  - Aggregated cost does not include:
    - Amounts contributed by an employer or employee to Archer MSAs or HSAs
    - Employee contributions to a medical FSA
- Applicable for taxable years beginning after December 31, 2010 (generally, 2011 calendar year) – included on Forms W-2 issued in ***January 2012***



# New Disclosure Requirements: Uniform Benefit Summary

- ***What is Uniform Benefit Summary?***
  - A “Summary, Summary Plan Description”
  - Summary of benefits and coverage explanation that accurately describes the benefits and coverage under the plan
  - Standards to be developed by the Secretary of HHS by March 23, 2011; will include standards for appearance, language, and content
  - If a plan is materially modified after the summary is distributed, notice of the modification must be provided 60 days **before** the date modification is effective (impact on open enrollment timing?)
- ***Who Is Responsible for Distribution?***
  - For self-insured plans, the employer
  - For insured plans, the insurer
- ***When Is First Distribution Required?***
  - March 23, 2012



# New Disclosure Requirements: Notice of Coverage Options

- Employers covered by Fair Labor Standards Act required to provide employees written notice about the availability of coverage on the Exchange and will include:
  - Information about the Exchange and its services.
  - Whether the employer's plan's share of total allowed costs is less than 60% of such costs.
  - Notification that the employee might be eligible for premium assistance or cost sharing reductions for coverage on the Exchange.
  - Notification that if the employee purchases Exchange coverage, he or she will lose the employer contribution (if any) to any employer-provided plan.
- Notice must be provided to all employees by 3/1/13 and to new hires thereafter.



# New Limitations on FSAs/HRAs/HSAs

## ■ *What Are the New Limitations?*

- **Effective January 1, 2011:** over the counter drugs are no longer qualified for purposes of distributions/reimbursements under HSAs, Archer MSAs, health FSAs, and HRAs, except for prescription medicines and insulin.
  - Restrictions on reimbursable **medications** do not appear to impact other medical expense items available for reimbursements, such as contact solution, band-aids, and other first aid supplies that are not medications
- **Effective January 1, 2011:** the tax on distributions from HSAs for nonqualified medical expenses is increased from 10% to 20% (Archer MSA penalty increased from 15% to 20%).
- **Effective January 1, 2013:** contributions to a health FSA under a cafeteria plan are limited to \$2,500 per year, indexed for inflation after 2013.

## ■ These changes are straightforward revenue raisers



# Changes on the Horizon

## ■ *What Didn't We Talk About Today?*

- Automatic enrollment for employers with more than 200 full-time employees, effective by regulation
- Second round of coverage reforms and reporting obligations take effect in 2014

<b>New Coverage Mandate</b>	<b>Applicable to Grandfathered Plans?</b>
No waiting period in excess of 90 days	Yes
Limits on cost-sharing and deductibles	No
Mandated coverage of clinical trials	No

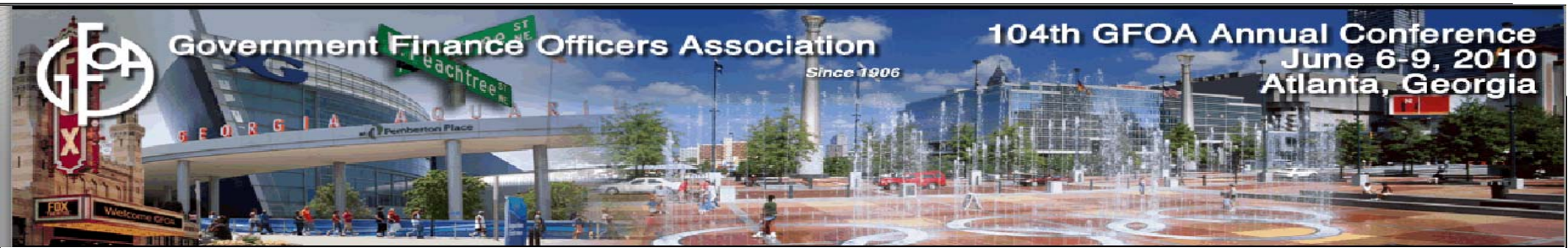


**For more information, see Ice Miller LLP's Health Care Reform website at:**

**<http://www.icemiller.com/searches/service.aspx?id=517>**



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# Retiree Health Plans

## ➤ Retiree reinsurance program— Effective 90 days from enactment:

- \$5 billion
- Pre-Medicare retirees age 55 – 64
- Reimburses 80% of claims between \$15,000 – \$90,000
- Plans must apply, document claims, and implement programs and procedures to generate cost savings for participants with chronic and high-cost conditions
- Plans must use funds to lower plan or retiree costs



- Are benefits provided to retirees not eligible for Medicare?
- If so, high priority to file the application timely.
- How can funds be used to lower plan or retiree costs?

# Application Process

- Regulations published May 5, 2010
- Application process will be modeled on the Retiree Drug Subsidy Program
  - Only one application required (not annual and no specific deadline)
  - No actuarial attestation required
- HHS will accept applications in the order in which they are received
- HHS will deny incomplete applications, and an application that is then resubmitted will be assigned a later filing date
- **As a result, it is critical that applications be complete when submitted the first time. HHS reserves the right to deny applications (and/or claims, in whole or in part) based on lack of funds**

# Application Requirements

- Must project the amount of reimbursement expected during the first two plan years
- Must explain how reimbursements will be used
- Must describe programs that have generated or have the potential to generate cost savings for participants with chronic and high-cost conditions
- Must include an agreement, signed by the plan's authorized representative, to comply with the federal requirements for the program. This agreement includes an assurance that there is an insurer/plan agreement in place regarding disclosure of data and an attestation that the plan (or its insurer/plan) has policies and procedures in place to detect fraud, waste and abuse in the operation of this program

# Use of Program Reimbursements

- Plan sponsors may use reimbursements to:
  - reduce the plan's health benefit premiums or health benefit costs, and/or
  - reduce health benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs for plan participants
- Funds may be used to lower health benefit costs for all participants, not just the early retirees, including active employees. However, the funds may not be used as general revenue of the plan sponsor
- Plan sponsors must maintain the level of effort to support their applicable plan or plans
- Funds received in Year 1 may be used in Year 2
- The application must explain the use of reimbursements

## Two-Year Estimate Required

- In the application, plan sponsors must project reimbursement amounts for the first two plan-year cycles with specific amounts for each of the two cycles, so that HHS can project total reimbursement amounts and determine when to stop accepting applications
- Unlike the RDS Program, the projection does *not* require an attestation from a qualified actuary



# Chronic Care Programs

- The plan sponsor must have in place programs and procedures that have generated or have the potential to generate cost savings for plan participants with chronic and high-cost conditions
  - A chronic and high-cost condition is defined as a condition for which \$15,000 or more in health benefit claims are likely to be incurred during a plan year by one participant
  
- The preamble includes two examples of programs:
  - A diabetes management program that includes aggressive monitoring and behavioral counseling to prevent complications and unnecessary hospitalizations
  - A program that covers all or a large portion of a cancer patient's coinsurance or copayments or reduces the plan deductible for cancer treatments

# Fraud, Waste, and Abuse Policies

- The plan must have policies and procedures to detect fraud, waste, and abuse
  - The plan also must retain data to substantiate the implementation and the effectiveness of the policies and procedures
- The plan sponsor must attest that the policies and procedures are in place as part of the application, even if the policies are maintained by the health insurance issuer or group health plan

# Medicare Changes

- New Annual Wellness Visit (includes a Health Risk Assessment)
- Increased Medicare payments for certain preventive care; decreased cost-sharing for beneficiaries
- New Medicare Advantage (MA) and Part D annual enrollment period – October 15 to December 7 beginning in 2011 (2010 period from November 15 to December 31 remains the same)
- No more open enrollment period to switch between MA plans, but can drop an MA plan and enroll in regular Medicare and a PDP from January 1 to February 15; begins 2011
- Medicare Independent Payment Advisory Board
  - Expansion of coverage financed partially by CMS.
  - Plans may need to coordinate enrollment with the new MA enrollment period.

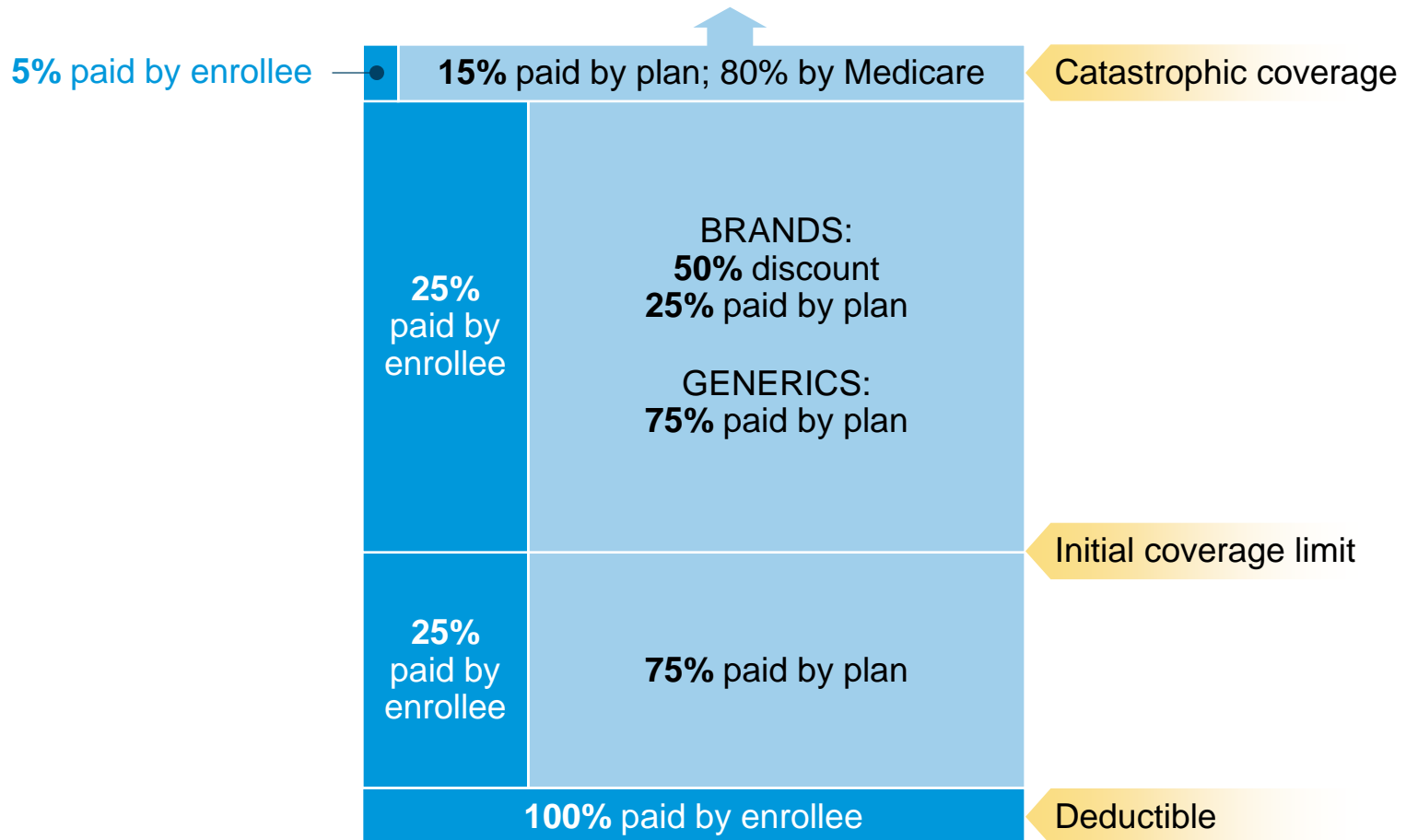
# Medicare Part D

- Medicare Part D Prescription Drug Plans and MA-PDs
  - \$250 rebate for beneficiaries who reach doughnut hole in 2010
  - In 2011 discounts on brand-name and generic drugs in doughnut hole for retirees in a Prescription Drug Plan; Close doughnut hole by 2020
- Part D premium indexed based on income just like Part B
- Medicare Part D Retiree Drug Subsidy would be taxable in 2013 for employer with a tax liability—Not applicable to governmental plans
- Medicare Advantage payment changes

**With increase in RDS value and PDPs getting higher subsidies, plans should revisit providing coverage directly and collecting the RDS vs. providing coverage through a Medicare PDP**

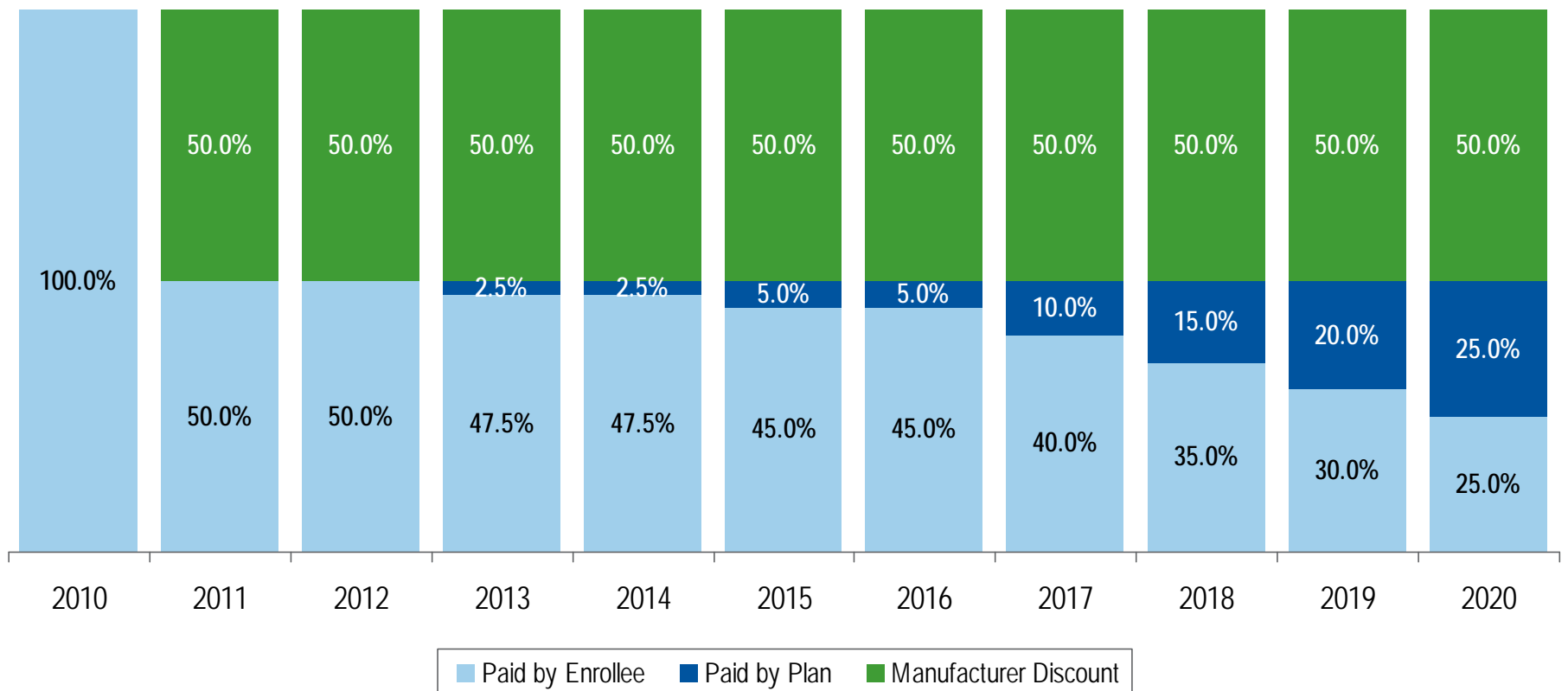
# Medicare Part D in 2020

## STANDARD MEDICARE PRESCRIPTION DRUG BENEFIT, 2020 WITH HEALTH REFORM



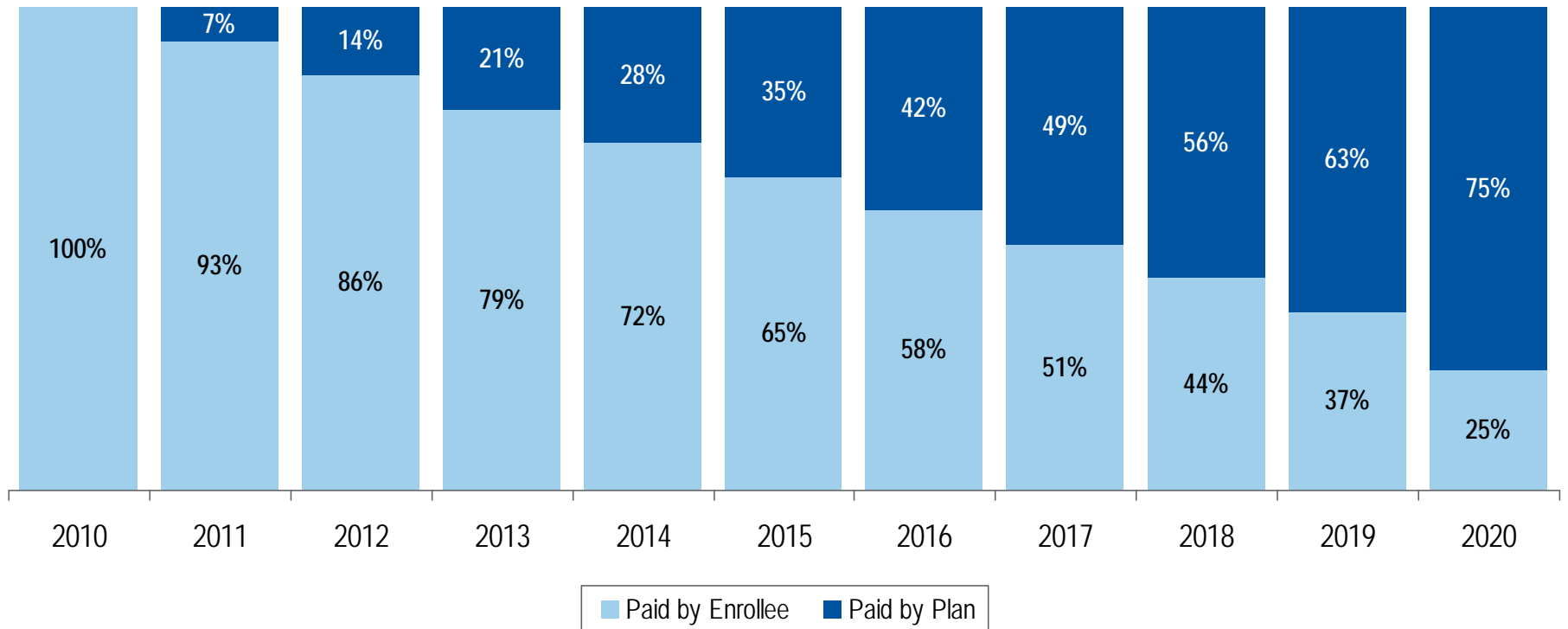
# Part D Brand Benefit in the Coverage Gap

## COST SHARING FOR BRAND-NAME DRUGS IN THE MEDICARE PART D COVERAGE GAP, 2010–2020



# Part D Generic Benefit in the Coverage Gap

## COST SHARING FOR GENERIC DRUGS IN THE MEDICARE PART D COVERAGE GAP, 2010–2020



# New Fees

## Comparative Effectiveness Fee

- First plan year ending after September 30, 2012—\$1.00 per covered life per year
- 2012 – 2019—\$2.00 indexed
- Sunsets in 2019
- Applies to insured and self-insured plans



**Comparative effectiveness is comparing two or more treatments for a given condition.**

# CLASS Act

- National, voluntary insurance program for purchasing community living assistance services and supports (CLASS)
- Five-year vesting period
- Cash benefit of not less than an average of \$50 per day
- Effective January 1, 2011
- Voluntary payroll deduction and employee opt-out process
- Intended to supplement existing long-term care insurance



**This will be an employer payroll issue**

# What is Still to Come?

- Excise Tax
- Exchanges
- Free-rider penalties
- Free-Choice Vouchers
- Tax changes



## Excise Tax Delayed to 2018

40% excise tax on cost of health plans above a certain threshold

- Threshold \$10,200/\$27,500 indexed to the CPI-U (2018 numbers)
- Adjustments due to age/gender
- Increased thresholds for high-risk professions (including public safety) and retirees (\$1,650/\$3,450)
- Thresholds increased in 2018 if CBO projections incorrect
- Excludes dental and vision; includes health HRAs, HSAs, and FSAs

## Excise Tax

### ➤ Example:

Plan costs are \$30,000 for family coverage in 2018

Plan exceeds threshold by \$2,500 ( $\$30,000 - 27,500$ )

Excise tax would be  $\$2,500 \times 40\% = \$1,000$

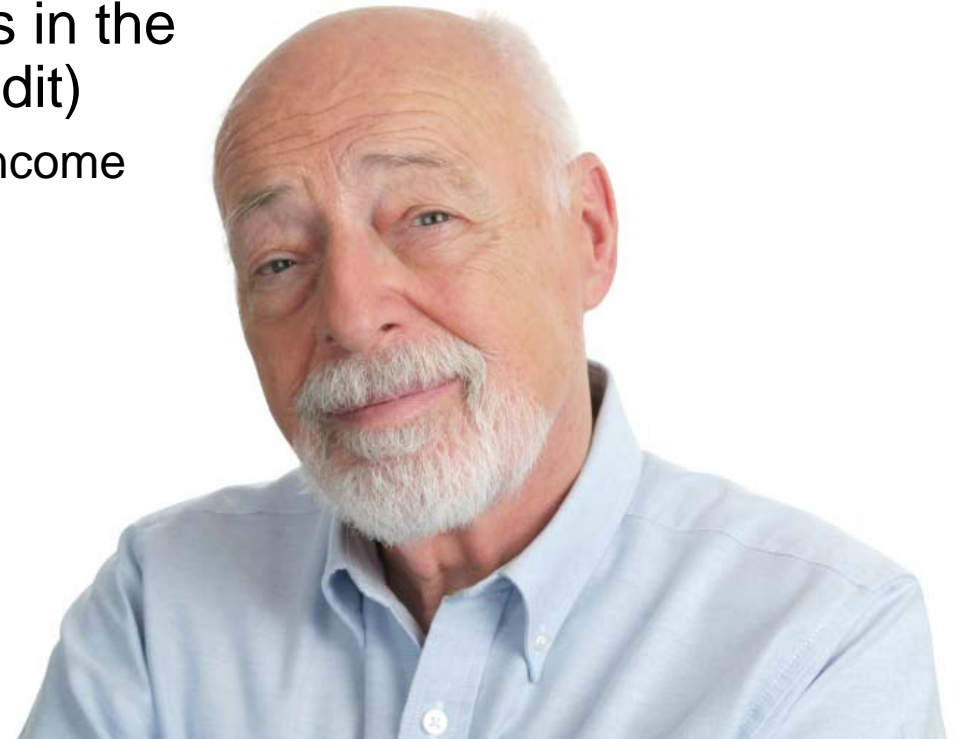
➤ Tax is paid by the plan or its insurer or administrator

➤ Employer is responsible for calculating amount due

**Although the excise tax is not effective until 2018, plan costs should be closely monitored.**

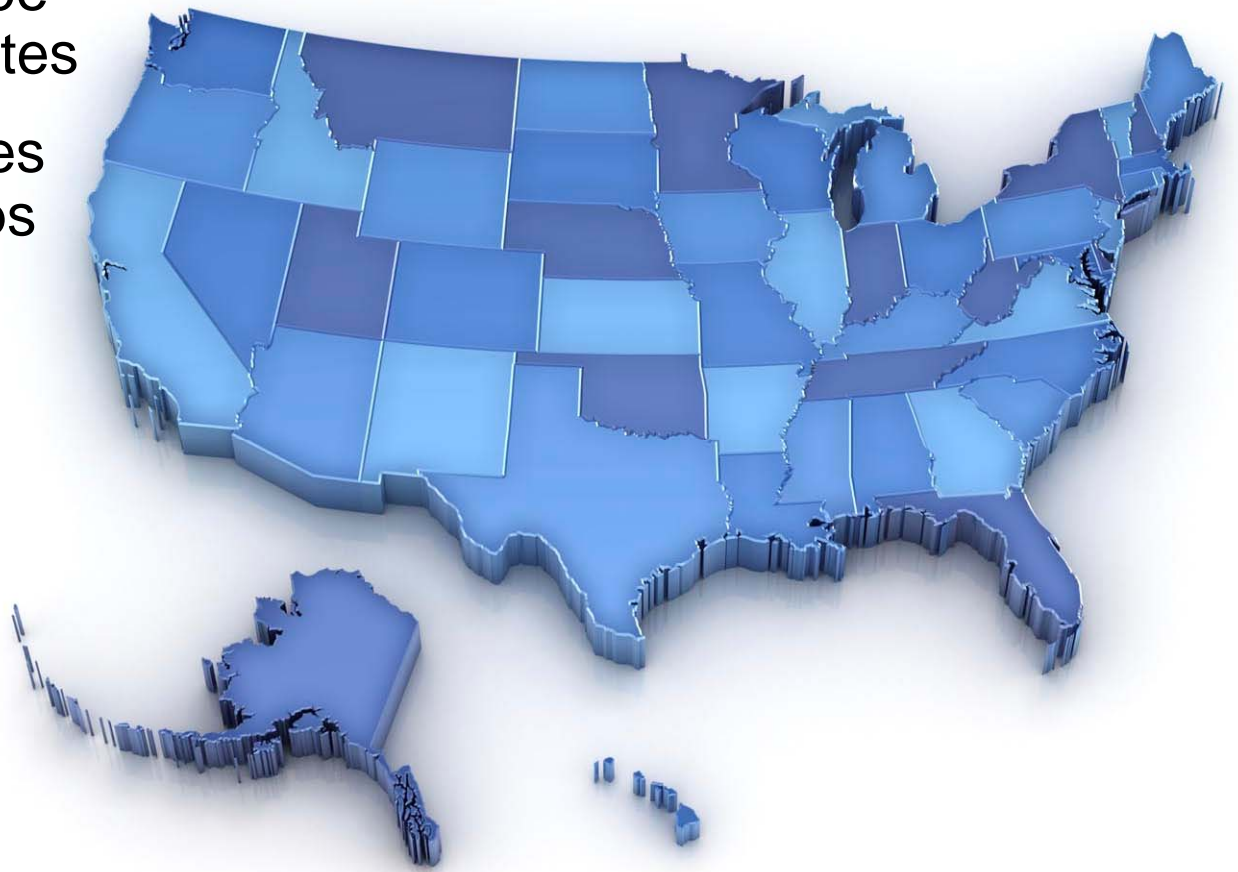
# Individual Mandate and Subsidies

- In 2014, individuals must have coverage or pay a tax penalty
- Expansion of Medicaid to 133% FPL; more federal money toward Medicaid expansion to ease burden on states
- Subsidies to individuals up to 400% of FPL; more money to subsidize lower income individuals in the Exchange (in the form of a tax credit)
  - Subsidies on a sliding scale based on income
  - Subsidies will provide lower premiums and lower cost-sharing



# The Health Insurance Exchange

- In 2014, a new marketplace where individuals and small groups can choose from a menu of regulated insurance products
- Final Exchanges will be established by the states
- **2017:** State Exchanges may allow large groups in Exchange



# How Could the new Health Exchanges Affect Costs?

- Some provisions may potentially **reduce costs** for plan sponsors *indirectly* and over the *long term*:
  - Reduced pool of uninsured may reduce the cost shift resulting from uncompensated care
  - A new insurance marketplace could bring down costs throughout the system due to increased competition and reduced administrative costs
  - Benefit requirements for exchange plans are extensive and could affect costs
  - Quality incentives/payment reforms will induce providers to coordinate care and redesign delivery systems around quality cost-effective care
  - Comparative effectiveness research and health IT are additional tools

# Free-Rider Penalty

- Free-rider penalty effective 2014
- Applies to employers with 50 or more employees
  - Must aggregate hours of part-time employees to create total number of employees
  - Subtract first 30 workers when paying assessment
- If the employer does not offer coverage (and one employee receives a tax credit in the Exchange)
  - \$2,000 times the total # of full-time employees
- If the employer does offer coverage but coverage is unaffordable or value is less than 60% of plan costs (and one employee receives a tax credit in the Exchange)
  - \$3,000 times # of full-time employees getting tax credit in Exchange

# Free-Choice Vouchers

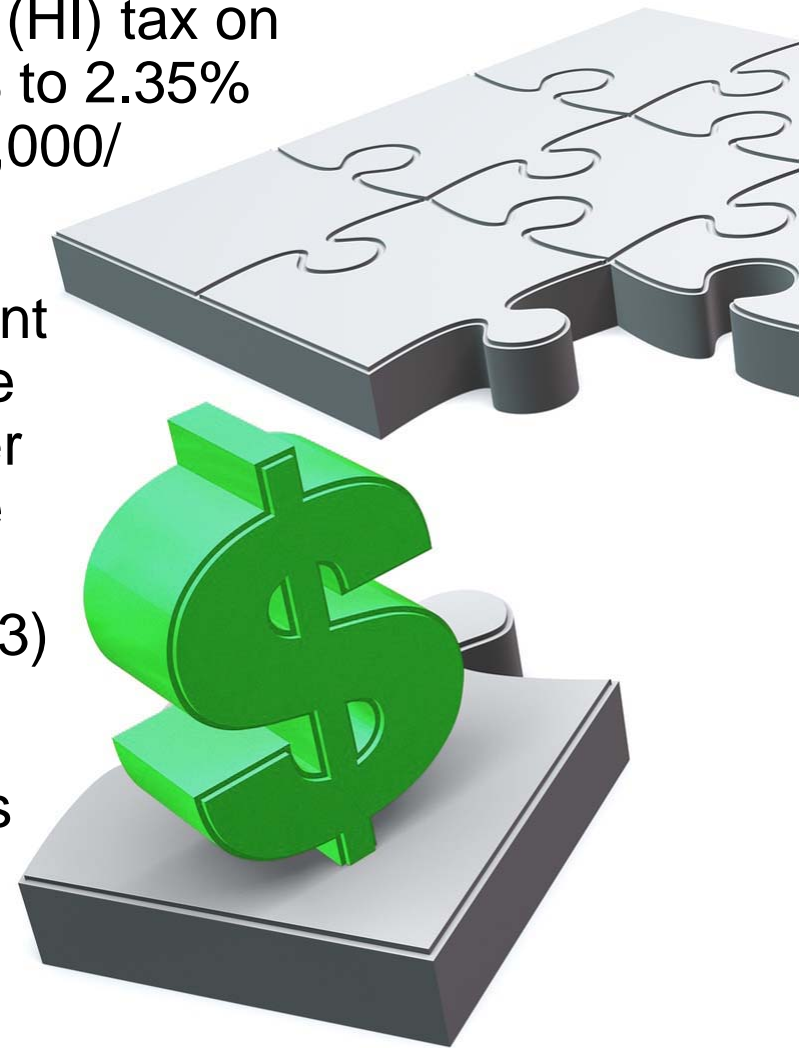
- In 2014, employers offering health coverage will be required to give Free-Choice Vouchers to certain employees, which allows them to take the employer contribution and purchase coverage in the exchange

**Criteria:** Employees with incomes less than 400% of FPL if contributions for employer plan are between 8% and 9.8% of employee's household income and employee does not enroll in employer plan



# Tax Changes

- The Medicare Part A hospital insurance (HI) tax on wages would increase 0.9% from 1.45% to 2.35% for high-income individuals (single \$200,000/ couple \$250,000) (2013)
- In addition, a new 3.8% tax on investment income would apply to individuals whose modified adjusted gross income is higher than \$200,000/\$250,000 (would include interest, dividends, royalties, rents, etc., but not retirement plan distributions) (2013)
- New fees on device manufacturers, pharmaceutical companies, and insurers



# Health Care Reform Timeline



## Health Care Reform

Timeline for Calendar-Year Group Health Plans\*

KEY HEALTH CARE REFORMS			
	Provisions Directly Affecting Existing Group Health Plans	Medicare Reforms	Other Health Reforms
<b>2010</b>	<ul style="list-style-type: none"> <li>Retiree reinsurance program</li> <li>Tax-free coverage for children through end of year child turns 26</li> <li>Small business tax credits</li> </ul>	<ul style="list-style-type: none"> <li>\$250 reimbursement in Part D coverage gap ("doughnut hole")</li> </ul>	<ul style="list-style-type: none"> <li>Temporary high-risk pool</li> <li>DOL to require Multiple Employer Welfare Arrangements (MEWAs) to register with DOL</li> </ul>
<b>2011</b>	<ul style="list-style-type: none"> <li>No lifetime dollar limits on essential benefits</li> <li>Only permitted annual dollar limits</li> <li>Extension of coverage for adult children until age 26</li> <li>No preexisting condition exclusion for children under 19</li> <li>Ban on rescinding coverage</li> <li>Flexible Spending Arrangements/Health Reimbursement Arrangements/Health Savings Accounts: over-the-counter medications reimbursable only with prescription</li> </ul>	<ul style="list-style-type: none"> <li>Additional Prescription Drug Plan (PDP)/Medicare Advantage plan with prescription drug coverage (MA-PD) discounts for brand and generic</li> <li>PDP/MA-PD may waive copayments for first fills of generic</li> <li>Medicare Advantage payments frozen at 2010 levels</li> <li>Medicare Part D premiums increased for high-income beneficiaries</li> <li>New Medicare wellness benefits</li> </ul>	<ul style="list-style-type: none"> <li>Higher penalty for Health Savings Account withdrawals for non-qualified expenses</li> <li>Medical loss ratio requirements for insurers (85% for large groups)</li> <li>CLASS program (voluntary, public long-term care program)</li> <li>Annual fee on pharmaceutical manufacturers and importers</li> </ul>
<b>2012</b>	<ul style="list-style-type: none"> <li>Employer W-2 reporting on 2011 coverage</li> <li>Standardized information disclosure (with notice of modifications 60 days in advance)</li> <li>Comparative effectiveness research fee paid by insurers and self-insured plans, beginning plan year ending after September 30, 2012 (\$2 per covered life; \$1 in first year)</li> </ul>	<ul style="list-style-type: none"> <li>Medicare Advantage payments decreased</li> </ul>	
<b>2013</b>	<ul style="list-style-type: none"> <li>FSA contributions capped at \$2,500 (indexed)</li> </ul>	<ul style="list-style-type: none"> <li>Corporate health plans lose tax deduction for Part D Retiree Drug Subsidy reimbursements</li> </ul>	<ul style="list-style-type: none"> <li>Increases in Medicare Hospital Insurance tax for high-income individuals</li> <li>Annual fee on medical device manufacturers and importers</li> </ul>
March 1	<ul style="list-style-type: none"> <li>Employer notice to employees about the Health Insurance Exchange</li> </ul>		
December 31	<ul style="list-style-type: none"> <li>Plans to certify compliance with certain Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) standards</li> </ul>		

\* Most of the law's provisions take effect at the start of a plan year. Plans that are not calendar-year plans would have different effective dates. For example, for a plan with a July 1 plan year, all but the last item listed in the left column for 2011 would take effect on July 1, 2011. The effective date for collectively bargained plans is unclear. Plan sponsors of collectively bargained plans should consult with legal counsel about the effective date.

# Health Care Reform Timeline *continued*



## Health Care Reform

Timeline for Calendar-Year Group Health Plans\*

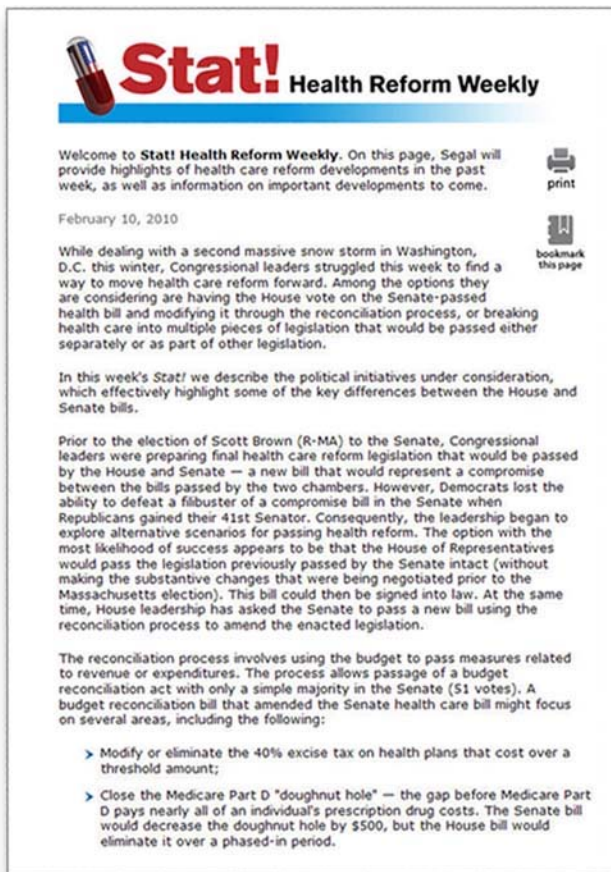
KEY HEALTH CARE REFORMS			
	Provisions Directly Affecting Existing Group Health Plans	Medicare Reforms	Other Health Reforms
<b>2014</b>	<ul style="list-style-type: none"> <li>No waiting periods longer than 90 days</li> <li>No annual dollar limits on essential benefits</li> <li>Employer free-rider penalty</li> <li>Free-choice vouchers</li> <li>Wellness program rules</li> <li>Employers to report to IRS on plan features (and provide statements to employees by January 31, 2015)</li> </ul>		<ul style="list-style-type: none"> <li>Health Insurance Exchanges</li> <li>Individual mandate with federal subsidies</li> <li>Medicaid expansion to 133% of Federal Poverty Level</li> <li>Annual fee on health insurance providers</li> </ul>
<b>2015</b> December 31	<ul style="list-style-type: none"> <li>Plans to certify compliance with other HIPAA EDI standards</li> </ul>		
<b>2018</b>	<ul style="list-style-type: none"> <li>Excise tax on high-cost health plans</li> </ul>		
Effective Date to be set in regulations	<ul style="list-style-type: none"> <li>Automatic enrollment by large employers (200 or more full-time employees)</li> </ul>		

\* Most of the law's provisions take effect at the start of a plan year. Plans that are not calendar-year plans would have different effective dates. For example, for a plan with a July 1 plan year, all but the last item listed in the left column for 2011 would take effect on July 1, 2011. The effective date for collectively bargained plans is unclear. Plan sponsors of collectively bargained plans should consult with legal counsel about the effective date.

# Website Resources

## Stat! Health Reform Weekly

<http://www.segalco.com/publications-and-resources/stat/>



**Stat! Health Reform Weekly**

Welcome to **Stat! Health Reform Weekly**. On this page, Segal will provide highlights of health care reform developments in the past week, as well as information on important developments to come.

February 10, 2010

While dealing with a second massive snow storm in Washington, D.C. this winter, Congressional leaders struggled this week to find a way to move health care reform forward. Among the options they are considering are having the House vote on the Senate-passed health bill and modifying it through the reconciliation process, or breaking health care into multiple pieces of legislation that would be passed either separately or as part of other legislation.

In this week's *Stat!* we describe the political initiatives under consideration, which effectively highlight some of the key differences between the House and Senate bills.

Prior to the election of Scott Brown (R-MA) to the Senate, Congressional leaders were preparing final health care reform legislation that would be passed by the House and Senate — a new bill that would represent a compromise between the bills passed by the two chambers. However, Democrats lost the ability to defeat a filibuster of a compromise bill in the Senate when Republicans gained their 41st Senator. Consequently, the leadership began to explore alternative scenarios for passing health reform. The option with the most likelihood of success appears to be that the House of Representatives would pass the legislation previously passed by the Senate intact (without making the substantive changes that were being negotiated prior to the Massachusetts election). This bill could then be signed into law. At the same time, House leadership has asked the Senate to pass a new bill using the reconciliation process to amend the enacted legislation.

The reconciliation process involves using the budget to pass measures related to revenue or expenditures. The process allows passage of a budget reconciliation act with only a simple majority in the Senate (51 votes). A budget reconciliation bill that amended the Senate health care bill might focus on several areas, including the following:

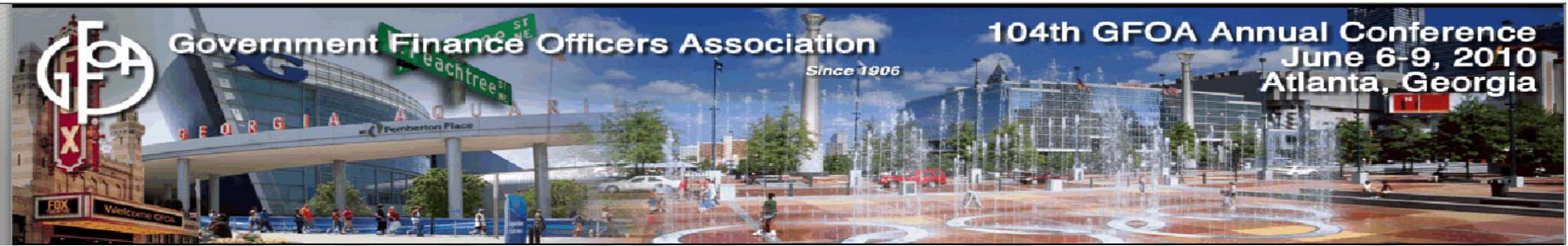
- Modify or eliminate the 40% excise tax on health plans that cost over a threshold amount;
- Close the Medicare Part D "doughnut hole" — the gap before Medicare Part D pays nearly all of an individual's prescription drug costs. The Senate bill would decrease the doughnut hole by \$500, but the House bill would eliminate it over a phased-in period.

### And Other Resources:

- Health Care Reform Timeline **New!**
- Issue Briefs **New!**
- *Bulletins*
- *NewsLetters*

### Can be found on:

- Segal's Health Care Reform Guide page <http://www.segalco.com/health-care-reform/>



# Questions

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# Implementing the New Health Care Law



a great place to live and work

What do we do now?



## Evaluate

- What is required immediately?
  - Coverage for young adults
  - Coverage of free preventive care
  - New Over-the-Counter Rules for FSAs, HRAs and HSAs
- What is the financial and operational impact?



## What needs to be done now?

- What is a grandfathered plan?
  - Do our plans fit the description
  - How do you lose your grandfathered status
- How do the new requirements fit our philosophy of benefits delivery?
- Should we chose to implement some or all of the requirements for new plans?
- How will changes affect our bottom line?



## What needs to be done now?

- **Wellness**
  - On Site Clinic
  - Evaluate current Wellness Program for enhancements
- Provide the best benefits at the best cost



## Next step - Consultants

- Verify assumptions
- Determine best practices
- Develop cost projections



## How do we make this work?

- **System changes**
  - Annual Enrollment October 2010
  - How to capture adult dependent data
  - Rates for adult dependent coverage
  - Looking forward to future changes
    - Analyze changes for unexpected consequences



## How do we communicate this?

- Employees have been hearing about the changes
  - Fear of loss of coverage
  - How to communicate changes
  - What do the changes mean to the employee
  - What new choices will they have



## Future Issues

- Health Care Value added to W-2 for 2011 (issuance in 2012)
- Auto Enrollment in 2014
- New interpretations as developed
- Part time employees coverage



Questions?