



# USE THIS QUICK GUIDE TO REVIEW HEALTH CARE REFORM KEY ITEMS

The Willis Human Capital Practice is prepared to provide you with accurate actionable information regarding Health Care Reform. Start by reviewing the key points provided in the following guide and contact your Client Advocate for additional information to assess your unique situation.

*Please note this guide is intended to present only a short-hand summary of Health Care Reform. For detailed information about Health Care Reform, please see our other Willis publications on this topic. Your Client Advocate can assist you with obtaining those publications. As none of the information presented here represents legal advice, you must direct specific legal issues to your attorney.*

# GROUP HEALTH PLAN INSURANCE REFORMS

## WHICH EMPLOYER PLANS ARE SUBJECT TO THE INSURANCE REFORMS?

- ERISA plans (self-funded and insured);
- Non-federal governmental plans;
- Insured church plans;
- Self-funded church plans;\* and
- Plans using the grandfathered exception (explained below) are still affected in key ways.

*\* Although somewhat unclear, our best analysis suggests these plans are also subject to the law. Any organization disputing applicability is urged to consider the matter with counsel and obtain a formal legal determination.*

## ARE ALL PLANS AFFECTED EQUALLY?

No. Grandfathered health plans are exempted from some (but not all) of the group health plan insurance reforms.

## WILL PLAN DESIGN CHANGES JEOPARDIZE THE EXEMPTION STATUS FOR GRANDFATHERED PLANS?

The law does not include provisions that directly preclude plans from making design changes. In fact, the law specifically allows plans to add or drop participants without affecting grandfather status. It therefore appears that coverage and terms of grandfathered plans may be reasonably changed without losing grandfathered status and current employer plans will be grandfathered indefinitely. Nevertheless, plan sponsors may find it prudent to limit the scope of new design changes until regulatory guidance is issued.

### **Grandfathered Plans**

A grandfathered health plan is any group health plan (self-funded or insured) in effect on March 23, 2010. As special rules govern the effective date of collectively bargained plans that were ratified before March 23, 2010, forthcoming regulatory guidance for employers subject to these agreements remains a concern.

### **Insurance Reforms May Not Apply to Excepted Benefits**

Forthcoming regulations will clarify, but when maintained as a separate plan, e.g. provided under a separate policy, certificate or contract of insurance, then most dental and vision plans will be exempt from the new requirements. A similar exemption applies for health Flexible Spending Accounts.

### **State Mandates on Dependent Child Age**

As the federal health care reform package does not change state law, insured plans must continue to comply with local requirements for coverage of older age dependents.



## Reinsurance for Early Retiree Coverage

The program may provide reimbursement of up to 80% of an individual's medical claim costs to the extent the costs exceed \$15,000 but are not more than \$90,000. A plan must implement programs and procedures that generate cost savings for participants with chronic and high cost conditions. Specifically, plans must use these proceeds to lower health care costs for enrollees.

## “Essential Health Benefits”

This includes at least items and services in the following broad categories:

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

# HEALTH CARE REFORM TIMELINES

## JUNE 21, 2010

For employers providing early retiree medical coverage, a temporary reinsurance program will provide reimbursement for a limited threshold of claims for those early retirees who are over age 55 and not yet eligible for Medicare.

## PLAN YEARS STARTING ON OR AFTER SEPTEMBER 23, 2010

### All Plans

1. No lifetime dollar limits on “essential health benefits.”
2. No annual dollar limits on “essential health benefits” (except as determined by the Department of Health & Human Services [HHS]).
3. No revocation of coverage (except for fraud/intentional misrepresentation).
4. No preexisting condition exclusions for enrollees under age 19.
5. Requirement for plan coverage to be available for children until they reach age 26 (grandfathered plans may deny coverage to any child who is eligible for other employment-based health coverage).
6. Requirement to file a medical loss ratio report with HHS for each plan year (does not apply to self-insured plans, except for employment-based health coverage available through a child's parent).

### Additional Measures for Non-Grandfathered Plans Only

7. Requirement for coverage of certain preventive health services and immunizations without cost-sharing.
8. No discrimination in favor of higher-wage employees (self-insured plans continue to be subject to prior non-discrimination rules).
9. Requirements to provide patient protections regarding emergency services, choice of primary care provider, and access to gynecological/obstetric services.
10. Requirement for internal and external appeals processes.



## JANUARY 1, 2011

- No reimbursement for non-prescribed over-the-counter drugs/medicines (OTC items) other than insulin, under Health Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs), Archer MSAs or Health Reimbursement Arrangements (HRAs).
- Increased penalties (20%) in the case of distributions from HSAs and Archer Medical Savings Accounts (MSAs) for non-qualifying expenses.
- Requirement to report the value of each employee's health coverage on W-2s starting with the 2011 taxable year.

## STARTING IN 2011

- Simple cafeteria plans for small employers. Cafeteria plan usage is encouraged for small employers by exempting such organizations from some cafeteria plan compliance duties.

## MARCH 23, 2012

- Requirement to prepare and provide uniform explanations of coverage.
- Requirement for plans to notify enrollees of material changes to the coverage described in the uniform explanation no less than 60 days before the change is effective. Caution: some authorities assert a possibly earlier effective date for this provision.
- Deadline for HHS to develop standards for annual reports to enrollees and HHS on plan benefits that improve health outcomes.
- No deadline is set for HHS to issue standards for "transparency" reports that plans are to send to HHS and make publicly available, but it is expected that plans may forego preparing these reports until standards are issued.

## SEPTEMBER 30, 2012

- Group health plans (self-funded and insured) will be assessed a tax of \$2 (\$1 in the case of plan years during fiscal year 2013) per average number of participants for "comparative effectiveness research." The tax will be indexed annually, and is scheduled to "sunset" for plan years ending after September 30, 2019.

## Self-Funded Plans and Lifetime Maximums

The law generally eliminates lifetime dollar limits. Self-funded plans will need to discuss the elimination of lifetime maximums with their stop-loss carriers to determine appropriate stop-loss levels in the future.

## CLASS Program

A national voluntary insurance program for purchasing community living assistance services. Following a 5-year vesting period, the program will provide individuals with functional limitations, a cash benefit of not less than an average of \$50 per day to purchase non-medical services and support necessary to maintain community residence. Financed through voluntary payroll deductions, all working adults will be automatically enrolled in the program, unless they choose to opt-out. Employers who choose to participate are required to automatically enroll employees unless the employee elects to opt-out.

## Compliant Summaries

Plans must have compliant summaries available starting March 23, 2012, even if the timing does not coincide with the plan's annual enrollment cycle.

It does not appear that these summaries are intended to replace current Summary Plan Descriptions (SPDs) required by ERISA, but are likely intended to work in tandem with SPDs to offer participants easy access to plan information.

## Employer "Free Rider" Penalty

Applies to large employers with 50 or more full-time equivalent employees.

- First 30 full-time employees excluded from tax.
- Employer does not provide coverage and at least one employee receives exchange coverage, the penalty is \$2,000 per full-time employee.
- Employer provides qualifying coverage which is deemed unaffordable; then for any full-time employee who accesses the exchange, the penalty is the lesser of \$3,000 per full-time employee receiving the credit, but no more than \$2,000 times all employees.



## JANUARY 1, 2013

- Annual salary reduction contributions to a health FSA may not exceed \$2,500.
- Subsidy for employers providing certain retirees with coverage equivalent to Medicare Part D is no longer deductible.
- 1.45% individual Medicare payroll tax increases to 2.35% on wages over \$200,000 (\$250,000 for joint return filers).

## MARCH 1, 2013

- Before March 1, 2013, employers must provide written notice to all new hires and current employees describing the new Insurance Exchange, explaining the premium tax credit and cost-sharing subsidies (if the employer's plan pays less than 60% of costs of benefits) and, if the employer does not offer a free choice voucher, that the employee may lose the employer contribution toward employer-sponsored coverage if he or she elects coverage through the Exchange.

## JANUARY 1, 2014

- Temporary reinsurance program for early retiree coverage ends. See page 4 of this document.
- Employers with 50 or more full-time equivalent employees may incur "free rider" penalties if they offer no coverage, or coverage deemed unaffordable or insufficient.
- Employers must offer "free choice" vouchers to certain eligible employees.
- Individuals who do not hold qualifying coverage must pay an excise tax (coverage under any grandfathered plan satisfies requirement).
- Plans must report coverage information to enrollees and the IRS.
- State health insurance exchanges begin operating for individuals and small employers (as defined by the state exchange).
- Eligible employers that offer coverage through an exchange may permit pre-tax contributions through their cafeteria plans.

## Automatic Enrollment Requirements

Employers with 200 or more full-time employees become subject to automatic enrollment requirements. Although the statute notes that this provision is to be implemented according to DOL regulations, a specific effective date for this rule was omitted. Absent an effective date, some authorities assert that *this provision may be effective as early as March 23, 2010, regardless of plan year, grandfathered plan status or applicability of a collective bargaining agreement.*

## FOR PLAN YEARS STARTING ON OR AFTER JANUARY 1, 2014

### All Plans

1. Waiting periods longer than 90 days prohibited.
2. Preexisting condition exclusions prohibited for *all* enrollees.
3. All annual dollar limits on essential benefits prohibited (including “restricted annual” limits previously allowed by HHS).
4. Grandfathered plans lose the ability to deny coverage to employee’s children who are under 26 based on eligibility for other employment-based coverage.

### Additional Measures for Non-Grandfathered Plans Only

5. Plans must cover routine patient costs for care in connection with clinical trials.
6. Discrimination against providers prohibited as long as they act within the scope of their licenses.
7. Out-of-pocket maximum can be no greater than that allowed for a high-deductible health plan offered in connection with a health savings account.
8. Deductibles can be no greater than \$2,000 for single coverage and \$4,000 for family coverage (may apply only to plans offered in the small group market).
9. Wellness incentives up to 30% of cost of permitted coverage (federal agencies may allow additional increases up to 50%).

## JANUARY 1, 2016

- State health insurance exchanges must be available for employers with up to 100 employees.

## JANUARY 1, 2017

- States may allow employers of any size to access coverage through health insurance exchange.

## JANUARY 1, 2018

- Excise tax (often called The “Cadillac” Plan tax) applies to high-cost coverage.

### Expansion of Child Coverage

Increased enrollment and costs for covering larger number of dependents, but payroll process may be simplified through tax code changes.

### Plan Documents and Communications

Employers will need to review plan materials to accurately describe plan changes and to effectively communicate impact on participants.