









Health Care Reform is:

- The Patient Protection and Affordable Care Act (or "PPACA") enacted March 23, 2010
and
- The Health Care and Education Affordability Reconciliation Act (or "HCEARA") enacted March 30, 2010
- We will refer to both as the "ACA" or the "Affordable Care Act"



The ACA mandates:

- Employer responsibilities and plan changes
- Changes to employer-sponsored wellness programs
- Restrictions to consumer-driven health plans
- Options for retiree coverage
- Reporting requirement
- New employer taxes



The ACA also includes:

- New HIPAA EDI – Administrative Simplification transaction requirements
- Health insurance market reforms
- State-based health care Exchanges
- Consumer Operated and Oriented Plans (CO-OPs)
- Accountable Care Organizations (ACOs)
- National, voluntary long-term care insurance plan



The ACA also includes:

- National health care workforce education and assessment initiatives
- Changes to Medicare
- Changes to Medicaid and CHIP
- Licensure for biological pharmaceutical products as bio-similar or interchangeable
- A host of miscellaneous commissions, pilot programs and taxes



Today's Focus:

- Employer Responsibility and Plan Mandates
 - 2010 – 2011
 - 2011 – 2014
- Consumer-Driven Health Plan Requirements
- Wellness Program Changes
- Retirees
- Taxes
- Court Challenges



**The '*Borogoves*':
Plan Mandates**

- Grandfathered Plan Mandates – 2010 – 2011
- Ohio Dependent Coverage to Age 28
- Non-Grandfathered Plan Mandates – 2010 – 2011
- Grandfathered Plan Mandates – 2012 – 2014
- Non-Grandfathered Plan Mandates – 2012 – 2014

(A '*Borogove*' is a thin, shabby-looking bird with no wings and a turned up beak. They are very annoying!)



Grandfathered Plan Mandates (2010 – 2011)

- Grandfathered Plans
- Prohibition on Lifetime Dollar Maximums
- Prohibition on Annual Dollar Maximums
- Prohibition on Plan Coverage Rescission
- Prohibition on Pre-existing Condition Exclusions (Enrollees under age 19)
- Continued Coverage for Dependents until age 26



Dependent Coverage to Age 28 (Ohio law)

- Must be a resident of Ohio or a full-time student at an accredited public or private institution of higher education
- Not eligible if married
- COBRA available at age 28 if coverage lost due to dependent limiting age



Non-Grandfathered Plans – Plan Mandates (2010 – 2011)

- Preventive Health Coverage Mandate
- Mandated Appeals and External Review Procedures
- Choice of Health Care Professional / Access to Obstetrical and Gynecological Care
- Coverage of Emergency Services



Grandfathered Plans – Plan Mandates (2012 – 2014)

- Mandatory 4-Page Summary (2012)
- General Prohibition on Pre-existing Condition Exclusions (2014)
- Prohibition on Excessive Waiting Periods (2014)



Non-Grandfathered Plans – Plan Mandates (2014)

- Mandated Coverage of Routine Patient Costs in Conjunction with Clinical Trials
- Automatic Employee Enrollment for Large Employers (upon issuance of regulations)



The '*Mome Raths*': Consumer-Driven Health Plans (January 1, 2011)

- Prohibition on Reimbursement of Over-the-Counter (OTC) Medications without a Prescription
- Changes to Health Savings Accounts (HSAs) and Archer Medical Savings Accounts (MSAs)

(A *Mome Rath* is a sort of green pig that eats cheese and has lost its way – similar to these mandates!)



The *'Mome Raths'*:
Consumer-Driven Health
Plans (January 1, 2013)

- Changes to Flexible Spending Account (FSA)
Salary Reduction Contributions



The *'Tumtum Tree'*:
Wellness Programs

- Protection of Second Amendment Rights (2010)
- Increased Incentives / Rewards (2014)

(A 'Tumtum Tree' is a very nice tree beneath which to rest. It makes you feel good!)



The *'Tugley Wood'*:
Retirees

- Availability of Reinsurance for Early Retirees
Health Care Costs (ERRP) (2010)
- Modifications to the Medicare 'Donut-Hole' (2011)

(The 'Tugley Wood' is a thick, dense and dark wooded area. It is easy to get lost here!)

The 'Slithy Toves':
Employer Taxes

- W-2 Reporting
- Data Collection from employers and plans
- Individual Mandate
- 'Play or Pay' & 'Play and Pay'
- Employer Vouchers
- Cadillac Tax

(A 'Slithy Tove' is a cross between a badger, a lizard and a corkscrew. It is slimy, revolling and makes an extreme mess of things!)

The 'Vorpal Sword':
The Court Challenges

- District of Columbia
- Michigan
- Virginia
- Florida and Judge Vinson (Our '*Beamish Boy*')
- The Administration's Appeal
- State Ballot Initiatives
- State Constitutional Amendments

(The 'Vorpal Sword' is a noble weapon which can also be used for precise verbal attacks!)

Summary

- Understand your options!
- Know the implementation timelines!
- Be prepared to report significant amounts of data regarding your employees, your plan and the benefits you offer!
- Be prepared to shift gears quickly or work with a benefit administrator that can!
- **MEDBEN WILL HELP!!!**



Overview of Key Group Health Plan Provisions

In March, 2010, the following two health care reform laws were passed by the United States Senate and the United States House of Representatives:

- Patient Protection and Affordable Care Act (“PPACA”) – March 23, 2010
- Health Care and Education Affordability Reconciliation Act (“HCEARA”) – March 30, 2010

Together these two new laws encompass the most significant changes made in employer-provided health coverage in over 40 years.

Grandfathered and Non-Grandfathered Plans

To determine if a group health plan is grandfathered, the plan must have at least one individual enrolled in the plan on March 23, 2010 and must continue to have one enrollee. Any new policy issued or plan adopted after March 23, 2010 is not a grandfathered plan. In general, any plan wishing to be considered grandfathered must not significantly increase deductibles, coinsurance amounts or copayments or reduce benefits under the plan after March 23, 2010. Any plan which is not considered grandfathered must make additional changes between 2010 and 2014.

2010 / 2011 – All Plans (Grandfathered and Non-Grandfathered) – Effective first plan year on or after September 23, 2010

- **Prohibition on Plan Lifetime Dollar Maximums** – Group health plans are prohibited from limiting coverage through the application of lifetime dollar maximums. PPACA requires all plans and policies give employees, including former plan participants, who had previously lost or were denied coverage due to reaching the plan’s lifetime maximum, a “special enrollment” period during which to enroll, provided they are otherwise eligible. The plan sponsor must provide written notice to such individuals prior to the special enrollment period, informing them of the opportunity to re-enroll.
- **Prohibition on Plan Annual Dollar Maximums** – Group health plans are prohibited from limiting coverage through the application of annual dollar limitations. However, prior to January 1, 2014, group health plans may establish a restricted annual dollar maximum as follows (although by doing so, plans will likely not be considered grandfathered):
 - ✓ for the 2010 – 2011 plan year – an overall annual dollar maximum per covered person of \$750,000.00 is permitted;
 - ✓ for the 2011 – 2012 plan year – an overall annual dollar maximum per covered person of \$1,250,000.00 is permitted; and
 - ✓ for the 2013 plan year until January 1, 2014 – an overall annual dollar maximum per covered person of \$2,000,000.00 is permitted.
- **Prohibition on Plan Coverage Rescission** – Group health plans are prohibited from rescinding the coverage of any plan participant or dependent unless the rescission is due to fraud or an intentional misrepresentation of material fact. 30 calendar days advance written notice must be provided before coverage can be rescinded. “Rescission” is defined as retrospective cancellation or discontinuance of coverage; prospective cancellations and cancellation due to failure to pay premium are not considered rescission.
- **Prohibition on Pre-existing Condition Exclusions (Enrollees Under Age 19)** – Group health plans may not impose any pre-existing condition exclusion with respect to such plan on any employee or dependent if the enrollee is under the age of 19.

- Continued Coverage for Dependents until Age 26 – Group health plans are required to make coverage available to all dependents, including married dependents, until the child reaches age 26. Before January 1, 2014, grandfathered plans do not have to provide continuing coverage to any dependent who is eligible to be enrolled in any other employer-sponsored health plan. PPACA requires that all plans and policies give dependent children, who had previously lost or were denied coverage, a “special enrollment” period during which to enroll, provided they are otherwise eligible. The plan sponsor must provide written notice to each eligible employee prior to the special enrollment period, informing them of the opportunity to enroll their eligible dependent(s).

2010 / 2011 – Additional Requirements for Non-Grandfathered Plans – Effective on the first plan year on or after September 23, 2010

- Preventive Health Coverage Mandate – Group health plans must provide 100% coverage for at least the following preventive services:
 - ✓ the United States Preventive Services Task Force recommended preventive services with either an “A” or “B” rating;
 - ✓ immunizations recommended by the Centers for Disease Control and Prevention;
 - ✓ evidence-based preventive care and screenings for infants and women recommended by the Health Resources and Services Administration.
 Preventive services only need to be covered at 100% at in-network levels; plans are free to either provide a reduced benefit or exclude preventive services entirely out-of-network. Non-PPO plans must cover the preventive services at 100%.
- Mandated Appeals and External Review Procedures – Group health plans must have in effect internal claims appeal procedures and external review processes which, at a minimum, include the consumer protections set forth in the NAIC Uniform External Review Model Act. Plans must provide enrollees with notice, in a culturally and linguistically appropriate manner, of internal appeals and external review procedures. The plan must also allow each enrollee to review his or her plan file and to present evidence and testimony as part of the appeals process.
- Choice of Health Care Professional / Access to Obstetrical and Gynecological Care – Group health plans, which require the election or designation of a primary care provider, must permit each plan enrollee (employee and dependent) to designate the primary care provider of his or her choice. These same rules apply to pediatric care and the designation of a pediatric primary care provider. Plans that provide coverage for obstetrical and gynecological care, must provide these services without requiring prior authorization or referral by a designated health care provider. Notice regarding the right to choose a health care professional, and the right to choose an obstetrician or gynecologist without referral, must be provided to covered persons in the plan’s SPD and any other summary of coverage.
- Coverage of Emergency Services – Group health plans that provide coverage for hospital-based emergency services must provide these services without requiring prior authorization, regardless of whether the health care provider is a participating provider, and without the application of cost-sharing or co-payment which is different in-network and out-of-network. Plans, however, do not have to cover the balance billing amounts imposed by out-of-network providers.

2012 – All Plans (Grandfathered and Non-Grandfathered) – Effective March 23, 2012

- Mandatory 4-Page Benefits Summary Required – Group health plans are required to provide a basic 4-page summary of benefits to all enrollees. The summary must include uniform definitions of standard insurance terms, a description of coverage – including cost sharing for

each “essential health benefit”; the exceptions, reductions, and limitations on coverage; all cost-sharing provisions – including deductibles, copayments, and coinsurance amounts; the renewability and continuation of coverage provisions; and several additional items. HHS is required to provide a format for this summary no later than March, 2011, and the first summaries are required to be distributed in March, 2012.

2014 – All Plans (Grandfathered and Non-Grandfathered) – Effective on the first plan year on or after January 1, 2014

- General Prohibition on Pre-existing Condition Exclusions – Group health plans may not impose any pre-existing condition exclusion with respect to such plan on any of its enrollees (employees or dependents).
- Prohibition on Excessive Waiting Periods – Group health plans with 50 or more employees may not have a waiting period that exceeds 30 days. Group health plans with fewer than 50 employees may not have a waiting period of more than 90 days.

2014 – Additional Requirements for Non-Grandfathered Plans – Effective as of the first plan year on or after January 1, 2014

- Mandated Coverage of Routine Patient Costs in Conjunction with Clinical Trials – Group health plans may not deny an individual participation in certain clinical trials. This does not mean that the plan must pay for the cost of the individual’s participation in the clinical trial or for experimental/investigational care. However, the plan must pay for “routine patient costs” associated with the individual’s experimental care or participation in a clinical trial. “Routine patient costs” include all items and services consistent with the coverage typically provided under the plan for individuals not participating in a clinical trial. “Routine patient costs” do not include the experimental/investigational item, device or service; items and services provided solely for the data collection needs of the clinical trial; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Automatic Employee Enrollment for Large Employers – Employers with more than 200 full-time employees that offer employees coverage in one or more health benefit plans must automatically enroll all new employees in one of the plans offered, subject to the plan’s waiting period.

2011 – Consumer-Driven Health Plans – Effective January 1, 2011

- Prohibition of Reimbursement of Over-the-Counter Medications without a Prescription – Reimbursement for expenses for over-the-counter medicines or drugs will not be eligible for reimbursement under a consumer-driven health plan (health FSA, HRA HSA or Archer MSA) unless a physician’s prescription is part of the substantiation documentation for reimbursement.
- Changes to Health Savings Accounts (HSA) and Medical Savings Accounts (MSA) – Health savings accounts and Archer medical savings accounts will be subject to an increased distribution tax on non-qualifying medical expenses (from 10% to 20%), including reimbursement for over-the-counter medications received without a prescription.

2013 – Consumer-Driven Health Plans – Effective January 1, 2013

- Changes to Flexible Spending Accounts (FSA) – A benefit provided under a medical cafeteria plan (health FSA) will not be treated as a qualified benefit unless the health FSA provides that an employee may not elect salary contributions in excess of \$2,500.

2014 – Wellness Benefits – Effective January 1, 2014

- **Increase in Incentives** – In 2014, the amount a plan can offer as a reward or incentive for participation or compliance with a wellness program will increase. Currently, the reward for a wellness program, along with the rewards for all other wellness programs offered, cannot exceed 20% of the cost of coverage. But, beginning in 2014, the incentive can be as much as 30% of the cost of coverage. The percentage is based on the total amount of employer and employee contributions for the benefit package the employee (or employee and dependents) is receiving. PPACA also leaves the door open for this percentage to increase to as much as 50% in the future.

2010 Retirees – Effective June 23, 2010

- **Early Retiree Reinsurance Program (ERRP)** – In June, 2010, the federal government implemented the early retiree reinsurance program. The program provides \$5 billion for temporary assistance to employment-based plans to reimburse a portion of the cost of providing health care coverage to early retirees (as well as spouses, surviving spouses and dependents). The program ends on January 1, 2014 when early retirees will be able to select from options in the newly created State Exchanges. The program is designed to reimburse 80% of insured claims between \$15,000 and \$90,000 for retirees between ages 55 and 64. The underlying early retiree health care plan or policy must have measures in place to generate cost-savings with respect to claims for chronic and high-cost conditions and the employer must attest to using the reimbursements for plan purposes only.

2011 Retirees – Effective January 1, 2011

- **Medicare Part D Retiree Subsidy Changes** – Beginning in January, 2011, the Medicare Part D “donut-hole” will be gradually reduced so that the gap in Medicare coverage (the ‘donut-hole’) will close by 2020. This is important because, as the actuarial value of the Medicare Part D prescription coverage increases (more prescriptions paid by Medicare with the closing of the ‘donut-hole’), some private plans prescription drug creditable coverage status may change. The creditable coverage status of employer-based prescription drug programs will have to be checked each year against the new Medicare Part D standard.

2011 / 2012 / 2013 Reporting

- **Health Plans Must Report Amounts Spent on Group Health Coverage (W-2)** – Employers must report on IRS Form W-2 the aggregate cost of the employer-sponsored group health plan coverage, including FSAs and HRAs, for each covered employee. This amount does not include the amount of any salary-reduction contributions under Section 125 plans. This reporting is voluntary for the 2011 calendar year and is presumably required beginning in 2012. The IRS has promised more guidance on how the amounts are to be calculated.
- **General Employer Reporting Requirements** – Effective no later than March 23, 2012, the Department of Health and Human Services must establish a process for collecting information from all plans about: 1) each plan’s benefit design; 2) hospital readmissions; 3) medical errors; and 4) wellness programs.
- **General Employer Reporting Requirements** – Effective no later than March 1, 2013, the Department of Health and Human Services (and the Government Accounting Office) may require information from plans in connection with coverage, claims denials, and potential conflicts of interest within self-funded plans.

2014 Taxes – Effective January 1, 2014

- **Individual Penalty for Failure to be Enrolled in Health Coverage** – Every individual (United State citizen and legal resident) not enrolled in qualifying coverage must pay a penalty for failing to purchase health care coverage. The penalty is the lesser of: 1) the greater of an individually determined dollar amount or percentage of income; or 2) a national average premium. The penalty is assessed through individual annual tax reporting. Certain exemptions and maximums do apply.
- **Employer No-Offer Penalty (Play *or* Pay)** – A large employer with at least 50 full-time employees that does not offer its full-time employees some type of “minimum essential coverage” must pay a penalty fee of \$2,000 per full-time employee per year (excluding the first 30 full-time employees) BUT ONLY IF the employer has as least one full-time employee who receives premium assistance credit (subsidy or cost-sharing reduction from the federal or state government) to buy health coverage on an Exchange. For purposes of this provision, “minimum essential coverage” is either a fully-insured or self-funded employer-sponsored plan.
- **Employer Unaffordable Coverage Penalty (Play *and* Pay)** – A large employers with at least 50 full-time employees [30 hours per week] on business days during the preceding calendar year who does offer “minimum essential coverage” through an employer-sponsored plan BUT has at least one full-time employee receiving premium assistance credit (subsidy or cost sharing reduction) will pay the lesser of \$30,000 for each full-time employee receiving assistance or \$2,000 for each full-time employee.
- **Calculating the Number of Full-Time Employees** – PPACA requires that an employer calculate its number of full-time employees for purposes of the penalty by determining the number of full-time employees (those working an average of 30 or more hours per week) and then adding to that the employer’s number of full-time equivalent employees. Full-time equivalent employees are counted by taking the number of hours all part-time workers work (those will less than 30 hours per week – even those without coverage) over the course of a month divided by 120. The resulting number is added to the number of full-time employees; if the total is 50 or more, the above penalties apply. When calculating the number of employees for penalty purposes, an employer can subtract the first 30 full-time employees.
- **Employer Must Provide “Free-Choice Vouchers”** – Employers that offer health coverage must also provide “free-choice vouchers” to eligible employees equal to the largest premium contribution amount the employer would make to the plan on behalf of the eligible employee. The vouchers are tax deductible to the employer and not taxable to the employee. The employee is free to keep the remainder of the voucher amount if there is any remaining after purchasing health coverage. “Eligible employees” are both full- and part-time employees whose share of the premium cost is at least 8% of the employee’s household income, the household income is less than 400% of the federal poverty level and the employee does not enroll in the employer’s health plan.

2018 Taxes – Effective January 1, 2018

- **Cadillac Plan Penalty** – Health insurance carriers and group health plan administrators (i.e., employer plan sponsors) are required to pay a 40% excise tax on the value of plan benefits in excess of \$10,200 for individual coverage and \$27,500 for family coverage (defined as coverage which is not individual-only coverage). The determination of how to calculate the “value of the plan benefits” is still unclear.

INFORMATION REGARDING OHIO'S DEPENDENT ELIGIBILITY CONTINUATION LAW
(Dependent Age 28 Law)

Who Is Eligible?

A Dependent child is eligible for an extension of coverage under an eligible Ohio insurance policy or public-employer self-funded plan provided he or she otherwise meets the criteria for dependent eligibility under the policy or plan and is:

1. unmarried;
2. under the age of twenty-eight (28);
3. the eligible employee's natural child, stepchild or adopted child;
4. either a resident of the State of Ohio, or a full-time student at an accredited public or private institution of higher education;
5. not employed by any employer that offers any health benefit plan under which such child is eligible for coverage; and
6. not eligible for coverage under Medicare or Medicaid.

When Is Coverage Effective?

In general, if coverage was previously terminated for such dependent child prior to the employer group's first renewal date on or after July 1, 2010, the eligible dependent child may re-enroll for coverage under the policy or plan, provided application is submitted to within thirty-one (31) days of the employer group's first renewal date on or after July 1, 2010.

What About COBRA?

This continuation is provided before any other continuation provision for which the dependent may be eligible. Any child losing eligibility due to marriage, divorce, termination of full-time student status, termination of the eligible employee's coverage due to termination of employment, or termination due to reaching the dependent limiting age will be considered a COBRA qualifying event. State conversion continuation provisions may also apply at this time.

To Learn More:

For more information and summaries of the current Health Care Reform regulations, employers and Plan Sponsors can visit MedBen's Blog, a link to which is located on our website: www.medben.com. Also, if you have any questions regarding the presentation materials, feel free to contact Caroline Fraker at 740-522-7386 or cfraker@medben.com.

Jabberwocky

'Twas brillig, and the slithy toves
Did gyre and gimble in the wabe;
All mimsy were the borogoves,
And the mome raths outgrabe.

“Beware the Jabberwock, my son!
The jaws that bite, the claws that catch!
Beware the Jubjub bird, and shun
The frumious Bandersnatch!”

He took his vorpal sword in hand:
Long time the manxome foe he sought—
So rested he by the Tumtum tree,
And stood awhile in thought.

And as in uffish thought he stood,
The Jabberwock, with eyes of flame,
Came whiffling through the tulgey wood,
And burbled as it came!

One, two! One, two! and through and through
The vorpal blade went snicker-snack!
He left it dead, and with its head
He went galumphing back.

“And hast thou slain the Jabberwock?
Come to my arms, my beamish boy!
O frabjous day! Callooh! Callay!”
He chortled in his joy.

'Twas brillig, and the slithy toves
Did gyre and gimble in the wabe;
All mimsy were the borogoves,
And the mome raths outgrabe.

Lewis Carroll – *Through the Looking Glass, and What Alice Found There* (1872)