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Health Care Reform – What Employers Need to Know Now

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 - Periodic client meetings/calls
 - Series of webinars
 - www.Huntonhealthcarereform.com – stay tuned
 - Labor/employment team blog – www.huntonlaborblog.com

Overview – Scope of Webinar



- ❑ *Focal Point* – the group health plan reforms and other changes going into effect over coming year
- ❑ *Road Map* –
 1. Reforms/changes applicable to all group health plans (GHPs)
 2. The rules for “grandfathered plan” status
 - ❑ What is a “grandfathered plan”
 - ❑ Loss of grandfathered status
 3. Reforms/changes only applicable to nongrandfathered GHPs

Key Concepts



- ❑ In general, reforms apply to all employer-sponsored GHPs (insured/self-insured & collectively bargained), BUT excludes –
 - Retiree-only plans
 - “HIPAA-excepted benefits”, principally –
 - healthcare flexible spending accounts &
 - dental/vision-only programs
- ❑ Grandfathered plans – generally, plans in existence on 3/23/10
 - ❑ Exempt from some of the immediate reforms
- ❑ “Plan Year” (PY) – basis for determining when the GHP reforms go into effect

Immediate Reforms/Changes -- All Plans



1. For First PY beginning on/after 9/23/10 (which, for a calendar year plan, will be 1/1/2011)--

□ *Dependent coverage* – For adult children under 26

- Applies even if child married or does not otherwise qualify as a “dependent” under the plan
- For grandfathered plans – does not apply to those who are eligible for other GHP coverage (prior to 2014)
- Terms of coverage cannot vary based on age
- Tax-free coverage
- Notice requirements

Immediate Reforms/Changes -- All Plans (cont'd)



- *Lifetime/annual limits for “essential” health benefits*
 - Lifetime dollar limits no longer allowed
 - Annual dollar limits allowed on essential benefits on a restricted basis (until PYs beg. In 2014)
 - *\$750,000* -- for plan years beginning on/after 9/23/10 (but before 9/23/11);
 - *\$1.25 million* -- for plan years beginning on/after 9/23/11 (but before 9/23/12); and
 - *\$2 million* -- for plan years beginning on/after 9/23/12 (but before 1/1/14).
 - Application to non-dollar based limits & non-essential benefits
 - Notice requirements

Immediate Reforms/Changes -- All Plans (cont'd)



☐ *Pre-existing condition exclusions*

- Not allowed for participants under 19
 - Applicable to all enrollees (and not just dependents)
- Will no longer be allowed at all beg. in 2014 PY

☐ *Coverage rescissions*

- Retroactive cancellation/discontinuation of coverage no longer allowed
- Exceptions –
 - Fraud or intentional misrep of a material fact
 - Failure to pay premiums
- Notice rights

Immediate Reforms/Changes -- All Plans (cont'd)



2. For 2011 Calendar Year –

- Reimbursement of OTC medicines* – will no longer be allowed unless physician prescribed
 - Applies to healthcare FSAs, HSAs and HRAs
 - Impact on FSAs that use 2-1/2 month grace period or have non-calendar plan year

- New W-2 reporting* –
 - Total annual cost of employer-provided coverage
 - Aggregate “premium” cost
 - Excludes HSA/MSA contributions and employee salary reduction contributions to a healthcare FSA

Grandfathered Plans



1. Government regulations issued 6/17/10 – provides guidance on the following:
 - Changes to plans that trigger loss of grandfathered status
 - Disclosure and documentation requirements
 - Anti-abuse rules
 - Confirmation of exemption of Retiree Only Plans and HIPAA-Excepted Benefits
 - Clarification of rules relating to collectively bargained plans



2. What is a Grandfathered Plan --

- ❑ Any GHP in effect on 3/23/10
- ❑ Applies separately to each benefit option (e.g. PPO, HMO or high deductible plan options); loss of grandfathered status for one option does not mean loss for all options
- ❑ Status not lost if 3/23/10 enrollees cease to be enrolled as long as there is continuous enrollment throughout the period
- ❑ New employees and dependents may be added after 3/23/10 without losing grandfathered status



3. Loss of Grandfathered Status --

Insured Options

- Entering into a new policy, certificate or insurance with plan's insurer
- Changing insurers

All Other Options

- Eliminating all or substantially all benefits (or benefits for any necessary element) to diagnose or treat a particular condition
- Increasing a percentage cost sharing requirement (e.g., coinsurance)
- Increasing a fixed amount cost sharing requirement other than copayments (e.g., deductible or out-of-pocket maximum) by total percentage greater than medical inflation plus 15%

Grandfathered Plans (cont'd)



- ❑ Increasing a fixed amount copayment by more than the greater of (i) medical inflation plus 15% or (ii) \$5 increased by medical inflation (i.e., \$5 x medical inflation plus \$5)
- ❑ Decreasing employer contribution rate (whether based on cost of coverage or a formula) for any tier of coverage by more than 5 percentage points
- ❑ Changes to annual limits in effect on 3/23/10
 - Imposing for the first time an annual limit on dollar value of benefits (unless this annual limit equals or exceeds existing lifetime limit)
 - Decreasing the dollar value of the annual limit (regardless of existing lifetime limit)



- ❑ Transition rules – Plan changes that will not trigger loss of status
 - Changes made pursuant to a legally binding agreement entered into, a written plan amendment adopted, or a filing made with state insurance department, on or before 3/23/10
 - Changes adopted prior to 6/14/10 if reversed or modified by first PY beginning on/after 9/23/10

Grandfathered Plans (cont'd)



- ❑ Changes That Will Not Affect Status
 - Changes in premiums
 - Changes to comply with federal or state law
 - Changes to comply with Health Care Reform Law (even if voluntary)
 - Changes in TPAs
- ❑ Changes That May Affect Status
 - Changes in plan design (e.g. HMO to PPO)
 - Changes in provider network
 - Changes in Rx formulary
 - Decrease in lifetime limits



4. Special Rules

- *Anti-abuse Rules – Restructuring triggers loss of status*
 - A merger, acquisition or other restructuring generally permitted unless principal purpose is to cover new individuals under grandfathered plan
 - Employees transferred to another “grandfathered” plan
 - Whose terms, as compared to transferor plan, would trigger loss of status for transferor plan (if made by amendment)
 - No bona fide employment based reason for transfer (plan cost/usage not bona fide in this context)
- *Collectively bargained plans –*
 - Special transition rule for insured arrangements



5. Required Documentation/Disclosures to Preserve Grandfathered Status

- Plan materials must disclose that plan benefits are believed to be grandfathered
 - Include contact information for participant questions
 - Model language provided in interim regulations

- Documentation requirements
 - Records documenting terms of coverage in effect on 3/23/10
 - Other documents verifying grandfathered status
 - Records must be available for examination upon request by participants and government agencies

Immediate Reforms/Changes – Non-Grandfathered Plans



1. Non-Grandfathered Plans

- ❑ Certain immediate GHP reforms and other changes that only apply to non-grandfathered plans (or apply to them differently)
 - Includes preventive healthcare, an external claims review process and other patient protections
- ❑ Loss of grandfathered status will result in immediate application of these reforms/changes

Immediate Reforms/Changes – Non-Grandfathered Plans (cont'd)



2. Non-grandfathered Plan Reforms

□ *Patient Protections – No-cost preventive healthcare*

- GHPs must provide certain preventive health services without cost to participants, including well-child care and various immunizations/screenings
- Four covered categories –
 - i. Items/services rated “A” or “B” by U.S. Preventive Service Task Force
 - ii. Immunizations recommended by CDC Advisory Comm. On Immunization Practices
 - iii. Childhood preventive care recommended by Health Resources and Services Admin. (HRSA)
 - iv. Other preventive care recommended by HRSA
- Application to GHPs with provider networks -- Only required “in-network”
- Special rules for office visits

Immediate Reforms/Changes – Non-Grandfathered Plans (cont'd)



□ *Patient protections – Provider choice*

- Selection of primary care provider (PCP)
 - Participants may select any participating doctor as their PCP (including, in the case of a child, a pediatrician),
- Access to OB-GYN care – prior PCP (or other) referral/authorization prohibited
- Notice requirements

□ *Patient protections – Emergency care*

- Access to out-of-network emergency services to be on same basis as in-network
- May not –
 - Require advance authorization
 - Impose higher cost sharing or more restrictive admin requirements/cover limitations
 - Impose any other term/condition other than benefit exclusions/coordination, waiting periods or cost sharing

Immediate Reforms/Changes – Non-Grandfathered Plans (cont'd)



- Special cost-sharing requirements –
 - Out-of-network copayments/coinsurance cannot exceed in-network charges
 - Regs establish a complicated formula for determining minimum plan payment
 - Application of out-of-network deductibles and out-of-pocket maximums
- *Patient protections – Expanded claims review process*
 - An internal claims review process that complies with ERISA claims process rules, with some twists –
 - Expanded claimant rights – e.g., shorter timeframe for “urgent care” claims, greater access to claim files/info, cultural/linguistic appropriate notice, new conflict of interest rules and tighter “deemed” exhaustion of claims process rules
 - Right to maintain coverage during internal process – limited to an on-going course of treatment

Immediate Reforms/Changes – Non-Grandfathered Plans (cont'd)



- An external claims review process
 - For insured (and nonERISA plans) -- complies with applicable state external review rules (that meet certain minimum standards for PYs beg. on/after 7/2011)
 - All other plans (including self-insured ERISA plans) -- meets federal standards
 - Includes review by an independent review organization (meeting certain min. requirements)
 - Currently no requirement to provide continued coverage during external review process

Immediate Reforms/Changes – Non-Grandfathered Plans (cont'd)



- *Adult child coverage*
 - May not exclude otherwise eligible children who have access to other GHP coverage
 - But same rules will apply to grandfathered plans beginning in 2014
PY
- *New nondiscrimination rules for insured plans*
 - Generally prohibits providing coverage/benefits for only (or are skewed in favor of) high-paid employees
 - Compliance failures subject to a \$100/day per participant excise tax



1. The Program

- ❑ \$5 billion early retiree reinsurance program that began 6/1/10
- ❑ For any employer-based health plan covering retirees ages 55-65
 - Also applies to coverage provided to a retiree's spouse and dependents
- ❑ Program scheduled to end 12/31/13 (or upon earlier exhaustion of program)

Retiree Reinsurance Program (cont'd)



2. Eligibility for Participation

- Plan must have procedures/programs that have generated or could generate cost savings for “chronic and high cost conditions”
- Plan sponsor must –
 - have agreement with plan or insurer for disclosure of plan/participant information to HHS to verify compliance and
 - ensure policies exist to protect against fraud, waste or abuse
- Plan sponsor must submit one application per plan which includes the following information –
 - Cost savings procedures/programs
 - How reimbursements will be used
 - Identify plan benefit options available to retirees
 - Provide projected reimbursements for two plan years

Retiree Reinsurance Program (cont'd)



3. Reimbursable Claims

- Medical, surgical, hospitalization, prescription drugs and similar benefits covered
- 80% of total cost of health care benefits paid by plan and each retiree in plan year between \$15,000 and \$90,000

4. Use of Reinsurance Proceeds

- Proceeds cannot be used for general corporate purposes
- May either –
 - Use to reduce participant costs (premiums, copayments, deductibles), or
 - Apply to future increases in employer premiums/healthcare costs.

Questions



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