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HOW DO YOU KNOW WHAT YOU DON'T KNOW ?

A Guide To Ongoing Health
Care Reform Changes

October 11, 2011

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Agenda

- I. What's Happened Since September 23, 2010?
- II. What's Delayed / Under Review / Stricken / Clarified
- III. Legal Update and Status of Appeals
- IV. New Requirements
- V. 2012 and Beyond
- VI. Do you Play or Pay ?

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What's Happened Since Sept. 23, 2010?

All Plans

- No pre-existing condition exclusions for children
- Restrictions on lifetime and annual* limits (except mini-meds with waivers)
- Prohibition on rescissions
- Dependent coverage to age 26
- Health Insurance Company Medical Loss Ratio reporting (insured plans)

Non-Grandfathered Plans

- Free preventive health services
- Internal/External review of appeals**
- Section 105(h) non-discrimination rules for fully insured plans*
- Health care provider choice provisions (impactful under managed care plans)
- Future effective date provisions – to be clarified

Other

- OTC drugs not reimbursable under FSA/HSA's without a prescription
- Small employers (<100 employees) may establish a simple cafeteria plan
- Small employer wellness grants

* "Essential benefits" definition is pending regulator clarification; 105(h) delayed, under review

** Internal appeals timing stratified

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Adverse Benefit Determination - Appeals

- Grandfathered plans are exempt
- When Grandfather status is lost, compliance requirement is immediate
- New terminology – ABD – Adverse Benefit Determination
- Insured plans may rely on insurers, however plan is responsible for Plan Documents & SPDs
- Self-funded plans will need assistance from Independent Review Organization (IRO)

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Adverse Benefit Determination - Appeals

Internal Review

- Effective at Plan Renewal on or after 9/23/2010
- Expanded Definition of ABD
- Full and Fair Review
- Avoid Conflicts of Interest
- Stricken from Regulations: Removed -
 - 24-hr deadline for initial determination of urgent claims
- Requirement plans automatically translate all subsequent notices
- Requirement for ABD notices to disclose diagnosis and treatment codes

External Review

- Effective at Plan Renewal on or after 1/1/2012 – Insured Plans
- Most States have External Review Procedures in place using NAIC model requirements
- Self-funded Plans can utilize Independent Review Organization - IRO – minimum standards compliance required for Plan Renewals on or after 9/23/2010
- IRO must be accredited / unbiased

Other Items to Note

- Updated Materials: ABD Notices, Plan Document, SPDs – Effective with Plan Renewals on or after 7/1/2011
- Strict Compliance Rules beginning with Plan Renewals on or after 1/1/2012

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Delayed / Under Review / Stricken / Clarified

Triggers that result in the loss of Grandfather status

- Changing carriers removed as a trigger for plans renewing after 11/15/2010

Debit card use for OTC medications

- Allowed when accompanied by a prescription and dispensed by a pharmacist

Essential Benefits

- Awaiting complete definition from regulators

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Delayed / Under Review / Stricken / Clarified

1. 1099 reporting

- Legislation repealed the scheduled expansion of 1099 reporting

2. W-2 reporting of aggregate cost of employee sponsored health insurance

- Compliance deferred until 2012 (W-2s issued January 2013)
- Required for employers if 250 or more W-2s were issued in the prior calendar year – Optional (for now) if fewer than 250 W-2s
- Reporting excludes HRA, HSA and employee FSA contributions
- Reporting excludes fully insured dental and vision plans not integrated with medical plan
- Self-funded church plans are exempt

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3. IRC § 105(h) nondiscrimination requirements for insured plan

- Compliance deferred until guidance issued

4. Auto Enrollment mandate for employers with 200+ employees

- Compliance deferred until guidance issued

5. Class Act – Voluntary Federal Long Term Care Insurance Program

- Projected date 10/1/2012

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6. 4 Page Summary of Coverage – “labeling”

- Proposed clarifications issued in August 2011 will require plans and issuers to provide consumers with user-friendly information about their health plans
- Requires inclusion of a Uniform Glossary of Terms and use of a standardized Summary of Benefits and Coverages
- Modification to cultural and linguistic requirement based on county population census statistics
- Variable timing requirement for summaries
- Compliance required beginning March 2012

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7. Addition of new Women's Preventive Care Mandates

- Guidelines released by HHS on August 1, 2011 for women's preventive services which apply to non-grandfathered health plans
- Services to be covered include: annual well-woman visit; gestational diabetes screening; HPV DNA testing; sexually transmitted infection counseling; HIV screening and counseling; FDA approved contraception methods, sterilization and counseling; breastfeeding support, supplies, and counseling; interpersonal and domestic violence screening and counseling
- Effective with non-grandfathered plan renewals on or after August 1, 2012
- Contraceptive/sterilization compliance exemption for religious organizations – 4 narrow exemption criteria

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8. Proposed Rules for Affordability

- August 2011, the IRS issued a set of proposed regulations addressing the affordability calculation
- Under the Affordable Care Act, coverage is deemed to be unaffordable if the cost of the employee's contribution for employee only coverage is greater than 9.5% of the taxpayer's "household" income
- Potential "safe harbor" that allows employers to utilize the employee's W-2 wages in calculating affordability without being assessed a penalty

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Legal Updates

On August 12, 2011, in *Florida v. U.S. Dept. of Health & Human Services*, the Eleventh Circuit Court of Appeals found the individual mandate contained within the Affordable Care Act to be unconstitutional. The Court held, however, that the mandate could be severed from the remainder of the law. This decision concluded the appeal of a prior ruling made by U.S. District Judge Roger Vinson of Florida, which held the entire law to be invalid. This lawsuit was brought by twenty-six states, a coalition of small businesses and private individuals. Both sides have now appealed the Eleventh Circuit's decision to the United States Supreme Court. The Court will likely grant certiorari, and the case may be on the docket for the 2011-12 session.

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Legal Updates

On September 8, 2011, in *Commonwealth of Virginia v. Sebelius* and *Liberty University v. Geithner*, the Fourth Circuit Court of Appeals dismissed two cases on procedural grounds, holding that Virginia did not have standing to challenge the Act based on its state statute opposing the individual mandate, and that Liberty University could not challenge the individual mandate before it took effect in 2014. The district court's decisions, which held the individual mandate unconstitutional, were vacated, and the cases will remand back to that court, with instructions to dismiss. The Virginia Attorney General has announced that he will appeal the decision in the *Virginia* case to the U.S. Supreme Court.

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Legal Updates

On June 29, 2011, in *Thomas More Law Center v. Obama*, the Sixth Circuit Court of Appeals held, in a 2-1 decision, that the requirement that most Americans must obtain health insurance starting in 2014 is constitutional. On other issues, the panel split three ways, with no majority to completely uphold the mandate under the Commerce Clause.

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Legal Updates

- Seventeen states have passed binding legislation opposing elements of health care reform. Voters in Oklahoma and Arizona have approved amendments to their state constitutions.
- There are proposed constitutional amendments pending in Alabama, Florida, and Wyoming.
- On August 16, 2011, Kansas Governor Sam Brownback announced that the State would return its \$31 million “early innovator” grant to Health & Human Services.

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Legal Updates

In Kansas, House Bill 2182 passed, and was signed by the Governor on May 25, 2011. The act opposes specific provisions of federal health care reform, stating “The government shall not interfere with a resident’s right to purchase or refuse to purchase health insurance.” The act also provides that residents, employers and health providers “shall not be required to pay penalties or fines” for direct payment without using health insurance, and that the government shall not “impose a form of punishment for exercising these rights.”

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New Requirements and Opportunities

Mini-Med/Limited Medical Plans

- Notice to plan participants for plans that were granted a waiver by regulators

Wellness Grants (2011-2015) \$200 Million Appropriation

- Small Employers with <100 employees working 25+ hours per week
- Did not provide a wellness program as of 3/23/2010
- Apply to HHS for grant (application process has not been defined)
- Programs must include specific components (specific criteria to be developed by HHS)
 1. Promote health awareness
 2. Maximize employee engagement
 3. Promote changing unhealthy behaviors and lifestyle choices
 4. Provide supportive environment

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2012 and Beyond

- Regulators expected to issue significant volume of clarifications and guidance.
- Grandfathered plans need to evaluate their status and act accordingly.

2012

- Quality of Care reporting requirements
- 4-Page Summaries
- **Comparative Effectiveness Fee** – paid by carriers or self-funded employers as a tax, begins w/ 11/1/11 policy renewals – under review by regulators for issuance of guidance

2013

- FSA - \$2,500 limit imposed – applies 1/1/2013 regardless of plan year (so 2/1/12 renewals must comply)
- Employers communicate information about Health Insurance Exchanges

2014

- No pre-existing limits for adults
- No waiting period >90 days
- Benefit eligibility defined as 30+ hours/week
- Minimum essential plan design requirements
- Exchanges available for individuals and small employers
- Play or pay rules

2018

- Excise tax for “Cadillac” plans

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2014 – Potential Penalties

- Employers with 50+ Full-time Equivalent (FTE) employees are subject to Pay or Play penalties
- FTE definition: employee works 30 or more hours per week; FTE calculation also converts part-time employees' hours worked to FTEs
- Temporary / Seasonal employees can be excluded if the employee works <120 days per calendar year
- Total FTE population is used to determine if an employer is subject to the penalty mandate

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2014 – Potential Penalties – The Play Landscape

- Two potential penalty scenarios even if the employer “Plays”
 1. Coverage is offered , but not to “all or substantially all” FT employees (30+ hrs/week)
 2. Coverage offered to “all or substantially all” FT employees but coverage is unaffordable OR is not minimum essential coverage
- Penalty trigger – at least 1 FT employee qualifies for an Exchange subsidy

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2014 – Potential Penalties – The Play Landscape

- How does an employee qualify for an Exchange Subsidy ?
- Subsidy can be granted even if Employer Sponsored Health Coverage is available

First Test is Income Based

Up to 400% of Federal Poverty Level (Household MAGI) - 2011
examples: 1 person family unit \$43,560; 4 person family unit \$89,400

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2014 – Potential Penalties – The Play Landscape

- If 400% FPL test is satisfied next test is:

Is the Employer Plan “Unaffordable”?

Unaffordable if: Employee’s contribution toward lowest priced single coverage exceeds 9.5% of household MAGI*

OR

The Employer Plan does not offer minimum essential coverage

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2014 – Potential Penalties – The Play Landscape

- *IRS Proposed *Safe Harbor*:

Employer exemption from Household MAGI comparison if Employer offers coverage to “all or substantially all FT employees (30+ hrs/week) and the employee contribution for the lowest priced single coverage is at or below 9.5% of the FT employees’ W-2 Wages at that Employer

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2014 – Potential Penalties – The Play Landscape

- If a FT employee elects to pursue coverage through the Exchange and meets the subsidy tests:

The Employer is subject to an annual penalty of \$3,000 for each FT employee that receives an Exchange subsidy

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2014 – Potential Penalties – The Play Landscape

- If the Employer does not offer coverage to “all or substantially all” FT employees (30+ hrs/wk), the Employer is subject to an annual penalty of \$2,000 for ALL FT employees, minus 30 FT employees, regardless of how many FT employees actually receive an Exchange subsidy when at least one FT employee receives a subsidy

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2014 – Potential Penalties – The Pay Landscape

- Employer with 50+ FTEs does not offer health insurance coverage:

The Employer is subject to an annual penalty of \$2,000 for each FT employees, minus 30 FT employees, *if* at least 1 FT employee qualifies for an Exchange subsidy (Up to 400% FPL – this is the only testing requirement)

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About the Presenters

Karen Vines – Vice President Benefits Division, IMA of Kansas, Inc.

Karen's over 25 years experience includes strategic planning, benefit analysis, plan design, self-funding, consumer-driven health plans, and value-based benefits. She leads IMA's Health Care Reform task force. Prior to joining IMA, Vines held positions in both management and sales during her 15 years of service with Blue Cross Blue Shield of Kansas.

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As an attorney for 24 years, Terry represents employers of all sizes in court and before various regulatory and administrative agencies. She is admitted to practice in Kansas and before the United States Supreme Court. Contact Terry at tmann@martinpringle.com or 316.265.9311.

Clinton Baker, CPA, MBA - Manager, Kennedy & Coe LLC

Clinton has twelve years of accounting experience. He is new to the Wichita area, but before Kennedy & Coe he was a partner with a large firm in the Mid-Atlantic region. He chaired that firm's strategic planning team and also led the real estate development/construction practice group. Contact Clinton at cbaker@kcoe.com or 316.691.3761

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