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Challenges of Employee Benefits and Healthcare Reform

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Agenda for Today

- **Status of health care reform**
- **Healthcare Review Overview**
 - Grandfathered plans
 - Plan coverage and administration changes
 - Employer reporting and disclosure rules
 - Medical loss ratio (MLR) regulations
 - CLASS Act
 - Cadillac Tax
 - Open Enrollment Compliance Checklist
- **Agency resources and requirements**
 - Model Notice



Health Care Reform – What is It?

- **Patient Protection and Affordable Care Act (PPACA) – signed on March 23, 2010**
- **Health Care and Education Reconciliation Act (Reconciliation Act) – signed on March 30, 2010**
- **The health care reform law makes sweeping changes to our nation’s health care system**



Health Care Reform – What's Next?

- **Action in Congress**
 - Republicans control House
 - Democrats maintain majority in Senate
 - Attempts to repeal or revise the law
 - Form 1099 reporting requirement repealed
- **Court Cases**
 - District courts split on constitutionality
 - Other courts have acted on procedural grounds
 - Supreme Court expected to decide



Health Care Reform – Which Plans Must Comply?

- **New plan rules generally apply to group health plan coverage**
- **Exceptions**
 - Excepted benefits (some Health FSAs, dental, vision, etc.)
 - Retiree-only plans
 - Group health plans covering fewer than 2 employees



Grandfathered Plans

- Existing plans = grandfathered plans
 - A group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of the health care reform legislation
- Certain health care reform provisions don't apply to grandfathered plans, even if coverage is later renewed
 - New employees can still enroll
 - Family members of current enrollees can still join
- Changes to plan design can cause loss of “grandfathered” status
 - **Plans will have to analyze changes at each renewal**



Grandfathered Plans – Which Rules DON'T Apply?

- Patient Protections
- Nondiscrimination rules for fully-insured plans
- New appeals process
- Quality of care reporting
- Insurance premium restrictions
- Guaranteed issue and renewal of coverage
- Nondiscrimination based on health status/in health care
- Comprehensive health insurance coverage
- Limits on cost-sharing
- Coverage for clinical trials



Grandfathered Plans – Which Rules Apply?

- **Health Insurance Changes – Prohibitions on:**
 - Lifetime and annual limits
 - Pre-existing condition exclusions
 - Rescissions
 - Excessive waiting periods
- **Required coverage of adult children up to age 26**
- **Summary of benefits and coverage**
- **Reporting medical loss ratio**



Grandfathered Plan Regulations

- **Permitted Changes**
 - Cost adjustments consistent with medical inflation
 - Adding new benefits
 - Modest adjustments to existing benefits
 - Voluntarily adopting new consumer protections under the health care reform law
 - Changes to comply with state or federal laws



Grandfathered Plan Regulations

- **Prohibited Changes**
 - Significantly reducing benefits or contributions
 - Significantly raising co-payment charges or deductibles
 - Raising co-insurance charges
 - Adding or tightening annual limits
 - Changing insurance companies (not TPAs) – **Changing insurers is now permitted!**
- **Special Rule for Insured Collectively Bargained Plans**
- **Additional Requirements**
 - Disclose grandfathered status
 - Status can be revoked if try to avoid compliance



Plan Years Beginning on or after September 23, 2010



Coverage for Adult Children Until Age 26

- **Plans that cover dependent children must make coverage available until child turns 26**
 - Includes grandfathered plans, unless child has own employer coverage (before 2014)
 - Covers married and unmarried children
 - Children of covered adult children do not have to be covered
- **State mandates above this level continue to apply**
- **Insurers complying early to avoid coverage gaps**
- **Tax exclusion applies to coverage**



Restrictions on Lifetime and Annual Limits

- Apply to new and grandfathered plans
- No lifetime limits on essential benefits
- **Restricted annual limits on essential benefits**
 - Allowed for plan years beginning before January 1, 2014
- **Essential benefits generally include:**
 - Ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehab services, lab services, wellness and disease management, pediatric care
- **Per beneficiary limits ok on non-essential benefits**
- **Some regulations issued, waiting on others**



Access to Coverage

- **No rescission of coverage**
 - Applies to group and individual coverage
 - Applies to new and grandfathered plans
 - Exception for fraud or intentional material misrepresentation
 - Individual must be given prior notice of cancellation for permitted reasons (including nonpayment of premium or plan termination)
- **No pre-existing condition exclusions or limitations for children under age 19**
 - This prohibition will apply to everyone in 2014
 - Applies to new and grandfathered group plans



Patient Protections

- **Apply to new plans**
- **Limits on preauthorization and cost-sharing**
 - No cost-sharing for some preventive care (including well-child care) and immunizations
 - No preauthorization or increased cost-sharing for emergency services (in- vs. out-of-network)
 - No preauthorization or referral for ob/gyn care
- **Patients can choose any available participating primary care provider (or pediatrician)**
- **Regulations issued**



Nondiscrimination Rules for Fully-Insured Plans

- Apply to new fully-insured plans
- Fully-insured plans must follow rules regarding nondiscrimination in favor of highly-compensated employees
 - Cannot discriminate with respect to eligibility or benefits
- **HCE:**
 - 5 highest paid officers, more than 10 percent shareholder, or highest paid 25 percent of all employees
- **Effective date delayed for regulations**



Calendar Year 2011 Changes



Limits on OTC Reimbursements

- ▶ Apply to Health FSAs, HRAs, HSAs and Archer MSAs
- **Medicine or drugs only treated as qualified medical expense for tax exclusion if they are prescribed or are insulin**
 - This means no reimbursement for OTC medicine or drugs without a prescription (except insulin)
 - New rules do not apply to OTC devices or supplies
- **Applies to expenses incurred after Dec. 31, 2010**
- **Debit cards can be used for prescription OTC medicines or drugs**



Medical Loss Ratio

- **MLR rules:**
 - Insurers must spend 80-85 percent of premiums on medical care and quality improvement (not admin costs) or give rebates
 - Effective January 1, 2011
- **HHS issued final rule**
 - Adopted NAIC recommendations
 - Outlines items counted as medical care/health care quality improvement (and items that are not)
 - Provides rules for rebates



2012 Changes



Employer Form W-2 Reporting

- Employers must disclose aggregate cost of employer-sponsored health coverage on Forms W-2
- Deadlines delayed:
 - Optional for 2011 tax year
 - **For small employers – optional for 2012 tax year and beyond**
- Includes group health plan coverage, whether paid by employer or employee
- Does not include:
 - Contributions to certain types of plans
 - Excepted benefits



Uniform Summary of Benefits and Coverage

- Applies to new and grandfathered plans
- HHS to develop standards for uniform summary within 1 year of enactment (March 23, 2011?)
- Plans to start using within 2 years of enactment (March 23, 2012)
- Standards
 - Easily understood language
 - Explanation of coverage
 - Four-page limit, 12-point font



CLASS Act

- Community Living Assistance Services and Supports Program
- Voluntary long-term care benefits program
- Effective date
 - Technically effective on **January 1, 2011**
 - HHS not required to determine details or establish benefits until **October 2012**
 - Enrollment will be available sometime after that



2013 Changes



Effective in 2013

- **Health FSA Limits: \$2,500 per year**
 - Currently no limit on salary reductions, although many employers impose limit
 - Limit is \$2,500 for 2013; indexed for CPI after that
 - Does not apply to dependent care FSAs
- **Medicare Part D Subsidy Deduction Eliminated**
 - Employers that provide retiree prescription drug coverage could deduct subsidy amount
 - That part of deduction is eliminated in 2013



2014 – A Big Year for Health Care Reform

- **No pre-existing condition exclusions or limitations**
 - Applies to everyone and all plans
- **Health Insurance Exchanges**
- **Limits on out-of-pocket expenses and cost-sharing**
- **No waiting periods over 90 days**
- **Coverage of clinical trial participation**
- **Guaranteed issue and renewal**



Employer Reporting

- **Employers will have to report certain information to the government**
 - Whether employer offers health coverage to full-time employees and dependents
 - Whether the plan imposes a waiting period
 - Lowest cost option in each enrollment category
 - Employer's share of cost of benefits
 - Names and number of employees receiving health coverage



2018 – Cadillac Plan Tax

- **40 percent excise tax on high-cost health plans**
- **Based on value of employer-provided health coverage over certain limits**
 - \$10,200 for single coverage
 - \$27,500 for family coverage
- **To be paid by coverage providers**
 - Fully insured plans = health insurer
 - HSA/Archer MSA = employer
 - Self-insured plans/FSAs = plan administrator
- **More guidance expected**



COMPLIANCE

[General Info](#)[Model Notices](#)

MODEL NOTICES

Included is a list of Model Notices and documents that may be required for your employees throughout the year. Please contact Kelly Insurance Agency if we can be of assistance in the delivery or explanation of this document library.

Notices listed below are categorized by the Grandfathered or Non-Grandfathered Status of your Health Plan.

If your Plan is **Grandfathered**, the following Health Plan Notices are required henceforth:

1. [Grandfathered Model Notice](#);
2. [Dependent to Age 26 Notice](#) (Coverage for Adult Children);
3. [Annual Limits on Essential Health Benefits Notice](#);
4. [Lifetime Limits on Essential Health Benefits](#);
5. [Pre-existing Conditions Exclusion for Children Under Age 19 Notice](#); and
6. [Patient Protections Notice-Prohibition on Rescissions](#)

If your Plan is **Non-Grandfathered**, the following Health Plan Notices are required henceforth:

1. 2-6 Notices listed above under "Grandfathered", plus;
2. [Appeals Process Notice-3 separate Notices](#) and [External Review Model Notice](#);
3. [Nondiscrimination Rules Extended to Insured Plans Notice](#);
4. [First Dollar Coverage for Preventative Care Notice](#); and
5. [Patient Protection-Provider Designation](#)

Finally, all Plans-**Grandfathered and Non-Grandfathered** alike-must also provide the following ERISA Notices:

1. [WHCRA Notice](#) (Women's Health and Cancer Right ACT);
2. [CHIPRA Notice](#) (Children's Health Insurance Program Reauthorization Act);
3. HIPAA Notice (for self-insured plans) (Contact your agent for assistance);
4. [Medicare Part D Notice](#); and
5. [MHPA Notice](#) (Mental Health Parity Act)

Grandfathered Plans will have **11 total Notice requirements** under PPACA and ERISA.

Non-Grandfathered Plans will have **16 total Notice requirements** under PPACA and ERISA.

Other Helpful Documents:

CLASS ACT



QUESTIONS?

- Did you learn something valuable?
- Do you have a plan in place?
- Are you prepared for the future?



THANK YOU!

For questions about today's information:
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