WHAT YOU NEED TO KNOW ABOUT HEALTH CARE REFORM COMPLIANCE

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A. Introduction

President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010. The law was almost immediately amended by the Health Care and Education Affordability Reconciliation Act of 2010. Together, the two laws are referred to as the PPACA or Health Care Reform Act.

The Health Care Reform Act is intended to increase the transparency and efficiency of the country's health insurance markets while substantially decreasing the number of uninsured persons in the country. This is to be accomplished, in part, by mandating health care coverage for individuals and providing subsidies to lower income individuals and families.

In addition, the Health Care Reform Act, imposes an assortment of new taxes and fees on individuals, employers, and health care insurers alike and imposes new responsibilities on employers, and insurers, as well as government programs such as Medicare and Medicaid.

Employers of all sizes are finding themselves subjected to new rules, regulations and penalties. All employers are be required to make substantial changes to their group health plans' design, as well as summary plan descriptions and other and employer benefit communications. In addition, while many of the provisions of the Health Care Reform Act will not be effective until 2014, most employers have already been required to assess their plans and prepare plan design, communication and administrative changes. But this was only step one, additional changes will be required in the not too distant future.

First, thought, let's review the major provisions of the Act that affect employers either directly or indirectly through their employees or insurance mandates. These include:

B. Mandatory Coverage for Individuals

Effective in 2014, most US residents will be required to maintain "essential health benefits".

Essential health benefits include: ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance abuse services; prescription drugs; rehabilitative services and devices; laboratory services; preventative and wellness services; chronic disease management; pediatric services; and other services as defined by the Department of Health and Human Services.

The health coverage must insure at least 60% of the actuarial value of covered services, with annual out-of-pocket limits equal to those that currently apply to high deductible health care plans associated with Health Savings Accounts. (For 2010, this would be $5,950 for an individual and $11,900 for a family.) Furthermore, employer-sponsored plans in the small group market will not be able to impose deductibles that exceed $2,000 for individuals and $4,000 for families.

Generally, the penalty for each individual who does not have this coverage will be the greater of $95 or 1% of income in 2014. This will increase to the greater of $695 or 2.5% of income in 2016.

C. Premium Assistance and Premium Tax Credit

Employers with fewer than 25 employees who have average wages of less than $50,000 will be given a tax credit, starting in 2010, of up to 35% of the employers' contribution towards health care coverage, if the employer contributes at least 50% of the total premium.

In 2014, employees (and other individuals) will receive advanceable and refundable premium tax credits if their incomes are between 100% and 400% of the federal poverty level. An employee who is offered coverage by his employer will be eligible for the premium tax credit if the employer's group health plan does not pay at least 60% of covered benefit costs or the employee contribution would be more than 9.5% of the employee's income. In addition, the Act provides federal cost sharing subsidies to employees and other eligible individuals with incomes below 200% of the federal poverty level.

D. American Health Benefit Exchanges

The Health Care Reform Act creates "American Health Benefit Exchanges" through which individuals may purchase insurance coverage. States may opt to have regional exchanges. The Exchanges are to be operational in 2014.

Four health care coverage benefit categories (Bronze, Silver, Gold and Platinum) will be offered by the Exchanges to individuals and families, in addition to a less expensive "Catastrophic Plan" for those under age 31. Other than the Catastrophic Plan, the least expensive Bronze Plan would provide "essential health benefits" and cover 60% of essential benefit costs. Out-of-pocket limits would be reduced for individuals with incomes below 400% of the federal poverty level. The Act also creates a Consumer Operated and Oriented Plan (CO-OP) program to help create non-profit, member-run health insurance organizations.

Small Business Health Option Program (SHOP) Exchanges will be created to allow small businesses of up to 100 employees to purchase qualified health care coverage.

E. Insurance Market

In addition to the coverage and design requirements for group health plans, insurers will be required to provide guaranteed issue (i.e., insurance companies cannot bar applicants based on health status) and guaranteed renewability in the group and individual markets. State or national high-risk pools must be created to provide health insurance coverage to certain individuals with pre-existing conditions until the Exchanges are established. Insurers' rating variations can only

be based on family structure, community rating area, actuarial value of benefits, age (limited to a 3 to 1 ratio) and smoking. The Department of Health and Human Services ("HHS") will work with the states to review "unreasonable" rate increases, which must be justified to HHS and each state insurance department. States may allow the creation of "health care choice compacts" to permit purchase of individual insurance across state lines.

F. Employer Group Health Plans – Future Considerations

The Health Care Reform Act makes significant changes that will affect the design and administration of employers' group health plans by 2014, regardless of whether they are insured or self-funded. Among the most significant provisions:

- Employers with more than 50 employees who do not offer minimum essential health benefits and have at least one employee who receives a federal premium tax credit because of coverage through an "Exchange", will be assessed a fee of $2,000 per full time employee, with an exception from the penalty for the first 30 employees.
- If the employer's group health plan requires contributions in excess of 9.8% of income for any employee, the employer will be assessed a penalty of $3,000 for each full time employee who receives a premium tax credit, with an exception from the penalty for the first 30 employees.
- Employers with more than 50 employees may not have a group health plan waiting period of more than 90 days.
- Employers with more than 200 employees must automatically enroll their employees in the employer-sponsored group health plan. Employees must be given the opportunity to opt out of coverage.
- Employers must offer a "free choice" voucher to an employee to help pay for coverage through an Exchange, if the employee's income is less than 400% of the federal poverty level, and the required employee contribution for the group health plan is between 8% and 9.8% of the employee's income. The value of the voucher must equal the contribution the employer would have made to the group health plan on behalf of the employee.
- For 2012, uniform summaries of benefits, based on HHS regulations, must be distributed. Changes to these summaries must be distributed 60 days before the change in benefits takes effect.
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In addition to the design changes, employers will have mandatory notification requirements. Among these, employers will have to include the cost of group health care coverage on their employees' Forms W-2 beginning with the W-2's delivered in January 2013. For 2014, employers (or their insurers) will also have to provide annual information returns stating the number of months during which an individual was covered by the employers' plan.

Also for 2014, employers must notify employees about the existence of the Exchanges and inform them they may be eligible for premium assistance and a cost sharing reduction if the employer's contribution to the plan is less than 60% of the total cost of coverage, and that if the employee chooses coverage through the Exchange, the employee may lose the employer's coverage contribution. Finally, group health plans will have to comply with HHS standards for the provision of information about benefits and coverage. HHS will provide these standards within 24 months of enactment of the Health Care Reform Act.

G. Where Are We Now?

By now you're probably all pretty familiar with the basics of health care reform, and the provisions that required your immediate attention

For example by now you should have already:

- determined if your plan has grandfathered status;
- be prepared to extend coverage to adult children up to age 26;
- removed lifetime limits from your plans and increased or eliminated annual limits for essential health benefits;
- held, or have prepared to hold, special enrollment periods for those individuals who had aged out of your plan or have previously hit lifetime limits; and
- made sure your plan is properly amended to comply with the requirements that take effect for the first plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans) and to ensure that your insurer or TPA had made any required benefit changes.

H. What's Next?

But now that you are finishing the first stage of health care reform you should be asking yourself: what's next?

First you should make sure that all required notices have been distributed.

Then, if you are currently in grandfathered status, you should examine your plan to see if the grandfathered status should be maintained.

Review changes to claims procedures, whether your plan is grandfathered or not, and ensure that you, or more likely, your insurer or TPA is ready to apply these changes.

You should prepare yourself and your employees for the new limits on health care flexible spending accounts.

If you have retiree prescription drug coverage, you should see if it makes sense to continue this coverage under the new tax rules.

Review upcoming W-2 reporting requirements on the value of health care coverage.

You should also prepare for the upcoming automatic enrollments, the new rules for benefit summaries and the requirements for advance notices of changes in benefits or plan provisions.

Let's look at these items one at a time.

I. Required Notices

For many employers, the first step in complying with health care reform involves or will involve the distribution of one or more newly-required notices to plan participants and other individuals. The number of notices that must be distributed will depend on the status and nature of their group health plan, as well as specific plan provisions and their plan's health care benefit delivery system. The new notices include the following:

- *Grandfathered Health Plan Notice*. A notice stating that the employer believes its group health plan is a "grandfathered" health plan and, therefore, not subject to various provisions of the Health Care Reform Act.
- *Special Enrollment Notice for Certain Children Who Aged Out*. A notice that the group health plan will cover children of participants until age 26, and that a there will be a one-time, 30-day open enrollment period for adult children who are currently not covered by the plan.
- *Lifetime Limits Notice*. A notice that the lifetime limits of the group health plan are no longer applicable and that a one-time, 30-day open enrollment opportunity will be available to participants and beneficiaries who left the plan because they had reached the previously applicable lifetime limit.
- *Patient Protection Notice*. A notice on patient protections regarding the right to select primary care providers, including pediatric care providers, from any provider participating in the plan's network. The notice must also provide that a referral is not required for obstetrical or gynecological care provided by a physician who is participating in the network.

For most employers, the distribution requirements for these notices can be met by including the notices in the open enrollment materials. Others can include the information in their SPD, with an SMM or with other employee communications.

J. Grandfathered Status

To temporarily avoid some of the new compliance rules, many employers are desperately holding on to grandfathered status. But...is it worth it?

Grandfathered status can be lost, in some cases, by obtaining a new insurance contract or policy (although the government agencies have recently limited this provision so that new contracts that take effect after November 14 will not, by themselves, terminate grandfathered status).

Grandfather status will also be lost if the plan:

- eliminates substantially all benefits to diagnose or treat as specific illness (*e.g.*, if a plan provides treatment for a particular mental illness which consists of counseling and prescription drugs, and then eliminates counseling benefits, the plan would lose its grandfather protection);
- increases the participants' fixed percentage co-insurance requirements (*e.g.*, increasing a co-pay from 20% to 30%);
- increases fixed dollar amount cost sharing requirements (*e.g.*, deductibles or out-of-pocket expenses) beyond a specified amount based on medical inflation plus 15%;
- increases co-payment amounts more than the rate of medical inflation plus 15%, or if greater, by $5.00;
- decreases the employer contribution for any tier of coverage by more than 5% (*e.g.*, decreasing the employer's share of premiums from 60% to 50%); or
- imposes certain new annual limits on essential benefits.

The question is: What are you really gaining by maintaining grandfathered status and is it worth it?

To make this determination you should first take a look at your current health care cost increases with a view as to whether a change such as additional cost sharing will cause a loss of grandfathered status. Then you should compare the amount you would gain by this cost-sharing with the cost of the additional rules to which your plan will become subject upon loss of grandfathered status.

To do this you should examine the health care reform provisions that are and are not applicable to grandfathered plans.

K. PPACA Provisions that Are Applicable to All Plans

Although these rules apply to all plans there are some small differences

- Coverage for adult children – Perhaps the most significant change. It will allow children up to age 26 to be covered by their parents plan. Grandfathering allows children who are eligible for other employer coverage, with the exception of coverage through the participant's spouse, to be excluded from your plan –but when you think about it, these 18 to 26 year olds are probably the healthiest beneficiaries in your plan- so it must be asked --How much does it really help your health care costs if you exclude these individuals from coverage ?
- Restrictions on annual and lifetime benefit limits for essential benefit Grandfathered plans are permitted to have limited annual maximums through the 2013 plan years—but these limited maximums are fairly high and will not often come into play. The regulations state that these limits are $750,000 for plan years beginning after September 22, 2010; $1.25 million for plan years beginning after September 22, 2011; and $2 million for plan years beginning after September 22, 2012. The limits will be applied separately to each covered individual. The limits only apply to essential health benefits and cannot be offset by other payments for non-essential health benefits, and will not often come into play.
- Elimination of pre-existing condition exclusions for children under age 19 – already rare in group health plans because of HIPAA and, as with the limitation of rescissions – it affects all plans in the same manner regardless of whether they are grandfathered or not.

Not much difference between grandfathered and non-grandfathered under these provisions, so lets look at.

L. <u>PPACA Provisions that Are Only Applicable to Non-Grandfathered Plan</u>

- Preventative care services must be provided without cost sharing requirements – non-grandfathered could have some additional expenses – I'd suggest you check with your insurer or TPA to get an estimate – it might not cost as much as you think
- Participants may select primary care providers, including pediatric care providers, and OB/GYNs from any such provider who participates in the plan's network – most plans already permit and if physician is in network, probably no additional cost
- Emergency care services must be provided without prior authorization and without regard as to whether the emergency health care provider is a participating – Again, most plans already permit this and the rules only require reimbursement at the in-network rate
- Insured group health plans will be subject to nondiscrimination rules similar to those currently in effect for self funded plans –this could have been a serious problem for discriminatory plans – $100 per day penalty for each individual discriminated against. However, in Notice 2011-1, IRS has delayed the effective

date of this non-discrimination rule, until final regulations are issued. However, based on the IRS's prior "progress" with regulations pertaining to discrimination in self-insured plans (which began decades ago and is still a work in progress), and the complete failure of the Section 89 discrimination rules for all group health plans (Internal Revenue Code Section 89 was subsequently repealed), it should be safe to say that the latest round of discrimination rule-making (and accompanying penalties) for insured plans, will not take effect for several years to come, if ever.

- Maintain effective internal and external appeals process. This one has caused a lot of concern so lets look at it separately

M. Internal and External Review

These rules only apply to non-grandfathered plans. These plans will be in compliance with the new internal claims and appeals process requirements if they comply with the current claims requirements of the Department of Labor, plus six new requirements. These new requirements are:

- An expanded definition of an "adverse benefit determination".
- A requirement that urgent care claims be determined and communicated within 24 hours of receipt. (not effective until July 2011)
- A requirement that the plan must provide the claimant with any new or additional evidence considered by the plan.
- That the hiring or compensation of a decision maker must not be based on the likelihood that the decision maker will support a denial of benefits. (This may have been a fiduciary violation anyway).
- The plan must issue notices to enrollees, in a "culturally and linguistically appropriate manner." (effective July 2011) Also, the notification of a negative benefit determination must include the reason for the adverse benefit determination, a description of internal and external reviews, and the availability of any applicable office of health insurance consumer assistance.
- The plan must continue ongoing treatments pending the outcome of any internal appeal.

For most insured plans, the regulations say that the external review requirement will be met if the plan is subject, through its insurer, to a state-required, external review process.

Self funded plans can comply with the external review process requirement if they either:

- Voluntarily comply with a state external review process. A state may choose to expand access to its external review process to plans that are not subject to the applicable state laws (such as self-funded plans), and those plans may voluntarily choose to comply with the state process;

- Comply with DOL Technical Release 2010-01. This Technical Release establishes the standards for external review that self-funded plans will have to follow if they are not in a state external review process.

Major changes – but in most cases insurer or TPA will be responsible, not the employer.

Also keep in mind that while these new rules only apply to non-grandfathered plans, DOL has already said it will be amending its own procedures shortly, so no plan will be immune from change to its claims review procedures.

N. FSA Changes

Under health care reform, in general terms, a health care flexible spending account, health reimbursement account or health savings account cannot reimburse non-prescription drugs, except insulin, on a tax exempt basis. The new limitation applies to all such expenses incurred on or after January 1, 2011, regardless of when the money was contributed. For purposes of this rule, all plans must comply on January 1, 2011, regardless of their plan year and regardless of whether the plan has a 2 ½ month grace period for health care expenses after the end of the plan year. However, all over-the-counter expenses that were incurred prior to January 1, 2011 can be reimbursed after that date.

It's important to note that, this new restriction only applies to medicines and drugs, and not to: equipment such as crutches; supplies such as bandages; and diagnostic devices such as blood sugar testing kits. These items will remain reimbursable as long as they meet the Internal Revenue Code definition for medical care expenses. So far, however, IRS has not defined these terms so it remains unclear whether certain items would be reimbursable or not

Also, effective January 1, 2013, employee pre-tax contributions to health care FSAs will be limited to $2,500. This rules regarding the timing of this new restriction will probably be similar to those issued for over-the-counter drugs. However, we are currently awaiting further guidance from the IRS and other agencies. The $2,500 will be adjusted for inflation after 2013.

You should make sure your plan has been amended to include the change to over-the-counter reimbursements and to maximum contributions. Also, health care FSAs should be amended before the end of the year to permit the coverage of health care expenses of adult children and premium conversion plans should be amended to permit pre-tax contributions to be made on their behalf.

O. Retiree Coverage Subsidy

When the Medicare Part D Prescription Drug Program was established, employers were provided with a retiree drug program subsidy to encourage them to continue their current retiree

coverage. Effective in 2013, employers will no longer be able to deduct expenses attributable to the subsidy.

Although, the new rule does not take effect for two more years, under financial accounting rules employers must begin reporting this change in future liabilities immediately.

Therefore, employers should also begin to examine their retiree prescription drug plans immediately to determine if this benefit should be continued, and, if not, to determine the plan amendments and communications that will be needed if the employer-provided retiree prescription drug benefit is reduced or eliminated.

P. W-2 Reporting

This slide could have been a lot worse.

The health care reform act requires employers to include the aggregate cost of employer-provided health care coverage on Form W-2, beginning in 2011. However, IRS has issued Notice 2010-69 which states that this requirement will be optional for 2011. The newly proposed W-2 for 2011 says that the cost of employer-provided health coverage may be reported in Box 12 using Code DD. Now, due to the IRS Notice, reporting this information is strictly voluntary for 2011, so most employers won't have to worry about reporting health care costs until the 2012 W-2s are issued in January 2013.

Q. Auto Enrollments

Under the Health Care Reform Act employers with more than 200 employees will be required to automatically enroll new full time employees in one of their group health plans, giving the employees adequate notice and the opportunity to opt out of the plan.

The Act does not say when this provision is to be effective. However, DOL has stated on its website, that the automatic enrollment rule will not take effect until after DOL and IRS have issued regulations, and that these regulations are not expected to be effective until 2014.

But, there are other questions regarding this rule. For instance, under these auto enrollment rules, will an employer be responsible for enrolling only the employee or the employees entire family. If the employer has multiple plan options, can it choose the option in which the employees will be enrolled. What time frames will be involved and will coverage have to be retroactive to the date of hire.

So, we will have to wait for regulatory guidance to get some answers.

On the other hand, employers should currently be examining their HRIS and Benefit Systems to see if they are capable of handling these automatic enrollments, including the provision allowing an employee to reject the automatic enrollment.

R. Uniform Explanation of Coverage

Health and Human Services is to develop standardized language for coverage and benefits. The material in the explanation must use uniform, understandable language and include items such as cost sharing, limitations on coverage, examples of common benefit scenarios and whether the plan provides the minimum essential health benefits that individuals will need to avoid penalties under the Health Care Reform Act. The summary can be no longer than four pages.

It is unclear whether this explanation will be part of, or in addition to, the plan's summary plan description or whether it will be subject to the same distribution rules as SPD's. It is also unclear whether foreign language editions of the explanations will be required and what exactly is meant by standardized language. And there are sure to be problems that will arise when your benefits don't quite fit these government-provided standards.

We are simply going to have to wait for guidance in the form of government regulations.

S. Notice of Modification

Similar problems will arise under the requirement that employers must notify plan participants 60 days in advance of any changes to the terms or coverage under a group health plan.

Again, it is not clear when this rule becomes effective. Presumably it will not be enforced until after explanatory regulations have been issued.

However when it becomes effective this provision may be difficult for employers (or their plan administrators) since it is often impossible to know of plan changes 60 days in advance. For example, what is an employer to do when negotiations for a new insurance contract are stalled until the end of the plan year or contract year. Will an employer be forced to make final concessions just so it can meet the 60 day requirement. In other words, would the threat of a delay in coverage changes until after the start of a new plan year force an employer to avoid an administrative and communications nightmare by conceding certain negotiating points to an insurer or collective bargaining unit?

Hopefully, the government agencies will recognize these difficulties and provide practical solutions in their regulations.

T. Penalties

Why should employers be concerned about all this?—PENALTIES!

Although the penalties applicable to violations of the Health Care Reform Act have not been firmly established, it is quite possible that, in addition to the penalties that have previously been mentioned, and the $110 per day penalty that courts can impose for a failure to provide a legally compliant summary plan description, that HHS may be able to apply the HIPAA non-compliance penalties to an employer's failure to comply with the Health Care Reform Act.

The civil monetary penalties, which can be quite severe, are:

- $100 per violation if the person did not know (and by exercising reasonable diligence would not have known) that a violation occurred up to a maximum of $25,000;
- $1,000 per violation if the violation is due to reasonable cause and not willful neglect up to a maximum of $100,000;
- $10,000 per violation if the violation is due to willful neglect and is corrected up to a maximum of $250,000; and
- $50,000 per violation if the violation is due to willful neglect and is not corrected properly up to a maximum of $1,500,000 during a calendar year.

HHS can determine the number of violations based on the nature of obligation that was violated (e.g., whether a failure to act in a certain manner or within a particular time affects some or all plan participants). In the case of a continuing violation, a separate violation occurs on each day the group health plan violates the provision.

V. Administrative Concerns

As you can see, while phase one of health care reform compliance may be coming to an end, the work is far from over. At this point, all employers should be examining their internal procedures to determine what they must do to prepare for these upcoming requirements. These include the new review processes, automatic enrollment as well as the new coverage explanations. Often these requirements will be delayed due to the grandfather rules or will be passed on to insurers or TPAs. But, in any event, employers must remain aware of all requirements to ensure compliance with the new law.

U. Conclusion – Action Steps for Employers

Many of the new provisions for employers and their group health plans have just come into effect, but more requirements are on the horizon, so employers must continue preparations to ensure that they are ready to comply with the new law.

By now employee benefit professionals should have assessed your plans to determine if plan amendments and modifications to your summary plan description are required and to assist in the preparation of these amendments and modifications.

Your first step should have been to determine which provisions must be complied with by the beginning of the plan year. To do this, you first had to determine whether you are afforded protection under the grandfather rules. Now, however, you should determine whether grandfathered status is worth it.

Next, you should assess your group health plan to determine if your insurers and your TPA are ready for the new claims procedures.

Also, you should assess your open enrollment procedures, to determine, for example, if your current system, and open enrollment dates, can support the additional special enrollments for adult children and employees who had previously reached their lifetime maximum benefits as well as future automatic enrollments.

Employee communication materials should be written to inform plan participants of the upcoming changes and to help them understand the provisions of the Health Care Reform Act.

Finally – Keep Alert. The government will be issuing new rules and regulations on the Act and, most likely, changing the rules it has already made, based on employers' and insurers' comments. Health care reform will remain a moving target for the foreseeable future and the only way to ensure compliance is to be constantly up-to-date on all matters effecting group health plans.