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NAVIGATING HEALTH CARE REFORM

**AN EMPLOYER GUIDE:
ARE YOU PREPARED TO COMPLY
WITH KEY IMPACT POINTS?**

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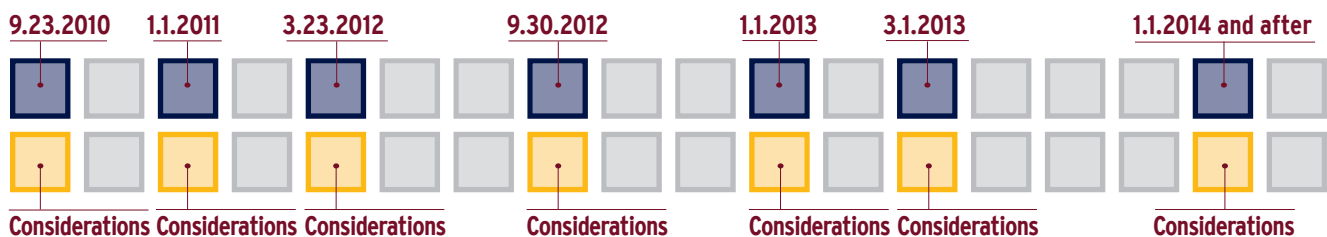
QUICK GUIDE TO REVIEW HEALTH CARE REFORM KEY ITEMS

The Willis Human Capital Practice is committed to providing your organization with accurate, actionable information regarding health care reform*. Start by reviewing the key points detailed in this guide, then contact a Willis North America representative for additional information to assess your unique situation.

This guide is structured to provide specific changes and requirements for each plan year from 2010 through 2013. In addition, at various points in the document you will find an “EMPLOYER CONSIDERATIONS” section. Here we provide a detailed list of items that should be considered by, or acted on, by your organization.

**This version reflects information that is current as of: December 30, 2010*

Click on dates/considerations to navigate.



GROUP HEALTH PLAN INSURANCE REFORMS MEASURING THE IMPACT: WHICH EMPLOYERS? WHICH PLANS?

Virtually all US employers and their group health plans will be subject to health care reform, known as the Patient Protection and Affordable Care Act (PPACA), in one way or another. These include self-funded and insured plans, whether it is an ERISA, non-federal governmental or church plan.

Many employers are understandably anxious to learn how their

businesses will be affected. Although many provisions do not actually take effect for years, employers face a multitude of changes that must be addressed quickly. To highlight immediate issues, summarized below are key PPACA changes affecting traditional group health plans.



WHAT IS GRANDFATHERED STATUS?

“Grandfathered” (GF) group health plans are generally defined as plans that were in effect on March 23, 2010 and covered at least one individual. Many PPACA mandates apply to both grandfathered and non-grandfathered plans. Thus, losing GF status likely has negligible impact on most employer plans. Still, employers must assess whether keeping GF status outweighs the value of making operational plan design changes needed to manage costs. In many cases, keeping the plan nimble by forgoing grandfather status will represent the better choice.

Certain limited changes are allowed without compromising GF plan status, including:

- Modifications to premiums
- Changes to comply with federal or state law and/or to voluntarily comply with PPACA
- Changes to increase benefits, switch third party administrators, or entering into new insurance contracts (provided that there are no changes in the coverage that would cause a loss of grandfathered status and the new contract is effective on or after November 15, 2010)

Changes that end GF protections include**:

- Eliminating all or substantially all of a benefit
- Increasing co-insurance percentages, co-payments, deductibles and out-of-pocket maximums
- Decreasing the employer contribution rate
- Changes in annual limits; either adding a limit or reducing a current limit

*** Regulations allow for some operational cost changes reflecting medical inflation.*

Plans seeking to keep GF status must:

- Document plan rules in effect on March 23, 2010 plus disclose GF status in benefit materials provided to participants.
- Model language is available by [clicking here](#).

HEALTH CARE REFORM TIMELINE

PLAN YEARS STARTING ON OR AFTER SEPTEMBER 23, 2010

ALL PLANS

- Cover children until they reach age 26
 - GF plans may exclude a child eligible for qualifying employment-based health coverage until 2014
- No lifetime/annual dollar limits on “essential health benefits”
- Restricted annual limits (as defined in the regulations) on the dollar value of essential health benefits permissible until January 1, 2014
- Waiver of restricted annual limits may be available for “mini-med” plans.
- No retroactive cancellation of coverage (rescission) except in cases of fraud, or intentional misrepresentation of material fact
- No preexisting condition exclusions for enrollees under age 19
- File a medical loss ratio report with HHS for each plan year (does not apply to self-insured plans)

ADDITIONAL MEASURES FOR NON-GRANDFATHERED PLANS ONLY

- Coverage of certain preventive health services and immunizations, without cost-sharing
- No discrimination in favor of higher-wage employees (self-insured plans continue to be subject to prior non-discrimination rules). This requirement has been delayed. The delay will remain in effect until sometime after the agencies issue regulations explaining how to comply.
- Provide patient protections regarding emergency services, choice of primary care provider (including a pediatrician), and access to gynecological/obstetric services
- Internal and external appeals processes (ERISA plans already comply to similar rules)

☒ **EMPLOYER CONSIDERATIONS - FOR ALL YEARS**

☐ **Consider plan design and benefit strategy**

- ☐ - Consider cost to comply with additional provisions if GF status lost.
- ☐ - Consider annual limit waiver for “mini-med” plan or converting to a traditional medical plan or plan termination
- ☐ - Consider excluding preventive care on an out-of-network basis.
- ☐ - Consider any “executive” plans as to nondiscrimination requirements and possibly maintaining GF status. (This requirement has been delayed. The delay will remain in effect until sometime after the agencies issue regulations explaining how to comply.)
- ☐ - Set cost-sharing limits for out-of-network emergency services

☐ **Amend plan and SPD to:**

- ☐ - Provide coverage for adult children
 - ☐ • GF option to exclude adult children with access to his or her own or a spouse’s employment-based coverage; plan should determine whether it will use this exclusion and if so, add administrative process for eligibility confirmation (e.g., create employee certification)
- ☐ - Remove lifetime dollar limits on essential benefits
- ☐ - Either remove annual limits or reflect restricted annual limits
- ☐ - Incorporate rescission rule if enrollee engages in fraud or intentional misrepresentation of fact
- ☐ - Remove preexisting condition exclusion for children under 19
- ☐ - Provide coverage for recommended preventive care services and remove cost-sharing requirements (if applicable)
- ☐ - Allow participants to choose any available PCP/Pediatrician
- ☐ - Provide participants direct access to OB/GYN
- ☐ - Update language regarding patient rights. **Click here** for model notice.
- ☐ - Ensure emergency services definition reflects PPACA
- ☐ - Review internal and external appeals process

☐ **Provide notice and 30-day special enrollment period to:**

- ☐ - Any child who previously “aged out” or denied eligibility due to age. **Click here** for model notice.
- ☐ - Anyone who previously exhausted lifetime limit. **Click here** for model notice.

☐ **Establish process to deliver 30 day notice before rescinding any coverage**

☐ **Distribute amended SPD or SMM to participants**

- ☐ - Amend Cafeteria plan document to allow coverage of adult children to be provided on a pre-tax basis
- ☐ - Amend eligibility under health Flexible Spending Account (FSA) to allow for adult child expenses to be reimbursed

☐ **Update payroll system to ensure that dependent coverage to age 26 is not taxed or calculated as imputed income**

☐ **Ensure FSA administration includes expense reimbursement for a dependent child up to the end of the tax year in which the child attains age 26**

☐ **Have carrier confirm its medical loss ratio (MLR) reporting obligation**

☐ **If MLR rebates provided to employers (rather than to individual enrollees) consider ERISA obligations involved in handling rebates**

JANUARY 1, 2011

- No reimbursement for non-prescribed over-the-counter drugs/medicines (OTC items) other than insulin, under Health Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs), Archer Medical Savings Accounts (MSAs) or Health Reimbursement Arrangements (HRAs)
- Increased penalties (20%) in the case of distributions from HSAs and Archer MSAs for non-qualifying expenses
- Report the value of employee's health coverage on W-2s starting with the 2011 taxable year
 - IRS issued a notice in October, 2010 providing that the reporting for coverage in 2011 is optional
- The Community Living Assistance Services and Supports (CLASS) program requires automatic enrollment for all working adults, unless they choose to opt out; employers who choose to participate are required to automatically enroll employees unless the employee elects to opt out

☒ **EMPLOYER CONSIDERATIONS - JANUARY 2011**

- ☐ Change any references in plan document or communication materials to current HSA/MSA penalties
- ☐ Notify employees that any OTC expenses must be incurred on or before December 31, 2010 (regardless of plan year) for valid reimbursement
- ☐ Amend health FSA plan document and review employee communications for PPACA

MARCH 23, 2012

- Prepare and provide uniform "explanations of coverage" (ERISA plans already comply to similar rules)
- Notify enrollees of material changes to the coverage described in the uniform explanation no less than 60 days before the change is effective (also similar to current ERISA duties)
- No deadline yet established for "transparency" reports that plans are to send to HHS and make publicly available; for now it appears that plans may forego preparing these reports until standards are issued



SEPTEMBER 30, 2012

- Group health plans (self-funded and insured) will be assessed a tax of \$2 (\$1 during fiscal year 2013) per average number of participants for “comparative effectiveness research”
 - Although the law makes insurers responsible for insured plan fees, employers should anticipate that expense passed through by way of increased premiums

JANUARY 1, 2013

- Annual salary reduction contributions to a health FSA capped at \$2,500
- Certain tax benefits for employers receiving subsidy payment for providing retirees with drug plan coverage equivalent to Medicare Part D no longer available
- 1.45% individual Medicare payroll tax jumps to 2.35% on wages over \$200,000 (\$250,000 for joint return filers)

☒ **EMPLOYER CONSIDERATIONS - JANUARY 2013**

- ☐ Communicate with employees the impact of the limited health FSA contribution amount
- ☐ Ensure payroll system is updated to stop contributions appropriately
- ☐ If required, amend plan to reflect benefit limitation, including an adoption agreement and updated SPD or an SMM to be kept with current SPD
- ☐ Analyze whether loss of tax benefits makes it more cost-effective to have retirees participate in Medicare Part D rather than providing retiree prescription drug coverage
- ☐ Review current payroll process to ensure tax is applied to employees receiving wages in excess of \$200,000

MARCH 1, 2013

- By March 1, 2013, employers must provide written notice to all new hires and current employees describing the new “Insurance Exchanges,” explaining the premium tax credit and cost-sharing subsidies (if the employer’s plan pays less than 60% of costs of benefits)

JANUARY 1, 2014

Under the employer mandate, there are two situations in which a large employer may be required to pay a penalty. The first way is if the employer fails to offer its full-time employees (and their dependents) the opportunity to enroll in “minimum essential coverage” under an eligible employer-sponsored plan for any month, and at least one full-time employee then accesses a program under which the employee is entitled to federal assistance (a premium tax credit or cost-sharing reduction). The second way that a large employer may be assessed a penalty is if it offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage but one or more full-time employees enrolls in a program under which the employee is entitled to federal assistance because the employee’s share of the premium for the employer’s plan exceeds 9.5% of household income (i.e., the coverage is unaffordable) or the actuarial value of the employer-sponsored coverage is less than 60% (i.e., the coverage is insufficient).

As regulations are still pending, and employers still have some time to consider compliance strategies, Willis will monitor developments and keep you updated.

FOR PLAN YEARS STARTING ON OR AFTER JANUARY 1, 2014

Several additional insurance reforms, and other requirements relevant to employers’ health plans become effective in 2014, and those are detailed in the following *Alerts*, which can be accessed by clicking on the publication desired.

Health Care Reform Timeline

Health Care Reform Summary

First Things First

*Please note this guide is intended to present only a short-hand summary of health care reform. For detailed information on this topic, please see other Willis publications. These can be accessed by **clicking here** or by contacting a Willis North America representative. As none of the information presented here represents legal advice, you must direct specific legal issues to your attorney.*