

The Impact of Health Care Reform

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Disclaimer

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Some provisions of the law and governing regulations are yet to be finalized and are subject to change. It is our intent to make periodic updates; however, the content may not be up to date at the time of viewing.

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Overview

- Dependent age 26
- Pre-existing conditions
- Lifetime limits
- Wellness and prevention
- Essential benefits
- Grandfather clause
- Discrimination-reporting 105(h)
- Small group tax credit
- W-2 reporting
- Minimum loss ratio

Additional timeline wrap-up

Dependent age 26

- Employees are allowed to add their dependents to their policy up until age 26.
- Specifically the new law raises the age to which members can add dependents to their policies. For plan years beginning after Sept. 23, 2010, members will be allowed to add dependent children up to the age of 26 back to their policies during their group's annual open enrollment.
- Additionally, neither a dependent's status as student, nor their marital status matter when determining dependent eligibility. All dependents will be eligible up until age 26.
- This provision applies to individual, self and fully funded groups. Employers may not discriminate on age when it comes to dependent contribution. Plans that are grandfathered, will not have to enforce this until 2014 unless dependents don't have a source of employer-sponsored coverage. We will go further in-depth on grandfathered plans later in this presentation.

Pre-existing conditions for children up to age 19

- Groups with plan years beginning after Sept. 23, 2010 a change to pre-existing conditions goes into effect.
- Starting at the group's annual enrollment, pre-existing conditions will be covered for dependents until the age of 19 however medical carriers may still rate accordingly for any current medical conditions of the individual. This applies to all group medical plans including those that are under the grandfather clause.
- Beginning in 2014, another change goes into effect and pre-existing conditions will be covered for all individuals regardless of age.

Lifetime limits on dollar amounts of “essential benefits”

- Plans may not impose lifetime limits on dollar amounts of “essential benefits”
- Can impose annual limits on “essential benefits” until 2014

Essential benefits

Services defined to date as “essential benefits”:

- Laboratory services
- Preventative and wellness services
- Mental health and substance abuse
- Prescription drug
- Hospitalization
- Rehabilitative services and equipment
- Maternity and newborn care
- Emergency services
- Chronic disease
- Pediatric care services

Wellness and prevention

- Medical plans will have to cover specific preventive care services with no cost to the member including:
 - Blood pressure, diabetes, and cholesterol tests;
 - Cancer screenings, including mammograms and colonoscopies;
 - Counseling from your health care provider on such topics as quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use;
 - Routine vaccinations against diseases such as measles, polio, or meningitis;
 - Flu and pneumonia shots;
 - Counseling, screening, and vaccines to ensure healthy pregnancies; and
 - Regular well-baby and well-child visits, from birth to age 21.
- Emergency room visits to be covered at the in network level.
- This provision does not apply to those medical coverages considered “grandfathered.”

Grandfathered plans: What they can and cannot do

Grandfathered plans CANNOT:

- Increase co-payments/co-insurance
- Change fixed-dollar cost-sharing
- Decrease contribution amounts
- Change annual and lifetime limits

Grandfathered plans CAN:

- Make enrollment changes
- Increase premiums
- Adopt health care provisions

As of Nov. 15, 2010

- Change medical carriers
- Change benefits

New rule for grandfathered plans

- Grandfathered status amendment effective Nov. 15, 2010.
- The Departments of Labor, Health and Human Services and Treasury have now amended the grandfathered plan regulations to **permit insured group health plans to change insurance policies or carriers.**
- However, making any other prohibited change will still cause a loss of grandfathered status.

New rule for grandfathered plans

- The new rule applies only to certain plans
- Applies to insured group health plans only
- The amendment does not apply retroactively. The amendment applies to changes to group health insurance coverage that are effective **on or after Nov. 15, 2010.**

Advantages of maintaining grandfathered status

"If you like your health care plan, you can keep your health care plan." – Pres. Obama

- IRS Section 105 (h) – discrimination reporting
- Mandated benefits exclusions

Grandfathered plans compared to non-grandfathered plans – 2010

Provision	Grandfathered	Non-grandfathered
No lifetime benefit maximum limits (2010)	✓	✓
Dependent coverage for adult children up to age 26 (2010)	✓	✓
No annual limits on certain types of benefits for group plans (2010)	✓	✓
100% coverage for preventive care in network (2010)		✓
No prior authorization for emergency services or higher cost-sharing for out-of-network emergency services (2010)		✓
No pre-existing limitations for children under the age of 19 for group plans (2010)	✓	✓
Coverage of routine patient costs for clinical trials of life-threatening diseases (2010)		✓
Non-Discrimination Reporting 105(h) (2010)		✓

Grandfathered plans compared to non-grandfathered plans – 2011 and beyond

Provision	Grandfathered	Non-grandfathered
Reporting the value of employer-sponsored coverage on W-2s (2011)	✓	✓
Automatic enrollment in long-term care program (2012)	✓	✓
Uniform explanation of coverage (2012)	✓	✓
Pre-enrollment document sent explaining benefits and exclusions (2012)	✓	✓
60-day notice for material modifications, required if material modifications aren't already disclosed in uniform explanation of coverage (2012)	✓	✓
Employer requirement to offer minimum essential coverage (50+ employees) (2014)	✓	✓
90-day limit on waiting periods for coverage (2014)	✓	✓

IMPORTANT UPDATE (December 22, 2010)- The Treasury Department, IRS, as well as the Departments of Labor and Health and Human Services will not require fully insured plans to comply with the nondiscrimination provisions until after regulations or other administrative guidance of general applicability is issued. More information to come once a final decision has been approved.

Discrimination-reporting (105)h

- Highly compensated and non-highly compensated employees
- Cannot discriminate on benefits, eligibility or contribution amounts
- Legislation defines a highly compensated individual as someone who:
 - Is one of the five highest paid officers
 - A shareholder who owns more than 10 percent in value of the company's stock
 - Among the highest paid 25 percent of all employees
- Stand alone dental and vision plans do not have to comply with these changes
- A non-grandfathered plan that fails to comply with the Section 105(h) nondiscrimination requirements, may be subject to a civil action under ERISA, the group would be liable for a penalty equal to \$100 per day-per the number of employees discriminated against times the number of days of noncompliance

Small group tax credit

- Designed to encourage small businesses to offer medical coverage for the first time or to help them maintain the coverage they already have
- Group must contribute at least 50 percent of premium
- Group must employ 25 or fewer employees
- Average annual salary cannot exceed \$50,000

W-2 reporting

- Employers must include the aggregate value of the employer-sponsored coverage on their employees W-2s
- Employees will not be taxed on this amount
- Calculations
- NOTE: IRS has deferred this requirement until Jan. 2012

Minimum loss ratio

Insurance carriers will be required to reimburse premium collected over the formula for amount paid out in claims:

- 85 percent for large group (100+) markets
- 80 percent for small group (2-99) and individual markets

Additional Timeline Wrap-Up 2011 and Beyond

2011

- Certain OTC products will no longer be reimbursable expenses under HSAs, FSAs, HRAs and Archer MSAs unless prescribed by a doctor
- The tax on HSA funds that are used for non-qualifying expenses, will increase from 10 percent to 20 percent
- Small group employers that establish wellness programs can receive grants for up to five years

OTC products no longer qualified under HSA, HRA or FSA

- Effective Jan. 1, 2011
- Unless prescribed by a physician

No longer a qualified expense
Anti-fungal
Anti-itch
Cough, cold and flu medications
Pain relief
Sleep aids and sedatives
Allergy and sinus medications
Motion sickness
Anti-gas
Laxatives
Acid controllers
Antibiotic products
Digestive aids
Respiratory aids
Baby rash ointments

OTC products still qualified under HSA, HRA or FSA

- Effective Jan. 1, 2011
- Items will still be reimbursable under these accounts

Still a qualified expense
Birth control products
Blood pressure kits
Diabetes testing supplies
Denture products
First aid dressing/band-aids
Hot/cold packs
Syringes
Diagnostic products
Smoking deterrents
Splints/braces/supports
Hearing aid batteries
Eye glass and lens accessories
Orthopedic aids
Canes/walkers/wheelchairs

2012

- All working adults will automatically be enrolled in the new Federal Self-Funded Long Term Care Insurance Program, unless they opt-out
- Employers are required to provide enrollees a benefit document explaining the medical plan offered by their group; documents must meet uniform standards such as format, appearance, language and content
- Employers are required to provide 60-day notice in advance of plan change

2013

- Employers are required to inform current employees and new hires written notice informing the existence of the health insurance exchange, as well as a description of benefits
- Employers are required to inform current eligible employees of subsidies and tax credits that are available through the exchange
- Maximum contribution to a Flexible Spending Account cap set at \$2,500

2014

- Plans may not impose restrictions for pre-existing conditions for anyone
- All individuals are required to be enrolled in medical coverage; tax penalties will be imposed for those who do not comply
- All coverages must be guarantee-issued and renewable

2014 continued

- Group health plans cannot require waiting periods for coverage of more than 90 days
- Employers will be responsible for providing employees with vouchers to use in the exchange in place of participating in group coverage

2018

- Employer sponsored medical insurance that exceeds an annual premium limit of \$10,200 for individuals and \$27,500 for families will be subjected to a 40 percent excise tax
- This is also referred to as the “Cadillac” plan

Questions?

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