



HEALTHCARE REFORM – WHERE WE’VE BEEN AND WHERE WE’RE GOING

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HEALTHCARE, HEALTH INSURANCE OR HEALTHCARE PAYMENT REFORM?

- **The Patient Protection and Affordable Care Act as amended by the Health Care Education and Reconciliation Act (the “Act”) implements sweeping reforms with respect to the provision of healthcare in the United States**
- **The short term impact of the Act primarily relates to health insurance or the payment for services**
- **This session will focus on what employers should be doing now**

APPLICATION OF THE ACT

- **All employer sponsored group health plans**
- **Insured and self-insured**
- **Exception for retiree only and single-employee plans**
- **Exception for limited-scope dental and vision plans**

EFFECTIVE DATES

- **Employer plans must generally be in compliance with the first leg of the Act as of the first day of the plan year beginning on or after September 23, 2010**
- **Calendar year plans – January 1, 2011**
- **Fiscal year plans – depends on the plan year**

GUIDANCE AND THEN SOME

- **Agency empowerment**
 - **Much of the implementation of the Act was left to regulations, guidance and recommendations to be issued by various government agencies including Department of Labor (DOL), Internal Revenue Service (IRS), Department of Health and Human Services (HHS), Center of Medicare and Medicaid Services (CMMS), and Center for Consumer Information and Insurance Oversight (CCIIO)**
 - **Over 1,000 references in the Act to the effect “HHS or other agency shall issue guidance”**
 - **Guidance will dwarf the over 2,700 pages of legislation**

WHERE WE'VE BEEN

Grandfathered Plan Status

- **“You can keep the coverage you had before the Act”**
- **An employer plan in place at the time the Act was passed (March 23, 2010) is deemed “grandfathered” and exempt for the time being from certain provisions of the Act**
- **Status determined on a benefit package basis**
 - **A PPO option and HMO option status tested separately**
- **Changes to employer plans after March 23, 2010, can result in the loss of grandfathered status**
- **Generally, grandfathered status is at risk if benefits reduced or costs shifted to employees**

GRANDFATHERED PLAN STATUS cont'd

Benefit of Grandfathered Plan Status

- **Grandfathered employer plans are not required to implement the following changes:**
 - **First dollar coverage for preventive care**
 - **Revised benefit claims review and appeal procedures**
 - **Nondiscrimination for insured plans**
 - **Certain reporting and disclosure requirements**
 - **Coverage for a child up to age 26, if coverage for the child is available under another employer plan**
 - **Certain patient protection provisions regarding designation of primary care providers and coverage for emergency services**

GRANDFATHERED PLAN STATUS cont'd

- **An employer plan will lose grandfathered status if the plan:**
 - **Eliminates benefits to diagnose or treat a particular condition**
 - **Increases percentage cost-sharing, e.g., co-insurance paid by employees**
 - **Increases deductibles or out-of-pocket limits by more than 15% above medical inflation**
 - **Increases co-payment by more than \$5 or, if greater, 15% above medical inflation**
 - **Decreases employer contributions for any tier of coverage (i.e., employee-only or family) by more than 5%, or**
 - **Imposes a new overall annual limit (if no lifetime or annual limits in effect), imposes a new overall annual limit that is lower than the lifetime limit in effect or decreases an existing overall annual limit**
 - **Participates in abusive transfers of employees among employer plans**

GRANDFATHERED PLAN STATUS cont'd

- **An employer plan will not lose grandfathered status if the plan:**
 - **Allows participants to renew coverage or enroll family members**
 - **Enrolls new employees (and their families)**
 - **Adds or enhances plan benefits**
 - **Changes third-party administrators, or**
 - **Enters into a new policy, certificate or contract of insurance that is effective on or after November 15, 2010**
 - **Under the original regulations (issued July, 2010), this would have resulted in a loss of grandfathered status**

GRANDFATHERED PLAN STATUS cont'd

- **Maintenance of grandfathered plan status**
 - Notice that the plan is grandfathered must be provided to participants whenever a summary of plan benefits is provided
 - Model notice is available on DOL website at www.dol.gov/ebsa/grandfatherregmodelnotice.doc
- **The terms of the plan as of March 23, 2010, must be documented**
 - Employer must retain documentation as long as grandfathered plan status desired
 - Documentation must be available for examination upon request
- **Upon insurance renewal, an employer's insurance company should obtain representations from the employer that the employer has not implemented a change to the employer's contribution rate that would cause the loss of grandfathered status**

WHERE WE'VE BEEN

- **Provisions of the Act that most employer plans should have in place now, i.e. for plan years beginning on or after September 23, 2010:**
 - **No lifetime limits on essential benefits**
 - **Restricted annual limits on essential benefits**
 - **No pre-existing condition exclusions for children under age 19**
 - **No rescission of coverage for reasons other than fraud or intentional misrepresentation**
 - **Dependent coverage for children up to age 26, subject to limited grandfathered exemption**
 - **No tax-free reimbursement for nonprescription medicine (other than insulin) (effective January 1, 2011)**

LIFETIME AND ANNUAL BENEFIT CAPS

- The Act prohibits all plans from imposing a lifetime benefit limitation with respect to “essential health benefits”
- The Act imposed a phased-in restriction on annual limitations with respect to “essential health benefits” until 2014
- Required notice to participants who previously reached a lifetime limit that they are again eligible for benefits and may re-enroll in the employer’s plan
 - Model notice is available on DOL website at www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc

LIFETIME AND ANNUAL BENEFITS CAPS cont'd

- **What are “essential health benefits”?**
 - **Minimum benefits in the following general categories:**
 - **Hospitalization**
 - **Emergency services**
 - **Prescription drugs**
 - **Maternity-related care**
 - **Ambulatory patient services**
 - **Mental health and substance use disorder services**
 - **Rehabilitative and habilitative services and devices**
 - **Laboratory services**
 - **Preventive and wellness services and chronic disease management**
 - **Pediatric services, including oral and vision care**

LIFETIME AND ANNUAL BENEFIT CAPS cont'd

What Are “Essential Benefits?” cont'd

- **The items and services required under each category are to be determined by HHS**
- **Formal guidance has not been issued**
- **Pending guidance, an employer’s good faith effort to comply with a reasonable interpretation of essential health benefits is acceptable**

LIFETIME AND ANNUAL BENEFIT CAPS cont'd

Phased-in Restriction On Annual Limits

- **Based on beginning of plan year**
 - **\$750,000 for plan years beginning September 23, 2010 – September 22, 2011**
 - **\$1,250,000 for plan years beginning September 23, 2011 – September 22, 2012**
 - **\$2,000,000 for plan years beginning September 23, 2012 – December 31, 2013**
 - **Prohibition on annual limits effective for plan years beginning on or after January 1, 2014**

- **Mini-med waiver and FSA exception**

DISCRIMINATION TESTING FOR INSURED PLANS

- **Non-grandfathered employer insured plans are subject to non-discrimination testing with respect to eligibility and benefits**
- **Self-insured plans have been subject to discrimination testing for some time**
- **Testing will be based on rules similar to those that apply to self-insured plans**
- **Penalty is more severe than that applicable to self-insured plans**
 - **\$100 per day for each non-highly compensated employee subject to discrimination**
 - **Civil action to compel provision of non-discriminatory benefits**
- **Rules suspended pending formal IRS guidance regarding testing**

FIRST DOLLAR COVERAGE FOR PREVENTIVE CARE

- **Non-grandfathered employer plans are required to provide first dollar coverage, i.e., no co-insurance, co-pay or deductible, for certain preventive care services**
 - **Exception for out-of-network services**

- **What is preventive care?**
 - **Determined in accordance with recommendations and guidance issued by HHS and various other government agencies**
 - **Examples:**
 - **Routine vaccinations**
 - **Blood pressure, cholesterol and diabetes tests**
 - **Many cancer screenings**
 - **Certain wellness counseling**

FIRST DOLLAR COVERAGE FOR PREVENTIVE CARE

cont'd

- Detailed information regarding preventive care services is available at www.healthcare.gov/center/regulations/prevention/recommendations.html or www.healthcare.gov/law/about/provisions/services/lists.html
- Additional preventive care services subject to first dollar coverage will be added periodically
- Employer plans must provide coverage for these additional items for plan years beginning one year or later following the date recommendation or guidance is issued

CHANGES TO CLAIMS APPEAL PROCEDURES

- **The Act requires a non-grandfathered employer plan to make changes to its internal claims review process and adopt external claims appeal procedures.**
- **Enforcement with respect to many of the required provisions has been delayed until July 1, 2011, or January 1, 2012, under grace periods established by applicable guidance**
- **Requirement that an employer plan must be making a good faith effort to implement the new procedures to qualify for the grace period no longer applies**
- **Plan documents must be updated to include a description of internal and external appeals procedures**

CHANGES TO CLAIMS APPEAL PROCEDURES cont'd

Changes to Internal Claims Review Process

- **Required changes to internal review process not subject to the grace period:**
 - **A participant may appeal a decision to rescind coverage, i.e. retroactive termination of coverage on account of fraud or misrepresentation**
 - **Any new or additional evidence or rationale used by the plan in connection with an adverse claims decision must be provided to a participant at no cost**
 - **The plan must assure that claims and appeal decisions are made impartially**
 - **Individuals involved in the review process cannot receive compensation tied to adverse claims decisions**

CHANGES TO CLAIMS APPEAL PROCEDURES cont'd

Changes to Internal Claims Review Process cont'd

- **Required changes to internal review process subject to initial grace period; i.e. enforcement delayed until July 1, 2011**
 - **Notice of adverse claims decision must include more detailed information**
 - **Information sufficient to identify claim**
 - **Reasons for the adverse benefit decision**
 - **A description of the plan's internal and external review processes; and**
 - **Contact information regarding State health consumer assistance program**

CHANGES TO CLAIMS APPEAL PROCEDURES cont'd

Changes to Internal Claims Review Process cont'd

- **Required changes to internal review process subject to the additional grace period, i.e. enforcement delayed until January 1, 2012:**
 - **Notification of a benefit determination (whether adverse or not) involving urgent care must be provided as soon as possible, but no later than 24 hours after receipt of the claim**
 - **Current rules require a 72 hour turn around**
 - **Notice of an adverse claims decision must include information sufficient to identify the applicable diagnosis and treatment codes and their respective meanings**

CHANGES TO CLAIMS APPEAL PROCEDURES cont'd

Changes to Internal Claims Review Process cont'd

Enforcement delayed until January 1, 2012 cont'd

- If the plan fails to strictly adhere to the all the new requirements, the participant may immediately initiate any available external review process and remedies available under ERISA or State law**

 - Notices regarding claims decisions must be provided in a “culturally and linguistically appropriate manner”**
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- Model notices for adverse benefit determinations are available on the DOL website at www.dol.gov/ebsa/healthreform/**

CHANGES TO CLAIMS APPEAL PROCEDURES cont'd

External Review of Adverse Claims Decisions

- **Participants have the right to appeal a final adverse claim decision to an independent review organization (“IRO”) whose decision is binding on the plan, the insurance company and the participant**
- **An IRO is an independent third party with clinical and legal expertise with no financial or personal conflicts with, and not employed by, the plan or the health insurance company**
- **The IRO must not give any deference to the plan’s internal decisions regarding the claim, but it must base its decision on the terms of the plan**

CHANGES TO CLAIMS APPEAL PROCEDURES cont'd

External Review of Adverse Claims Decisions cont'd

- **Cost of the external review, i.e. the IRO fees, must be borne by the insurer or the plan, though a nominal filing fee may be charge to the participant**
- **Claims decisions by insured plans are already subject to external review in most States**
 - **Insurers and participants will continue to follow the existing State external review procedures**
 - **State procedures must be updated to comply with minimum requirements under regulatory guidance (i.e., Uniform Health Carrier External Review Model Act) for plan years beginning on or after July 1, 2011**

CHANGES TO CLAIMS APPEAL PROCEDURES cont'd

External Review of Adverse Claims Decisions cont'd

- **Self-insured plans will be subject to external review procedures to be developed by the various agencies implementing the Act**
 - **Pending these procedures, self-insured plans may comply with the new rules by:**
 - **Voluntarily complying with existing State external review procedures applicable to insured plans, if available, or**
 - **Using a safe harbor procedure set-forth in currently available guidance**

ENFORCEMENT AND PENALTIES

- **The agencies charged with enforcement of the Act (the IRS, DOL and HHS), have stated that they will be working with employers to support implementation of the Act and their emphasis in the short term will be to assist employers with compliance as opposed to the imposition of penalties**
- **Each agency has separate enforcement mechanisms**

ENFORCEMENT AND PENALTIES cont'd

■ IRS Penalties

- Excise tax imposed on employers who sponsor plans that fail to comply**
- \$100 per day excise tax for each participant with respect to whom the failure relates**
- Excise will not apply if:**
 - Employer can demonstrate that it did not know or in exercising reasonable diligence, would not have known, that there was a compliance failure**
 - Employer can demonstrate that the failure was due to reasonable cause, not willful neglect, and was corrected within 30 days after the employer first knew or in exercising reasonable diligence would have known of the failure**

ENFORCEMENT AND PENALTIES cont'd

IRS Penalties cont'd

- This excise tax is subject to self-reporting by the employer on Form 8928**
- If compliance failure discovered upon examination, the minimum excise tax is generally \$2,500, and increased to \$15,000 if the failure is not “de minimis”**
- The maximum excise tax for unintentional failures is the lesser of 10% of the amount paid by the employer during the prior year for group health plans, or \$500,000**

ENFORCEMENT AND PENALTIES cont'd

- **DOL enforcement and consequences of ERISA violations**
 - **DOL civil action to enforce Act mandates and civil penalty for various failures under general ERISA provisions, e.g. failure to operate, fiduciary breach, failure to provide documents, etc.**
 - **Participant lawsuits to enforce Act mandates, including required coverage, damages for unpaid benefits, interest and attorneys fees.**

- **HHS penalties**
 - **Civil penalty of \$100 per day per participant, subject to exceptions similar to those that apply to IRS impose penalties**

WHERE WE'RE GOING

Upcoming Guidance

- **Four page summary of plan benefits**
- **60-day advance notice of plan changes**
- **To be issued by March 23, 2011**
- **Distribution to participants beginning March 23, 2012**

WHERE WE'RE GOING cont'd

Challenges To The Act

- **Legislative repeal**
- **Funding roadblocks**
- **Court decisions**
- **Reform the reform**
- **Resistance at state level**

WHERE WE'RE GOING cont'd

Planning

- **Will the Act survive legislative and court challenges?**
- **Regardless of uncertainty, employers should proceed with compliance measures**
- **Train Human Resources**
- **Do not assume grandfathered plan status**
 - **Question TPA, broker and insurance company**
 - **Review with counsel**
- **Update plan documents and summary plan description for required plan design changes**
 - **Including revised claims review procedures, if applicable**
- **Distribute required notices**

WHERE WE'RE GOING cont'd

Planning cont'd

- **Communicate changes to employee-participants**
- **Stay abreast of guidance**
 - **Visit websites**
 - www.healthcare.gov
 - www.dol.gov/ebsa/faqs/main.html for FAQ's under "Health for Consumers" or "Guidance"
 - www.dol.gov/ebsa/healthreform/
 - **Subscribe to auto e-mail updates at DOL/EBSA website**

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