New England BENEFITS

Summary of Key Provisions

Revised 10/14/2011

Overview

- **What are the new requirements under National Health Reform (PPACA)?**
- **Which requirements apply to your business?**
- **What is the Plan of Action to comply?**

Common Reform Features (PPACA vs. Massachusetts)

Many of the changes under National Health Reform (PPACA) were based upon the MA Health Reform Bill.

Reform Feature	PPACA	MA Health Care Reform
Individual Mandate	Yes	Yes
Essential/Minimum Required Benefits	Yes	Yes Minimum Creditable Coverage
Insurance Exchanges	Yes	Yes Commonwealth Health Connector
Pay or Play	Yes	Yes Fair Share Contribution Free Rider Surcharge
ER Reporting	Yes	Yes Form 1099-HC / HIRD Report

Timeline of PPACA Reforms

Immediately

- Grand-fathering
- Small Business Tax Credits
- Medicare Part D Subsidy

2010

- Temporary Reinsurance-Retiree Health Coverage
- Temporary High-Risk Pool
- Federal Web Health Insurance Portal
- Prohibit Discrimination in favor/highly compensated (delayed implementation)
- No Lifetime/Annual Limits on Essential Health Benefits
- Dependent Coverage/Age 26
- Pre-Existing Conditions to age 19
- Rescissions prohibited
- Appeals Process
- Preventive Care/No Cost Sharing
- Federal Grant for small employers wellness programs

2011

- W-2 Reporting (delayed a year)
- Higher tax on ineligible H.S.A. distributions
- OTC Drugs no longer reimbursable
- Small Employer "Simple Cafeteria Plans"
- National public LTC program **(Repealed)**
- Business Owner's tax on fixed/determinable income
- DOL annual studies

2012

- Summary of Benefits/Coverage Explanation
- Annual HHS reports

2013

- Federal Premium Tax
- FSA Contributions for medical capped at $2,500
- Medicare Payroll Tax increase
- Deduction for unreimbursed medical expenses-10% AGI
- Notice to employees regarding State-Based Exchanges

2014

- Individual Mandate
- Employer Mandate
- Waiting Period > 90 days prohibited
- Market Reforms take effect:
  - Guarantee Issue
  - No Pre-Ex
  - No Annual/Lifetime Limits
- States required to have Exchanges up and running
- Essential Benefits Standard for all plans
- Employee Free Choice Voucher Program **(Repealed)**
- Auto-Enrollment in health plans for Employers 200+
- Premium Taxes on private health insurers
- Employer-Sponsored Wellness rules improve
- COOP plans allowed to be sold
- Premium Assistance Tax Credits for individuals
- Expansion of Medicaid

2015

- Children's Health Insurance Program reauthorized

2017

- States may allow large employers (100+) to use Exchanges

2018

- "Cadillac Tax"

Grandfathered vs. Non-Grandfathered Health Plans

In PPACA, new grandfather rules allow plans that were in existence (and had at least one person on the plan) on the day the law was signed (March 23, 2010) to make certain changes and maintain "grandfathered" status.

The following actions <u>will NOT cause</u> a plan to lose its Grandfathered Plan status:

- Employer changing health plan carriers (**amended 11/16/2010: "allows all group health plans to switch insurance companies and shop for the same coverage at a lower cost while maintaining their grandfathered status, so long as the structure of the coverage doesn't violate one of the other rules for maintaining grandfathered plan status,"*
- Adding new employees or family members to a grandfathered plan
- Employees voluntarily making a plan change to a different plan that was in place on March 23, 2010 *(This applies to employers offering more than one plan design, and all plans had at least one person enrolled in the plan on March 23, 2010)*
- Amendments required to conform to legal requirements/changes (Federal and State mandates)
- Voluntary adoption of other PPACA consumer protections

The following actions <u>WILL CAUSE</u> a plan to lose its Grandfathered Plan status:

- Employer making a plan change at renewal (increasing co-pays, deductibles, coinsurance)
- Employer reduces benefits
- Lowering employer contributions to the health plan by more than 5 percent
- Merging or acquiring a business for the primary purpose of covering individuals on a grandfathered plan

Local Impact:

Blue Cross Blue Shield: will not recognize Grand-fathered status for groups with fewer than 100 eligible employees.
Harvard Pilgrim: will not recognize Grand-fathered status for groups with fewer than 2000 eligible employees.
Tufts Health Plan: will not recognize Grand-fathered status for groups with fewer than 51 eligible employees.

Advantages of Grandfathered Status

Many PPACA provisions apply to all plans whether grandfathered or not. The following provisions, however, do not apply to Grandfathered Plans:

- 100% coverage for preventive care
- No prior authorization for emergency services or higher cost sharing for out-of-network emergency services
- Coverage of routine patient costs for clinical trials of life-threatening diseases
- Non-discrimination in favor of highly compensated employees.

Note:

It is unlikely there is any long-term value in grand-fathering health plans. The short-term value applies to self-funded plans and large groups (2000 plus members).

Other Compliance Requirements

Provision	Effective Date	Action Required
Prohibit Discrimination in favor/highly compensated There are two ways an employer's plan can discriminate: *Eligibility*: A plan is considered discriminatory unless it benefits a majority of specified employees. *Benefits*: A plan is considered discriminatory unless all the benefits it provides to participants who are HCEs are provided for all other participants. For insured health plans, employers will be fined $100 per day per individual discriminated against. (The value of amounts that a discriminatory plan pays or covers for HCEs is **not** taxable to such individuals.) Employers will need to perform testing to ensure their plan is not discriminatory. While the rules and regulations for the non-discrimination tests are forthcoming, the tests will be complicated. Employers should contact their tax advisor or legal counsel for more specific guidance. **Highly Compensated Employees** The second major non-discrimination mandate of Health Care Reform prohibits discrimination in favor of a company's highly compensated employees (HCEs). This applies only to new employer health plans established on or after March 23, 2010 (plans that do not have grandfathered status). Individuals are considered HCEs if they are: One of the five highest paid officers of a company. A shareholder of more than 10 percent of the company's shares (taking into account attribution rules), or One of the highest paid 25 percent of all the company's employees.	Plan years beginning on or after six months after date of enactment (September 23, 2010).	**Delayed until further guidance.**
No Lifetime/Annual Limits on Essential Health Benefits Beginning with plan years that start September 23, 2010, group health plans and health insurers are prohibited from establishing lifetime limits on essential benefits for any participant or beneficiary. All group health plans and issuers offering group coverage or individual health insurance coverage may only establish a restricted annual limit on the dollar value of essential health benefits.	Plan years beginning on or after six months after date of enactment (September 23, 2010).	**Provide Model Notice to employees.**

Other Compliance Requirements

Provision	Effective Date	Action Required
Dependent Coverage/Age 26 The Patient Protection and Affordable Care Act (PPACA), enacted on March 23, 2010, requires plans that provide coverage to dependents to offer coverage to **all adult children up to age 26, regardless of the dependent's IRS tax qualification status, marital status, or student status**. This provision is effective for fully insured and self-insured business for plan years[1] beginning on or after September 23, 2010. **Mandated 30-Day Enrollment Period** Extending dependent coverage to age 26 provides transitional relief for children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26. The regulations require that you give dependents an opportunity to enroll for at least 30 days (including written notice of the opportunity to enroll), regardless of: (1) whether the plan or coverage offers an open enrollment period and (2) when any open enrollment period might otherwise occur. You must provide this enrollment opportunity no later than the first day of the first plan year beginning on or after September 23, 2010. The notice may be included with other enrollment materials that your plan distributes, provided the statement is prominent. Enrollment must be effective as of the first day of the first plan year beginning on or after September 23, 2010.	Plan years beginning on or after six months after date of enactment (September 23, 2010).	**Provide Model Notice to employees.**
Pre-Existing Conditions to age 19 All group and individual health plans, included self-insured plans, will have to cover preexisting conditions for children up to age 19 for plan years beginning on or after six months after date of enactment. Grandfathered status applies for group health plans.	Plan years beginning on or after six months after date of enactment (September 23, 2010).	None. Pre-Existing conditions are covered by MA plans.

Other Compliance Requirements

Provision	Effective Date	Action Required
Preventive Care/No Cost Sharing All group health plans and issuers offering group coverage or individual health insurance coverage may not impose cost-sharing for preventive coverage, including, but not limited to, immunizations, screenings, and other services, as recommended by certain federal agencies. Coverage of certain preventive services is also required. In order to meet this requirement, for in-network benefits, we will be removing all cost-sharing, including deductibles, copayments, and co-insurance. In certain plans, we will also be adding coverage for preventive care services with no cost-sharing.	Plan years beginning on or after six months after date of enactment (September 23, 2010).	These changes will be included in next year's renewal.
W-2 Reporting Requires all employers to include on W-2s the aggregate cost of employer-sponsored health benefits for informational purposes only. If employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage, but exclude all contributions to HSAs and Archer MSAs and salary reduction contributions to FSAs.	Plan years beginning on or after six months after date of enactment (September 23, 2010).	IRS Notice 2010-69 made the new Form W-2 reporting requirement optional for all employers for the 2011 Forms W-2 (generally furnished to employees in January 2012). In Notice 2011-28, the IRS provided further relief for smaller employers (those filing fewer than 250 W-2 forms) by making this requirement optional for them at least for 2012 (i.e., for 2012 Forms W-2 that generally would be furnished to employees in January 2013) and continuing this optional treatment for smaller employers until further guidance is issued.

Other Compliance Requirements

Provision	Effective Date	Action Required
National Public LTC Program (C.L.A.S.S.) HHS will establish a voluntary long-term care (LTC) insurance program called Community Living Assistance Services and Supports (CLASS) by January 1, 2011. The program will offer the CLASS Independence Benefit Plan. The long-term care provision of health care reform law is designed to help individuals and families pay for long-term care. Employers will need to decide if they will offer the CLASS program to employees. If an employer chooses to participate, employees age 18 and older must be automatically enrolled in the program, regardless of their pre-existing conditions. Employees can choose to "opt-out" if they don't want to participate. CLASS is also available to individuals who are self-employed, have more than one employer or have an employer who chooses not to participate. Premiums will be established by the U.S. Department of Health and Human Services secretary and will be based on age and not health risk. Based on the information available, we believe premium subsidies will be available for workers with incomes below the federal poverty level and full-time students age 18 to 21 who work. After paying premiums for five years, enrollees will be eligible to receive benefits. CLASS will be administered by the U.S. Department of Health and Human Services.	HHS will develop by January 11, 2011 but the new law does not specify a date for enrollment.	**Repealed**
Amendment to Fair Labor Standards Act The Patient Protection and Affordable Care Act and Reconciliation Act includes a provision that amends the Fair Labor Standards Act to require employers to provide nonexempt nursing mothers unpaid breaks to express breast milk in a private place other than a restroom for up to one year after the child's birth. The breaks must be given as frequently as necessary. Employers with fewer than 50 employees, who can demonstrate that compliance would cause them significant difficulty or expense, are not subject to the law's requirements.	March 23, 2010	Allow nursing mothers unpaid breaks to express breast milk in a private place.

Other Compliance Requirements

Provision	Effective Date	Action Required
Summary of Benefits/Coverage Explanation Requires that all group health plans (including self-insured plans) and group and individual health insurers provide a summary of benefits and a coverage explanation to all applicants at the time of application, to all enrollees prior to the time of enrollment or reenrollment and to all policyholders or certificate holder at the time of issuance of the policy or delivery of the certificate. The summary must include specific information to be determined by the Secretary of DHHS in consultation with the National Association of Insurance Commissioners and can be provided in paper or electronic form. It must be no more than 4 pages in length with print no smaller than 12 point font written in a *culturally linguistically appropriate manner*. If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective. Employers and health plans that willfully fail to provide the information required can be fined up to $1,000 for each such failure. Each failure to provide information to an enrollee constitutes a separate offense.	On Monday, August 22nd, HHS, DOL and IRS issued proposed SBC rules intended to give consumers straightforward, standardized information on their health plan choices in order to help them understand the key features of a health insurance policy or group health plan and help them to make a more informed decision. Health plans and issuers must also provide notice at least 60 days before any significant modification is made in the plan or coverage during the plan or policy year that affects any content of the SBC.	The requirement to provide Summary of Benefit Coverage (SBC) is effective **March 23, 2012**.