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HEALTHCARE REFORM: The New Paradigm for America's Healthcare Financing

Introduction

The Health Care Reform enacted in early Spring 2010 is the product of two new laws: the Patient Protection and Affordable Health Care Act, Pub. Law No. 111-148 (March 23, 2010); amended by the Health Care and Reconciliation Act of 2010, Pub. Law No. 111-152 (March 30, 2010). The resulting law makes major changes in the rules relating to employment-based plans providing health benefits and requires, beginning in 2014, that individuals obtain health coverage for themselves and their dependents. Insured and self-funded plans will be forced to adopt major changes as early as plan years beginning after September 23, 2010. This article will describe the changes required for Plan Sponsors and provide some rough estimates of their potential impact on Plans.

Since the legislation was adopted, regulations have been forthcoming at a rapid pace. These regulations help the industry as well as all Americans understand the impact of this legislation, which is intended to change the way healthcare is financed in America. Exhibit 1 provides the timeline for which major guidance has been issued.

Cheiron has already emailed Cheiron Health Alerts to Executive Directors and Administrators on the three key items that need to be implemented and/or decided upon this year:

1. Early Retiree Reimbursement Program Application Process – May 6, 2010
2. Grandfather Notification Requirement – June 24, 2010
3. Gradual Elimination of Annual and Lifetime Maximums – June 29, 2010

Copies are available by emailing info@cheiron.us.

The remainder of this Advisory is split into three key topics – Decisions and To Dos for 2010, The Grandfather Advantage and Requirements, and 2014 Full Implementation = Play or Pay. Plus there is an insert containing a timeline for Plan Sponsors with some financial impacts.

Exhibit 1 – 2010 Legislation and Regulations

3/23/2009	**Patient Protection and Affordable Care Act (PPACA)***
3/30/2010	**Health Care and Education Reconciliation Act (HCERA)***
4/27/2010	Notice 2010-38 - Adult Children Health Benefits Tax Free
5/05/2010	Final Interim Rule - Early Retiree Reinsurance Program
5/10/2010	Final Interim Rule - Adult Children Coverage
6/04/2010	Early Retiree Reimbursement Program (ERRP) Draft Application
6/18/2010	Final Interim Rule - Grandfathering Rules
6/28/2010	Final Interim Rule - Annual Limits
6/29/2010	ERRP Applications Acceptance Begins
7/14/2010	Final Interim Rule - Preventive Care Coverage

* References the Public Health Service Act originally enacted in 1944

As of July 15, 2010 – Waiting

- Details to define essential benefits, e.g., wellness
- Details to define appeals process
- Details on loss ratio requirements for insured funding options
- Details on reporting requirements

Section 1- Decisions and To Dos for 2010

Exhibit 2 contains a list of items that most Health Benefit Plan Sponsors will need to decide and/or implement in 2010. Of particular note is that only **insured** collectively bargained plans are allowed to defer implementation until the end of an existing collectively bargained agreement (assuming the agreement was effective on March 23, 2010), even if it enters into a new health insurance contract. **Self-funded** collectively bargained plans may not defer implementation and are required to comply with the rules immediately, as any other non-collectively bargained plan would be required to do.

Exhibit 2 - 2010 To Dos

1. Apply for the Early Retiree Reimbursement Program (**ERRP**) if covers non-Medicare retirees.
2. Amend Plan and prepare enrollment forms and notifications for dependents up to **26**.
3. Determine if the Plan will attempt to keep its **Grandfather** status and prepare notices.
4. Amend Plan if an **annual or lifetime limit** below $750,000 exists on essential benefits.
5. Determine if **discrimination** issues impact the Plan and adjust as needed.
6. Amend **Flexible Spending Account** if currently covers over the counter drugs (OTC).
7. Evaluate Medicare **Part D** supplemental vs. the Retiree Drug Subsidy (**RDS**) program.

1. For plans offering benefits to non-Medicare eligible retirees, the first action is to apply for the Early Retiree Reimbursement Program (ERRP), which has been allocated $5 billion. This allows Plan Sponsors to reduce future cost increases or improve benefits with monies reimbursed by the United States (US) federal government. Eighty percent of claims between $15,000 and $90,000 for a participant in a plan year is reimbursed beginning after June 1, 2010 until the $5 billion is exhausted (see the May 6, 2010 Cheiron Alert for details).

Next on the agenda are the benefit changes required for self-funded Plans effective the beginning of the **Plan Year following September 23, 2010**. Those Plan amendments include:

2. **Dependents *must be covered* up to age 26** in the same way as dependents below 18 are covered UNLESS that dependent has access to employer sponsored health insurance. The "UNLESS" disappears when a plan loses grandfathered status, i.e., dependents below age 26 must be covered in the same manner as those under age 18 even if they have access to other employer based health coverage.

3. **Lifetime limits must be eliminated and annual limits** on ***essential benefits (see Exhibit 3)*** must be phased out. (See Cheiron Alert emailed on June 29, 2010.)

Annual Limit Phase-out

Plan years beginning on or after 9/23	But before 9/23	Annual dollar limit must be at least
2010	2011	$750,000
2011	2012	$1,250,000
2012	2014	$2,000,000
2014		unlimited

Note: A "Plan Year" is generally defined as either the year listed in the plan document (and thus listed on the Form 5500) if one exists, if not then the year for which Plan limits such as deductibles, copays, out-of-pocket maximums, and annual maximums accumulate (if one exists), if not then the renewal date with the insurer.

Exhibit 3 - Essential Benefits *

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Laboratory services;
5. Maternity and newborn care;
6. Mental health and substance abuse services;
7. Rehabilitative and habilitative services and devices;
8. Pediatric services, including oral and vision care;
9. Prescription drugs; and
10. Preventive and wellness services.

** HHS is required to establish a complete list of essential benefits by 1/1/2014. [PPACA § 1302(b)]*

4. Plans must decide if they are going to try to remain a **Grandfathered Plan** by the time they send out any participant communication on benefits after September 23, 2010 since ***notification*** to participants must be provided. For all Plans this will be with the new enrollment package. For many calendar year Plans this will be with their open enrollment. For Plans that do not do open enrollment, the notification of whether or not the Plan is a Grandfathered Plan will be included in their Medicare Part D credible coverage notice. In Section 2 we discuss the additional requirements if Grandfather status is not maintained along with discussing the requirements to remain a Grandfathered Plan.

5. Plan Sponsors with Executive Wrap-around Plans will need to evaluate to see if they can maintain those Plans and still not be **discriminatory**.

6. **Flexible Spending Accounts** can only provide a pre-tax benefit below $2,500 and can no longer cover over the counter medications.

7. For Plans currently offering Medicare retirees prescription drug coverage and receiving partial reimbursement from the Retiree Drug Subsidy (RDS) program consideration should be given to switching to a **supplemental or wrap-around Medicare Part D** benefit because of i) the taxation for taxable entities of the subsidy and ii) the closing of the donut hole or improved benefits by Medicare Part D.

Section 2 – The Grandfather Advantage and Requirements

Plans that were in existence on March 23, 2010 (called "Grandfathered Plans") are exempted from many of the new requirements for as long as they can maintain that status. Self-funded Grandfathered Group Health Plans are exempt from the following major requirements:

1. Cover **preventive health services** without imposing any cost sharing;
2. Cover **wellness** benefits;
3. Cover **clinical trials**;
4. Provide the same benefits regardless of **health status** or conditions;
5. Inclusion of **any willing provider** from network providers list;
6. No **discrimination in favor of highly compensated** employees (however, Code, sec. 105(h) has its own set of non-discrimination rules, which remain applicable to self-funded group health plans);
7. If a **designation of a primary care provider** is required, then it can be any OB/GYN (for women) or a physician specializing in pediatric care (for any newborn); and that coverage must be on the same basis as for any primary care provider;
8. A new **appeals process** that allows independent outside professional oversight must be adopted; and
9. **Reporting** on the Plan's Quality of Care to HHS would be required after March 23, 2013.

How Grandfathered Status is Lost:
Under the June 17, 2010 joint regulation issued by the Department of Labor, Treasury, and HHS, a self-funded Group Health Plan or a non-collectively bargained insured plan will lose its grandfathered status if it:

1. **Eliminates coverage** for any existing covered illness or condition or procedure to diagnose or treat such;
2. **Reduces the employer contribution rate**, or the employee organization contribution rate, for any tier of coverage **by more than 5%**, or, if based on a formula (such as hours worked), decreases the rate by more than 5%;
3. Increase fixed amount **co-payments** by more than the greater of (A) medical inflation plus 15% or (B) $5 plus medical inflation;
4. Increases **fixed amount cost-sharing** (such as deductibles or fixed out of pocket limits) **by more than medical inflation plus 15%** as compared with the levels in effect on March 23, 2010;
5. Makes any increase in **percentage cost-sharing**, e.g., increases coinsurance from 20% to 25% or increases the employees' percentage of premiums or costs; and
6. Imposes an overall **annual limit** where no annual or **lifetime** limit previously existed, imposes a new annual limit that is less than the existing lifetime limit where no annual limit previously existed, or reduces an existing annual limit.

Note: Medical inflation (CPI – M) is compared with the levels in effect on March 23, 2010.

The regulation contains special rules for ***insured*** plans maintained under collective bargaining agreements for which the last bargaining agreement in effect on March 23, 2010 has not yet expired. The Plan may enter into a new health insurance contract and will not lose its grandfathered status even if the contract makes any non-allowed changes in co-pays, deductibles, employee or employer premium payments, discussed above. Once the last such agreement expires, it is treated like any other Plan. This exemption does not apply to ***self-funded*** Plans.

The regulation requires Grandfathered Plans to report their status to participants and beneficiaries and provides a model notice to be used for that purpose. Please see Cheiron Health Alert emailed on June 24, 2010 for details on the notification requirements.

Section 3 – 2014 Full Implementation = Play or Pay

Starting in 2014, the bulk of Health Care Reform will become effective. States will establish Health Insurance Exchanges that will offer comparable policies from different insurers. Each individual, with certain exceptions, will be required to obtain health insurance for himself and his dependents or pay a tax. Each large employer (50 or more full time employees (FTE), defined as working 30 or more hours per week) will be required to offer employees "minimum essential health coverage," or pay a tax. Special rules apply for small employers.

Large Plan Sponsors will be in one of four situations:

Situation 1 (Adequate Coverage with Acceptable Contribution Levels) – Provide coverage that covers 60% or more of the total allowed cost of benefits. No tax assessed.

Situation 2 (Adequate Coverage with High Contribution Levels) – Provide coverage that covers 60% or more of the total allowed cost of benefits and charge FTEs [with household income less than 400% of the Federal poverty limit ($80,050 for a family of 4 in 2010)] between 8% and 9.8% of their pay. Then the affected FTE has the choice to continue in their current Plan or go to an Exchange. The Plan Sponsor gives them a Free Choice Voucher in the amount that they contribute for the largest share of employees. So no tax assessed.

Situation 3 (Inadequate Coverage *or* Unacceptable Contribution Levels) – Provide coverage that is less than 60% the cost of the total allowed cost of essential benefits ***or*** charges some FTE [with household income less than 400% of the federal poverty limit ($80,050 for a family of 4 in 2010)] more than 9.5% of their pay. The Plan Sponsor tax is either the total number of assisted FTE less 30 times $3,000 *or* all FTE less 30 times $2,000. Assisted FTE is an employee who qualifies for either a Premium Tax Credit and/or Cost Sharing Reduction ***and*** enrolls in an Exchange.

Situation 4 (No Coverage) – Provide no coverage at all. Plan Sponsor tax will be equal to $2,000 per year multiplied by the number of all FTE minus 30 FTE.

To better understand the employers' responsibilities and the interrelationship of the rules would help. Please contact your Cheiron Consultant if you would like a detailed write-up of our interpretation of the rules regarding employee responsibilities and potential tax credits.

Conclusion

Employers and Boards of Trustees that provide health benefits through Grandfathered Plans must review their plans for compliance with those PPACA provisions that apply to them and make any changes required to comply with the law. If the Group Health Plan provides coverage to non-Medicare eligible retirees, the Plan administrator should act now to prepare an application for the federal subsidy for such retirees.

The anticipation is that Health Care Reform will be evolving and changing as more regulations are provided and additional legislation is passed. Plan Sponsors are certain to face many difficult decisions. As a result, our expert Health Team feels that understanding the available options, the evolving marketplace, and the financial consequences via simulating the impact of the Trustees' choices are critical in order for a Health and Welfare Plan to survive.

Cheiron is a full-service actuarial consulting firm assisting Taft-Hartley, public sector and corporate plan sponsors manage their benefit plans proactively to achieve strategic objectives. We can be reached via email at info@cheiron.us. The issues presented in this Advisory do not constitute legal advice.

Exhibit 4 - Plan Sponsor Implementation Timeline

	Effective Date:	Key Items:		Estimated Impact Financial (2010$):
1	PYB 1/1/10	Subsidy:	File for Early Retiree Reimbursement Program **(ERRP)**	**$33 - 100 PPPM**
2	PYB 9/23/10	Benefits:	Remove **Lifetime Maximum** on Essential Health Benefits (if $1,000,000 max →)	**< 0.5%**
3	PYB 9/23/10	Benefits:	Prohibits **pre-existing limitation** for enrollees under age 19	
4	PYB 9/23/10 [1]	Benefits:	Must Cover **Preventive Care at 100%** (if $250 deductible/80% coinsurance plan →)	**$1.50 PPPM**
5	PYB 9/23/10 [1]	Benefits:	Mandates **Patient Protection** - pick own PCP & OB/GYN, covers all ER	**< 0.1%**
6	PYB 9/23/10 [1]	Benefits:	Requires **external claim review process** & communicative participant info	
7	PYB 9/23/10	Eligibility:	Must Cover **Adult Children** to Age 26 [3] (if current is 19 or 23 if Full Time Student →)	**< 3%**
8	PYB 9/23/10	Eligibility:	**Rescinding** Coverage is Prohibited	
9	PYB 9/23/10 [1]	Tax:	Fully insured plans may not **Discriminate**	**$1,000-10,000+per exec**
10	PYB 1/1/11	Benefits:	**Over-the-counter drugs** not a qualified expense for Flexible Spending Account **(FSA)**	
11	PYB 1/1/11	Indirect:	Fully Insured must **rebate if Cost Ratio <80%** for small groups, **85%** for large groups	
12	1/1/2012	Reporting:	List cost of provided coverage (FTE paid portion + Plan Sponsor paid portion) on **W-2**	
13	PYB 9/30/12-19	Tax:	**Average Enrolled Person Tax:** FY2013 $1 PPPY, then $2 PPPY until 9/30/19	**$2 PPPY**
14	TYB 12/31/12	Tax:	Medicare Part D **Retiree Drug Subsidy (RDS)** is taxable	**May Save $ if Pt D Supp**
15	TYB 12/31/12	Tax:	**FICA increased 0.9%** for income over $200,000 (joint over $250,000)	
16	PYB 3/23/12	Reporting:	Provide a standard **Summary of Benefits** - HHS to provide rules by 3/23/11	**$1,000 per failure**
17	PYB 1/1/13	Benefits:	**FSA** pre-tax **reimbursement capped** at $2,500 + index after 2013	
18	3/1/2013	Reporting:	Provide **Employee Notices Regarding Exchanges**	
19	PYB 3/23/13 [1]	Reporting:	Provide a standard **Summary of Quality of Care** - HHS rules by 3/23/12	

Important Notes: 1) **Effective Date** uses PYB to mean effective date is for **Plan Year Beginning On or After (PYB); T=Tax**
Insured **Collectively Bargained** Plans are not effective until the PYB last Collective Bargained Agreement (CBA) expires.
2) **Financial Impact** uses PPPM to mean **Per Person Per Month (PPPM)** or % is of medical claims. It is for a Large Group.
Actual Financial Impact will vary significantly depending on underlying plan participants, benefit levels, industry turnover, etc.

Exhibit 4 continues on next page

Exhibit 4 - Plan Sponsor Implementation Timeline (continued)

	Effective Date:	Key Items:		Estimated Impact Financial (2010$):
20	PYB 1/1/14	Benefits:	Allowed **Wellness Incentive** increased from 20% to 30%	
21	PYB 1/1/14	Benefits:	Remove **Annual Maximum** on Essential Health Benefits[2] phased in (if $100,000 cap →)	**7% of Medical & Rx**
22	PYB 1/1/14	Benefits:	Prohibits **Pre-existing Limitation** for all enrollees	
23	PYB 1/1/14 [1]	Benefits:	**Max Caps on Cost-Sharing** (e.g., Deduct.-$2000 & OOP Max-$5,950+trend)	**Average Plan Lower**
24	PYB 1/1/14	Benefits:	**Can offer Voucher**, if FTE contrib.>9.8% & FTE HHI <400% Fed Poverty	
25	PYB 1/1/14	Eligibility:	**Auto-Enrollment** (for some plans no impact; for some Building Trade Plans, it could be →)	**$3 PPPM**
26	PYB 1/1/14	Eligibility:	**New Employee Waiting Period** must be less than 3 months (instead of 6 months →)	**< 0.5%**
27	PYB 1/1/14 [1]	Eligibility:	Prohibits **excluding from coverage** because of **Health Status**	
28	PYB 1/1/14 [1]	Eligibility:	Prohibits **excluding from coverage** because of **Clinical Trial**	
29	PYB 1/1/14 [1]	Eligibility:	Fully Insured plans must provide **Guaranteed Availability and Renewability**	
30	PYB 1/1/14 [1]	Indirect:	Fully Insured plans have **rating restrictions** on age of 3:1; on tobacco use of 1.5:1	
31	PYB 1/1/14	Tax LPS[4]:	**If Adequate Coverage but High Contributions**[5], then Plan Sponsor must offer the qualifying FTEs a **Free Choice Voucher** in the amount the majority of employees costs the Plan	**$0**
32	PYB 1/1/14	Tax LPS[4]:	**If Inadequate Coverage *or* Unacceptable Contribution Level** [6] then Plan Sponsor **No Coverage Tax**=all FTE - 30 x $2000 ***or*** **Assisted Coverage Tax**=assisted FTE x $3000	**Depends on # Assisted**
33	PYB 1/1/14	Tax LPS[4]:	**If No Coverage *and*** 1 FTE qualifies, then pay **No Coverage Tax**[7] = (FTE - 30) x $2000	**(#FTE-30) x $2000**
34	1/31/2015	Reporting:	Special IRS Report required by Plan Sponsor on **Minimum Essential Coverage**	
35	1/31/2015	Reporting:	Special **IRS Report** from Large Plan Sponsor[4] to IRS and FTE	
36	PYB 1/1/18	Tax:	**Excise Tax** on cost of more than $10,200 single / $27,500 family; industry and retiree adjusted	**40%, e.g., $20 PPPM**

Special Provisions that apply only to Employers with less than 25 FTEs are not listed.

[1] Grandfathered Plans are exempt from this requirement.

[2] HHS has until 1/1/2014 to issue regulations on what can be covered under the annual limits.

[3] If dependents are covered under the Plan. If a Grandfathered Plan, then can exclude those with other ER sponsored coverage until PYB 1/1/2014.

[4] Large Plan Sponsor (LPS) is defined as having 50 or more FTEs on average during the Plan Year. An FTE works 30 or more hours a week.

[5] Covered FTE qualifies for **Free Choice Voucher** if their HHI <400% FPL ***and*** goes to an Exchange ***and*** their Contribution between 8% and 9.8% of HHI .

[6] FTE qualifies if HHI <400% FPL ***and*** goes to an Exchange ***and*** A or B

A) **Benefit Ratio** on **Essential Benefits < 60%**, or

B) **FTE contribution > 9.8%** HHI.

[7] **No Coverage FTE** qualifies if their Household Income (HHI) is below 400% of the Federal Poverty Level (FPL) ***and*** goes to an Exchange.