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Health Care Reform 2.0:

Redesigning Your Health Plan and Planning A Successful Open Enrollment Season for 2011

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Agenda

- Welcome
- Overview of Plan Redesign For 2011 under Health Care Reform (HCR)
  - Exemptions, Restructuring, and Grandfathering
- Changes You Must Make Whether Your Plans are Grandfathered or Not
- Limits on Cost-Sharing for Grandfathered Plans
- Coverage & Benefit Requirements for Non-Grandfathered Plans
- Claims Procedures for Non-Grandfathered Plans
- Mental Health Parity
- 10 Steps to a Successful Open Enrollment
- Questions?

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Overview of Plan Redesign for 2011 Under HCR

- Plans Subject to HCR
  - Group health plans
  - Individual health policies/contracts
- Plans Exempt from HCR
  - “Retiree-only” plans
  - Limited scope dental & vision plans
  - Specified disease plans
  - Fixed dollar indemnity plans
  - Mini-med plans
- Restructuring Opportunities?

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Overview of Plan Redesign for 2011 Under HCR

DELAYING CERTAIN HCR REQUIREMENTS BY GRANDFATHERING

- Which plans can be grandfathered?
  - Plans in effect on 3/23/2010, but only if certain steps are taken
  - Any policy, certificate or contract of insurance issued after 3/23/2010 ***cannot be*** grandfathered, even if product was offered in the market before 3/23/2010
  - Remember:
    - The grandfathering decision applies separately to each benefit package
    - Aggregation rules for controlled group and affiliated businesses will apply – especially important in evaluating whether executive-only plans will be grandfathered to avoid 105(h) nondiscrimination coverage & benefits testing

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Overview of Plan Redesign for 2011 Under HCR

DELAYING CERTAIN HCR REQUIREMENTS BY GRANDFATHERING

- What does grandfathering mean?
  - Subject to certain HCR "market reform" changes, which will apply to all plans (whether grandfathered or not)--adult children; pre-existing conditions; waiting periods; dollar limits
  - Subject to certain cost-sharing limits
  - Exempt from certain HCR "market reform" changes on coverage & benefits
  - Exempt from new claims procedures
  - Subject to administrative requirements

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Design Changes that Apply for 2011, Whether Grandfathered or Not

- Expansion of coverage to adult children to age 26
- Elimination of lifetime maximums on essential health benefits
- Phase-out of annual limits on essential health benefits
- Elimination of certain pre-existing condition exclusions
- Prohibition on rescissions of coverage

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Design Changes that Apply for 2011, Whether Grandfathered or Not

EXPANDED ADULT CHILD COVERAGE

- Plans providing dependent coverage must cover adult children up to age 26
- Status based on relationship and age only
- No age-based terms or premiums
- Special enrollment and notice required
- Effective January 1, 2014 for calendar year grandfathered plans; prior to 2014, grandfathered group health plans must only cover adult children who are not eligible for other employer-sponsored coverage

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Design Changes that Apply for 2011, Whether Grandfathered or Not

LIMITS ON "ESSENTIAL HEALTH BENEFITS"

- "Essential" only defined in statute – additional guidance forthcoming
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance abuse services
  - Rx drugs
  - Rehabilitative services and devices
  - Lab services
  - Preventive/wellness; Chronic disease management
  - Pediatric services, including oral and vision

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Design Changes that Apply for 2011, Whether Grandfathered or Not

ELIMINATION OF LIFETIME MAXIMUMS FROM ESSENTIAL HEALTH BENEFITS

- Prohibits lifetime limits on "essential health benefits"
- 30-day special enrollment period for previously-ineligible
- Notice required
- DOL model notice: http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc

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Design Changes that Apply for 2011, Whether Grandfathered or Not

PHASE-OUT OF ANNUAL LIMITS ON ESSENTIAL HEALTH BENEFITS

- 3-year phase-out of annual limits for individuals
- Limit must be at least $750,000 in 2011, $1,250,000 in 2012, $2 million in 2013
- No limit allowed in 2014 and beyond
- Apply on individual-by-individual basis
- Restrictions not applicable to health FSAs, HSAs, MSAs
- Coordination with annual limit rules for grandfathered plan

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Design Changes that Apply for 2011, Whether Grandfathered or Not

ELIMINATION OF CERTAIN PRE-EXISTING CONDITION EXCLUSIONS

- Pre-HCR, certain exclusions allowed under HIPAA (e.g., for lapse in creditable coverage)
- HCR prohibits all pre-existing condition exclusions for children under age 19 in 2011
- Beginning in 2014, all exclusions prohibited, regardless of age
- Cannot deny enrollment to applicants or limit/exclude coverage for those already enrolled

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Design Changes that Apply for 2011, Whether Grandfathered or Not

PROHIBITION ON RESCISSIONS OF COVERAGE

- Generally may not rescind plan or coverage for enrolled individuals
- Exceptions for fraud, material misrepresentation of fact, or non-payment; 30-day advance notice required
- Regulations define rescission: “cancellation or discontinuance of coverage that has a retroactive effect”

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Limits on Benefit Changes & Cost-Sharing For Grandfathered Plans

- Not specifically addressed by statute
- Addressed by regulatory guidance
- Interim Final Regulations

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Limits on Benefit Changes & Cost-Sharing For Grandfathered Plans

WHAT CHANGES CAN YOU MAKE?

- CAN make changes to voluntarily comply with HCR, or other federal or state law
- CAN increase benefits
- CAN add new employees (new hires or new enrollees)
- Transitional Rules – Changes between March 23, 2010 and June 14, 2010
  - Ok if change them back on or before first plan year following March 23, 2010 begins.

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Limits on Benefit Changes & Cost-Sharing For Grandfathered Plans

- **Self-Insured Plans**
  - Can change third-party administrator (TPA)
  - BUT Caution: A change in network could trigger a loss of grandfathered status
- **Insured Plans**
  - Cannot have new policy, certificate or contract of insurance (e.g., policy not renewed; new issuer)
- **All Plans**
  - Cannot eliminate a benefit for a particular condition
  - Cannot eliminate all or substantially all benefits for a condition, including "necessary element" to diagnose or treat a condition
  - Example: Plan covers mental health benefits, including counseling and Rx drugs. If plan eliminates counseling, but keeps Rx, plan loses grandfathered status because counseling is necessary treatment for the condition – mental illness

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Limits on Benefit Changes & Cost-Sharing For Grandfathered Plans

- Changes to annual limits on all benefits – depends on limits in place as of March 23, 2010. If:
  - Plan does not have an annual or lifetime line
    - Cannot add annual limit
  - Plan has only a lifetime limit
    - Cannot add an annual limit that is less than the lifetime limit
  - Plan has an annual limit
    - Cannot decrease the annual limit

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Limits on Cost-Sharing For Grandfathered Plans

- Limits on Cost-Sharing
  - Co-insurance
  - Deductible and out-of-pocket maximums
  - Co-pays
  - Employer contributions/Employee premiums

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Limits on Cost-Sharing For Grandfathered Plans

- Co-insurance increases
  - No increases of <u>any</u> amount above level in effect on 3/23/2010

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Limits on Cost-Sharing For Grandfathered Plans

- Deductible or out-of-pocket maximum increases
  - Permitted increase capped at medical inflation from 3/23/2010 *plus* 15%
  - <u>Example</u>: Plan has a $1,000 deductible on 3/23/2010. Assuming that medical inflation from 3/23/2010 to 1/1/2011 is 5%, and to 1/1/2012 it is 10%:

    For 2011, the deductible can be increased to $1,200 or 20% of the 3/23/2010 amount (5% + 15% of $1,000 = $200).

    For 2012, the deductible can be increased to $1,250, or 25% of the 3/23/2010 amount (10% + 15% of $1,000 = $250).

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Limits on Cost-Sharing For Grandfathered Plans

- Co-pay increases
  - Permitted increase capped at greater of:
    - (1) $5 adjusted for medical inflation ($5 +$5 *times* medical inflation)

      or
    - (2) medical inflation from 3/23/2010 *plus* 15%
- Example: 2010 co-payment for office visits is $5. In 2012, the co-payment is increased to $10, a 100% increase. If medical inflation is 25% during this time, the plan is OK because $5 increase is less than $6.25 ($5 +($5x25%) =$6.25).

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Limits on Cost-Sharing For Grandfathered Plans

- Decrease in employer contribution
  - Employer contribution rate may not drop by more than 5% points below rate in effect on 3/23/2010
  - Measure contribution rate on tier-by-tier basis (e.g., self only, family)
  - Based on cost of coverage or formula
- Examples:
  - Employer has two-tiered coverage: self and family. Employer contributes 80% to self and 60% to family. If the employer reduces its contribution percentage to 50% for family coverage, plan loses grandfather status.

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Limits on Cost-Sharing For Grandfathered Plans

	2010		2011		2012	
	Self	**Family**	**Self**	**Family**	**Self**	**Family**
Total Cost of Coverage	$5,000	$12,000	$6,000	$15,000	$8,000	$20,000
Employer Contributions	$4,000	$8,000	$4,500	$9,300	$6,000	$12,400
Employee Contributions	$1,000	$4,000	$1,500	$5,700	$2,000	$7,600
Ratio	80%	67%	75%	62%	75%	62%

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Limits on Cost-Sharing For Grandfathered Plans

- To grandfather, or not to grandfather, that is the question.

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New Coverage & Benefit Rules for Non-Grandfathered Plans

- First dollar preventive care
- Emergency care without pre-authorization and out-of network emergency care without increased cost-sharing
- Selection of participating primary care provider (or pediatrician for child); access to OB/GYN care without referral

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New Coverage & Benefit Rules for Non-Grandfathered Plans

PREVENTIVE CARE

- Must provide coverage for certain items and services classified as "preventive care"
  - Evidence-based
  - Routine immunizations
  - Complete list found at http://www.HealthCare.gov/center/regulations/prevention.html.
- No cost-sharing
  - No co-payment, co-insurance, or deductible
- These rules apply only to in-network benefits
- May apply reasonable medical management techniques when recommendation does not specify frequency, method, treatment or setting for services

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New Coverage & Benefit Rules for Non-Grandfathered Plans

PREVENTIVE CARE

- 3 Rules for Office Visits
  - Preventive care billed separately, then cost-sharing requirements can be applied to office visit
  - If charges are bundled and primary purpose of office is preventive care, then first dollar coverage must be provided for the entire office visit
  - If charges are bundled and primary purpose of office visit is not preventive care, then cost-sharing requirements may be applied to entire office visit

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New Coverage & Benefit Rules for Non-Grandfathered Plans

EMERGENCY CARE

- If plan offers emergency care, then
  - May not impose a pre-authorization requirement, even if the care is provided out-of-network
  - Must be offered without regard to whether the provider is in-network or out-of-network
  - If provided out-of-network, cannot impose any administrative requirement that is more restrictive than applied to in-network care
  - Co-payment and co-insurance on out-of-network care cannot be more than on in-network care
- Plan may apply
  - Exclusions
  - Coordination of benefits provision
  - Affiliation or waiting period
  - General out-of-network deductible

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New Coverage & Benefit Rules for Non-Grandfathered Plans

EMERGENCY CARE

- Out-of-network provider may balance bill, but plan must reimburse provider the **greater** of
  - Amount negotiated with in-network providers for emergency care
  - Amount calculated using same method plan generally uses to determine out-of-network payments (*e.g.*, usual, customary, and reasonable amount)
  - Medicare

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New Coverage & Benefit Rules for Non-Grandfathered Plans

DESIGNATION OF PRIMARY CARE PROVIDER

- If PCP required, plan must permit participant to designate any in-network PCP (who can be a pediatrician for a child)
- Plan may not require referral for OB/GYN care
  - Can require OB/GYN to notify PCP of treatment decisions
- Notice must be included in SPD and “similar descriptions of benefits”

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New Claims Procedures for Non-Grandfathered Plans

- New claims and appeals interim final regulations were issued by DOL, HHS, and Treasury on July 23, 2010
- DOL Technical Release issued August 23, 2010
- Effective January 1, 2011 for calendar year plans
- Based on regulations' preamble, also expect changes to the current claim regulation

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New Claims Procedures for Non-Grandfathered Plans

- New regulations describe internal review process
- Technical Release describes when the state and federal review processes apply and the two interim federal external review safe harbors

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New Claims Procedures for Non-Grandfathered Plans

- New internal process
- Applies to insured and self-insured group health plans
- Applies to group health plans whether or not governed by ERISA
- Starts with existing DOL claims regulation
- Modifies it in eight ways

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New Claims Procedures for Non-Grandfathered Plans

1. Strict adherence to the regulatory requirements
   - No substantial compliance doctrine available under regulations
   - Failure to strictly adhere means deemed denial
   - Without exercise of fiduciary discretion
   - Claimant proceeds
   - No deference in litigation
   - Adversely affects negotiation leverage

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New Claims Procedures for Non-Grandfathered Plans

2. Flesh out full and fair review
   - Allowed to review claim file
   - Allowed to present written evidence and testimony
   - Provided new evidence and rationale with time to respond
   - Add new appeal layer
   - Compress decision-making time-frames

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New Claims Procedures for Non-Grandfathered Plans

3. Non-English notice required
   - Mathematical tests apply
   - Statement about availability of non-English notices
   - All subsequent notices in non-English
   - Available customer assistance in non-English

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New Claims Procedures for Non-Grandfathered Plans

4. Internal adverse benefit determination content requirements
   - Service date, health care provider, and any applicable claim amount
   - Diagnostic, treatment, and denial codes and their meanings
   - Applicable standards
   - Discussion of decision in final determination

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New Claims Procedures for Non-Grandfathered Plans

5. No conflicts
   - Ensure independent and impartial decision-making
   - Medical experts
   - Individual employment decisions
   - Address TPAs processes in vendor contract

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New Claims Procedures for Non-Grandfathered Plans

6. 24 hour urgent care claim notice
7. Concurrent care reductions require notice and review
8. Adverse benefit determinations include coverage rescissions

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New Claims Procedures for Non-Grandfathered Plans

- Does the state or federal external review process apply?
- Answer differs depending upon whether
  - The plan is self-insured or fully-insured
  - The state external review process is available

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New Claims Procedures for Non-Grandfathered Plans

- Self-insured plan governed by ERISA?
  - Federal process always applies
- State external review process available?
  - Fully-insured plans must comply with state process
- No state external review process available?
  - Fully-insured plans must comply with federal process

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New Claims Procedures for Non-Grandfathered Plans

- Has the state elected to apply its external review process to self-insured plans not governed by ERISA?
  - If so, those plans must comply with the state process
  - If not, those plans must comply with the federal process

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New Claims Procedures for Non-Grandfathered Plans

- Two interim federal external safe harbors
- Voluntary compliance with an available State's external review process
- Meet standard and expedited external appeal requirements

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New Claims Procedures for Non-Grandfathered Plans

- Four months to request review
- Preliminary review by plan
- Referral to an IRO
- Detailed contractual provisions with IRO
- Thorough IRO review within 45 days
- Immediate provision of benefits if reversed

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New Claims Procedures for Non-Grandfathered Plans

- Expedited process includes the same steps
- IRO decision within 72 hours

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Design Changes for 2011 For Mental Health Parity

- Mental Health Parity Act of 1996
- Mental Health Parity and Addiction Equity Act of 2008
- Detailed interim final regulations issued February 2, 2010

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Design Changes for 2011 For Mental Health Parity

- Annual and aggregate lifetime dollar limits apply to substance abuse
- Financial requirements and treatment limitations applied to mental health or substance abuse benefits
- Cannot be more restrictive than the predominant requirement or limit
- Applied to substantially all medical/surgical benefits

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Design Changes for 2011 For Mental Health Parity

- Single plan
- Six separate classifications
- Separate coverage units
- Complicated mathematical determinations
- Quantitative and non-quantitative treatment limits

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Design Changes for 2011 For Mental Health Parity

- Evaluate plan
- Determine if changes are needed
- Redesign and reprice

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Planning for Open Enrollment

STEP 1: INVENTORY AND ASSESS

- Inventory health plans and determine which ones are subject to HCR
  - Group health plans include: Medical, dental, and vision plans, healthcare FSAs, retiree medical plans, and mini-med plans
  - Determine whether dental, vision, and retiree plans can be restructured to be stand-alone and exempt from HCR
    - But determine whether to provide coverage to adult children for administrative ease even if exempt

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Planning for Open Enrollment

STEP 2: THE GRANDFATHERING DECISION

- Determine whether or not to grandfather each plan subject to HCR
  - Cost/benefit analysis for each benefit option
  - Non-grandfathered plans subject to
    - Preventive care rules
    - Emergency care rules
    - PCP provider rules
    - New internal/external claims process
    - 105(h) non-discrimination testing
  - Grandfathered plans subject to
    - Can only make limited changes in the future to March 23, 2010 cost-sharing arrangements and benefits
    - Additional administrative & recordkeeping requirements
  - Grandfathered and non-grandfathered plans subject to
    - Limitations on annual and lifetime dollar limits
    - Pre-existing condition and waiting period changes
    - Coverage of adult children (with limited transition)

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Planning for Open Enrollment

STEP 3: ADMINISTRATIVE SUPPORT

- For non-grandfathered plans, immediately take steps to comply with new internal/external claims process
  - Determine that TPA/carrier can accommodate new procedures
  - Ensure EOBs, if used as denials, will include the required data elements (or use new Model forms)
  - If self-insured, execute contracts with IROs & anticipate changes to TPA service agreement
- For grandfathered plans, take steps to preserve records of costs and benefits as of March 23, 2010 to comply with recordkeeping requirements

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Planning for Open Enrollment

STEP 4: CALENDAR KEY DATES

- Create an open enrollment timetable
  - Calendar a 30-day open enrollment period to accommodate special enrollment of
    - Adult dependent children
    - Individuals who have reached lifetime maximum
  - From there, back into deadlines for other open enrollment deliverables

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Planning for Open Enrollment

STEP 5: IMPLEMENT COMMUNICATION STRATEGY

- Prepare communications
  - HCR changes
  - Mental health parity and other design changes
  - Treatment of "other" children, such as grandchildren
  - New notices
    - Addition of adult dependents
    - No lifetime maximums
    - PCP provider
    - Grandfathered status (if applicable)
    - Regular notices (CHIP, Michelle's Law, WHCRA, HIPAA)

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Planning for Open Enrollment

STEP 6: AMEND HEALTH PLANS AND SPDS

- Amend health plan & SPDs to
  - Remove lifetime and impermissible annual limits on essential health benefits
  - Extend coverage to adult children up to age 26
  - Remove pre-existing condition exclusions on enrollees under age 19
  - Review provisions on rescission
  - Comply with mental health parity requirements
- And, if not grandfathered, further amend health plan & SPDs to comply with
  - Preventive care rules
  - Emergency care rules
  - PCP provider rules
  - New internal/external claims process
  - 105(h) non-discrimination testing

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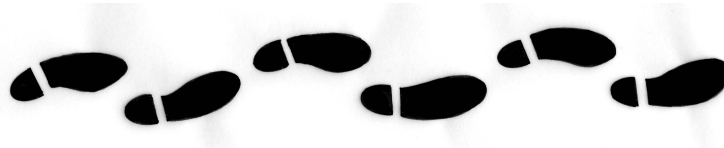
Planning for Open Enrollment

STEP 7: AMEND CAFETERIA PLANS

- Amend Cafeteria Plan to
  - Provide tax-free coverage to adult children (must be adopted by year end)
  - Prohibit reimbursement of expenses incurred for medicines without a prescription as of January 1, 2011



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Planning for Open Enrollment

STEP 8: CONSIDER WAIVER APPLICATION

- Consider whether to apply for waiver if offer a mini-med plan
  - Applications due by December 1st for calendar year plans
  - Must describe why compliance would result in significant decrease in access to benefits or significant increase in premiums
  - Annual exemption
  - In all events, must remove all annual limits on essential health benefits as of January 1, 2014, for calendar year plans

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Planning for Open Enrollment

STEP 9: COORDINATE W-2 REPORTING

- Coordinate W-2 reporting of health coverage with Accounting
  - First applicable to 2011 W-2 issued in January 2012
  - Includes premiums (both the employer/employee portions) for
    - Major medical coverage
    - HRAs
    - On-site Wellness centers
  - Excludes
    - Archer MSAs
    - HSAs
    - Employee contributions to medical FSA's
  - Purpose is to track fulfillment of individual mandate (effective 2014) and tax on Cadillac plans (effective 2018)

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Planning for Open Enrollment

STEP 10: STAY TUNED…

- Stay tuned for more guidance and plan ahead for
  - Automatic enrollment
  - Medicare reporting on earned income as of January 1, 2013
  - New HHS/IRS reporting requirements
  - Pay or play penalties as of January 1, 2014
  - And more…..

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Questions?

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