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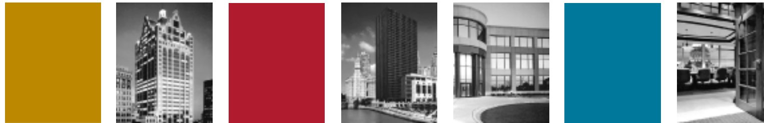

2010 Plan Design Modifications

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Topics for Today

- Which plans must comply with health care reform changes?
- New eligibility rules
- New benefits a plan must offer (or restrictions a plan must eliminate)

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First Things First: Which Plans Must Comply with 2010-11 PPACA changes?

- Likely subject to nearly all PPACA changes, if active employees covered:
  - Major medical; "mini med"; most health reimbursement arrangements ("HRAs"); employee assistance plans ("EAPs"); supplemental executive policies; dental and vision benefits integrated into major medical;
  - Regardless of whether offered by private employer or nonfederal governmental entity
- Possible exception from annual limit rules:
  - Mini med plans may have a limited "out" from annual limit rules
  - Stand-alone HRAs with active employees

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First Things First: Which Plans Must Comply?

- Likely exempt from most PPACA changes:
  - Retiree-only plans
    - Some concern that retiree-only plan of nonfederal governmental sponsor could be subject to state or private lawsuit
  - Stand-alone dental, stand-alone vision plans
    - Ensure that participants in self-funded dental / vision plan must pay something for coverage (e.g., such a plan IS subject to HIPAA portability and PPACA if employer pays 100% of cost)
  - Health FSAs (except for changes specific to them)
  - Health savings accounts ("HSAs") (except for changes specific to them)
  - Fixed indemnity plans (i.e., independent and non-coordinated)
  - Certain supplemental benefits (e.g., Medigap policies)

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New Eligibility Rules

- Older child coverage (limited exception for GF plans)
- Auto enrollment (no GF exception; all plans must comply)
- Dates noted in titles
  - Some are "fixed" dates – e.g., new over the counter rules for HRAs and health FSAs are 1/1/2011
  - Most vary based on plan year
  - Many changes generally effective on or after 9/23/2010 (e.g., October 1, 2010 for an "October 1 plan year"; January 1, 2011 for "calendar year" plan)
  - References to "2010-2011" effective date means it is based on first plan year on or after 9/23/2010

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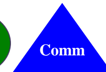
Older Child Coverage (2010 – 2011)



- Plans that cover dependent children must provide coverage for children until age 26 (i.e., through age 25)
  - There is no requirement that the child be unmarried but children and spouses of dependent children need not be covered
  - Limited GF rule: For plan years before 2014, grandfathered plans need not cover a child who is eligible to enroll in "eligible employer-sponsored health coverage" through own employer
    - Consider cost / benefit of asking this; also, how often can plan follow up?
    - Oddly, "eligible employer-sponsored health coverage" may not include a self-funded plan (possible error in PPACA)
- Interim final regulations issued 5/13/10
- "Dependent" definition – only in terms of child's relationship to employee
  - Do not use residency, financial dependence, student status, or employment

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Older Child Coverage (2010 – 2011)

- Enrollment and notice
  - Children eligible (employee ok) must be given written notice by 1st day of 1st plan year after 9/23/10 and must have 30 days to enroll
  - Can provide notice with open enrollment materials, if prominent
    - Modify open enrollment materials
  - Coverage must be effective no later than 1st day of plan year and retroactive if necessary (unclear if salary reduction can be retroactive)
- Can tie to open enrollment period
  - If open enrollment period not 30 days long (as is typical) likely can send it out in advance of open enrollment period, then have 30 days expire when open enrollment expires
  - If do so, provide alternative method of demonstrating election during pre-open enrollment period, if necessary

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Older Child Coverage (2010 – 2011)

- Applies to children who were on the plan and aged out, as well as children never previously enrolled or eligible
  - Identify these individuals; if not possible, send notice to everyone
- Special enrollment rights of affected children
  - Treated as HIPAA special enrollees with same rights to enroll
  - Parent is allowed to change benefit options and, if enrollment of parent is required, non-enrolled parent is allowed to enroll
    - Communicate these rights in enrollment notice (prior slide)
- Can employer charge more for older dependents? No, but can move to “per covered person” standard
  - Consider if this plan design works better (if so, there will be Administrative and Communication action items)

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Auto Enrollment

- No specific effective date in PPACA
  - Would seem to be effective 3/23/2010
  - But compliance effectively delayed until regulations issued
- Amends FLSA and applies to employers with 200 or more full-time employees that offer enrollment in a "health benefits plan"
- Enrollments required by rule –
  - Automatic enrollment for "new" full-time employees in one of employer's plans (subject to any waiting period authorized by law)
  - Does "new" mean "newly hired" or "newly eligible"?
  - Employer must also "continue the enrollment of current employees"
    - Oddly broad--meant to be an "evergreen" election provision?
- If follow rules, state law (e.g., wage withholding) preempted
  - ERISA preemption possible also

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New Benefits Plan Must Offer (or Restrictions Plan Must Eliminate)

- No lifetime limits (no GF exception; all plans must comply)
- Restricted (no) annual limits (no GF exception; all plans must comply)
- No preexisting condition exclusions (no GF exception; all plans must comply)
- No rescission of coverage (no GF exception; all plans must comply)
- Over the counter (OTC) reimbursement restrictions (no GF exception; all specified plans must comply)
- Preventive care coverage (GF plans are excepted)
- Designation of primary care provider (GF plans are excepted)
- Pediatrician as primary care provider (GF plans are excepted)
- Coverage of emergency services (GF plans are excepted)
- Ob/gyn coverage without referral (GF plans are excepted)

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No Lifetime Limits (2010 – 2011)

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- No lifetime limits on dollar value of "benefits", but:
  - (1) Can completely exclude all benefits for a specified condition
  - (2) Can place lifetime limit on benefits which are not "essential health benefits"
- "Essential health benefits" to be defined by regulation
  - Must include ambulatory care, ER, hospitalization, maternity / newborn, mental health / substance abuse, drug, rehab, lab, preventive, and certain pediatric care
  - Probably does not require that a plan cover all these
- If "any benefits are provided for a condition", then no lifetime limit rules apply
  - What if benefits "accidentally" provided?

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No Lifetime Limits (2010 – 2011)

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- Regulations and statute silent on visit-based or treatment-based limits; seems permissible but some uncertainty
  - Possible way to "save" mini med plans?
- If plan wishes to exclude particular conditions, consider other laws (e.g., Americans with Disabilities Act)
- What if someone has already reached lifetime limit?
  - If individual had coverage "end" because of lifetime limit on dollar value of benefits and individual becomes eligible for benefits not subject to lifetime limit, must send two notices
  - Examples indicate that coverage can "end" either automatically per plan's terms or by employee voluntarily dropping coverage

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No Lifetime Limits (2010 – 2011)

- Notice #1: Lifetime limit on dollar value of all benefits no longer applies
  - Must also state that individual, if covered, is once again eligible for benefits under plan
- Notice #2: If individual not enrolled in plan, or if enrolled individual eligible for but not enrolled in any benefit package under plan, plan must provide 30-day opportunity to enroll
- Provide notices by first day of first plan year beginning on or after 9/23/2010
  - Like coverage for older child, try to tie to open enrollment
- Discuss with carriers / TPAs which individuals fall into these categories
  - Not clear if plan / employer would always know; send out broad notice to many employees not currently enrolled?

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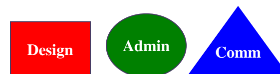
No Lifetime Limits (2010 – 2011)



- Can provide notices with other enrollment materials but must provide a “prominent” statement of this rule
  - Perhaps note it on cover / first page of enrollment materials
- If carrier sends notices, that relieves plan of its obligation
  - Ask if carrier will send the notices (effect of mistake?)
- Special enrollment rights
  - Treat person as if special enrollee – offer all benefit packages made available to similarly situated individuals
    - Any difference in benefits / cost-sharing create separate benefit package
  - Unclear whether certain HRA plan designs could be impacted by rule
  - E.g., HRA with both active employees and retirees; retirees no longer accruing new HRA benefits; will their current account balance be an effective “lifetime limit”?

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Restricted (No) Annual Limits (2010 – 2011; 2014)

- Beginning in 2014, cannot have any annual dollar limits on "benefits" but:
  - (1) Can completely exclude all benefits for a specified condition
  - (2) Can place annual limit on benefits which are not "essential health benefits"
- For plan years from 9/23/2010 – 2014, "restricted" annual limits on "essential health benefits" allowed
  - Non-essential health benefits can always be limited (now and after 2014)
  - "Essential health benefits" same definition as before
- "Restricted" annual limits ok if follow this schedule:
  - Plan years on or after 9/23/2010 but before 9/23/2011, $750,000
  - Plan years on or after 9/23/2011 but before 9/23/2012, $1,250,000
  - Plan years on or after 9/23/2012 but before 1/1/2014, $2,000,000

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Restricted (No) Annual Limits (2010 – 2011; 2014)

- Some relief may be available -- HHS notes that, prior to 2014, it has "waiver authority" that it may use if complying would:
  - (1) Result in a significant decrease in access to benefits under the plan or health insurance coverage; or
  - (2) Significantly increase premiums for the plan or health insurance coverage
- No such program set up yet; raises numerous questions
  - Why would access to benefits ever be decreased because annual limit is increased? As a cost-cutting measure?
  - How much of an increase is "significant"? Who determines? Rely on insurer rate quote? Hire actuary?
  - When, if ever, will waiver program become available? Will it be available in time for sponsors to submit request for 2010 - 2011? How quickly will agencies respond to waiver relief request?

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No Preexisting Condition Exclusions (2010 – 2011; 2014)

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- Plan cannot impose preexisting condition exclusion for enrollees who are under age 19
- "Enrollees" broad – includes children, employees, dependents, etc.
- No limit on "look back" period – condition could have occurred 6 weeks ago or 6 years ago – cannot exclude enrollee due to condition
- No guidance in regulations on exact cut off date
  - E.g., suppose Cindy Child turns age 19 on December 15, 2011. Can plan start imposing preexisting condition exclusion on December 15? January 1, 2012? Probably December 15

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No Preexisting Condition Exclusions (2010 – 2011; 2014)

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- Rule applies immediately, first day of new year
  - Example: Ed Employee begins working at Acme and enrolls Steve the Son on October 15, 2010. Ed and Steve had 64 day lapse in coverage, so Acme's plan imposes preexisting condition exclusion against Steve (who was recently treated for asthma). Normally Steve could be subject to 12-month (or 18-month) waiting period for benefits. However, if Acme's plan is calendar year plan, no PCE can be asserted against Steve as of January 1, 2011
  - Identify enrollees in plan now for whom you impose a PCE; prepare to remove it
- Applies regardless of age in 2014 to prohibit all PCEs
  - Modify plan documents in 2013 or 2014 to reflect this
- Still must issue HIPAA certificates of creditable coverage (oddly, even in 2014)

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No Rescission of Coverage (2010 – 2011)

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- No rescission of coverage except if individual makes: (1) act, practice or omission that constitutes fraud; or (2) intentional misrepresentation of material fact, both (presumably) as prohibited by plan terms
- Focus on mental state of individual – tough standard
- "Rescission" is a cancellation or discontinuance of coverage that has retroactive effect
  - Appears it includes any cancellation that is retroactive, whether it goes back 1 day, 1 year or beginning of coverage
  - What about "pending" claims? Presumably would also be covered by "no rescission" rule
  - "Rescission" does not include retroactive termination attributable to failure to timely pay required premiums or contributions toward cost of coverage

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No Rescission of Coverage (2010 – 2011)

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- If only one employee commits fraud, can entire family unit be punished? Can insurer revoke coverage for everyone?
  - Regulations vague but it appears so. Preamble discusses example of insurer attempting to rescind coverage of an entire employment-based group because of the actions of one individual
- Plan or issuer must provide at least 30 calendar days advance written notice to each participant who would be affected before coverage may be rescinded
- No model language or guidance on what plan should say about prohibiting this type of fraud or intentional misrepresentation
  - Check plan document and include sufficient language
  - Check plan document to see if current language is too broad—e.g., coverage can be terminated retroactively if fail to provide information needed for coordination of benefits

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Preventive Care Coverage (2010 – 2011)

- First dollar coverage (i.e., no cost-sharing) must be provided for certain evidence-based preventive care (including well-child care) and certain immunizations
  - Regulations provide four categories of "preventive care"
- Presumably plan can still include some restrictions (e.g., UCR limits; in-network requirement)
- Estimate cost – could be important factor in GF decision

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Designation of Primary Care Provider (2010 – 2011)

- If plan requires or provides for designation of a participating primary care provider, plan must permit each participant or beneficiary to designate any participating primary care provider who is available to accept them
- Example and model language (see upcoming slide) clarify that plan can require primary care provider to be in-network
- Term "available" not defined – seems to mean the provider is not too busy to accept the individual (i.e., not really a plan issue)
- Term "primary care provider" not defined – presumably plan can define term (e.g., exclude specialists)
- Plan must provide notice of this requirement

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Designation of Primary Care Provider (2010 – 2011)

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- Model language for notice provided:

  [Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

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Designation of Primary Care Provider (2010 – 2011)

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- Notice must be included whenever plan or issuer provides a participant with an SPD "or other similar description of benefits under the plan or health insurance coverage"
  - Would this apply to employee handbooks that "describe" benefits?
  - What if SPD / benefit description is provided to a "beneficiary" (but not a participant)?
  - Discuss with carrier / TPA if they will include and distribute model language
  - Identify any other benefit "descriptions" provided (possibly employee handbook) and include notice there

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Pediatrician as Primary Care Provider (2010 – 2011)

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- Some plans require or provide for designation of participating primary care provider for a child by a participant or beneficiary
- If so, plan must permit participant or beneficiary to designate a physician who specializes in pediatrics as primary care provider
  - Plan can require that physician be in-network
- Model language – take model language from prior slide and "add":

For children, you may designate a pediatrician as the primary care provider.

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Coverage of Emergency Services (2010 – 2011)

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- If plan covers any benefits with respect to services in emergency department of a hospital, plan must cover emergency services:
  - (1) Without need for any prior authorization determination, even if services are provided on an out-of-network basis
  - (2) Without regard to whether provider furnishing services is in-network for those services
  - (3) If services are out-of-network, without imposing any "administrative requirement" or "limitation on coverage" that is more restrictive than those applying to in-network provider emergency services
  - (4) If services are out-of-network, must follow "cost-sharing" rules (see later slide) and
  - (5) Without regard to any other term or condition of coverage, other than: (a) exclusion of or coordination of benefits; (b) an affiliation or waiting period otherwise allowed; or (c) applicable cost sharing

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Coverage of Emergency Services (2010-2011)

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- Balance billing: Regulations concerned that participant may be required to pay, beyond network cost-sharing, the "balance owed" to the provider—i.e., excess of the amount out-of-network provider charges over amount plan or issuer is required to pay
- Problem under PPACA, which states that cost-sharing requirements for emergency services must be the same, whether in- or out-of-network
- "Solution": Plan must, in some situations, pay more than what it normally does for such emergency services
  - Rules vary, though, depending on whether the cost-sharing is: (1) a copayment or coinsurance; or (2) other cost-sharing (e.g., deductible or out-of-pocket maximum)

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Coverage of Emergency Services (2010-2011)

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- Copayment / Coinsurance: No violation if plan pays greatest of (1), (2) or (3):
  - (1) Typical Negotiated Rate. Amount negotiated with in-network providers for emergency services provided, excluding in-network copayment or coinsurance
    - E.g., emergency room exam at negotiated rate of $100
  - If plan works with multiple providers and has multiple negotiated rates, take median of rates
    - E.g., rate of $100 with two providers, $115 with one provider, $125 with one provider and $150 with one provider; amounts are $100, $100, $115, $125 and $150; median is $115 (if had been only four amounts, median equals average of middle two)
  - If no per-service amount negotiated with in-network provider (e.g., capitation arrangement), amount under (1) is disregarded (i.e., just look at greatest of (2) and (3), on following slides)

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Coverage of Emergency Services (2010-2011)

- Copayment / Coinsurance: No violation if plan pays greatest of (1), (2) or (3):
  - (2) Out-of-Network Amount (Ignoring Out-of-Network Charges, Reduced by In-Network Charges). Amount calculated using same method plan uses to determine payments for out-of-network services (such as usual, customary and reasonable amount), excluding any out-of-network copayment or coinsurance imposed with respect to participant or beneficiary (reduced by in-network copayment or coinsurance enrollee would typically pay)
  - Example: If plan generally pays 70% of UCR amount for out-of-network services, amount under (2) equals 100% of UCR amount (i.e., ignore 30% out-of-network coinsurance that would usually apply)
    - Then, reduce by copayment or coinsurance individual responsible for if in-network
  - (3) Medicare Rate. Amount that would be paid under Medicare for the emergency service, excluding any in-network copayment or coinsurance with respect to the participant or beneficiary

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Coverage of Emergency Services (2010 – 2011)

- Example: Individual from prior slide receives $125 emergency service from out-of-network provider. Calculate greatest of (1), (2) and (3).
  - In prior slide, “median amount” for (1) was $115. Assume plan pays 80% of negotiated rate with different in-network providers. Plan will therefore pay $92 (80% x $115) = value of (1).
  - In calculating (2), assume plan reimburses individuals 50% of reasonable amount for out-of-network services. Plan uses third party guidance and determines UCR charge should only be $116 (not $125 as provider wishes). Ignore plan’s typical reimbursement rate of 50% -- instead, use 80% (same as used for in-network). 80% x $116 = $92.80 = value of (2).
  - Assume Medicare rate (3), excluding any copayment or coinsurance, is $80.
  - Greatest of (1), (2) and (3) is $92.80 – plan pays that (not $92)
  - Individual is responsible for remaining balance due of $32.20 (i.e., $125 charge - $92.80 plan payment)
  - Unclear how to run example if assumed 80% rate varies among providers

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Coverage of Ob/Gyn (2010 – 2011)

- Many plans provide obstetrical or gynecological care and require designation by participant or beneficiary of participating primary care provider
- If so, plan may not require authorization or referral by plan, issuer or any person (including primary care provider) in case of:
  - (1) a female participant or beneficiary
  - (2) seeking coverage for ob/gyn care
  - (3) provided by a participating health care professional
  - (4) who specializes in ob/gyn care
- "Health care professional" any individual (including someone other than a physician) authorized under applicable state law to provide ob/gyn care

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Coverage of Ob/Gyn (2010 – 2011)

- Plan must notify each participant of this rule
  - Notification rule only to participants, not just "female" participants; apparently no notification to beneficiary (even a female beneficiary)
- Model language:

  You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

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OTC Reimbursement Restrictions (2011)

- No reimbursement of over the counter (OTC) medicines or drugs (except insulin) by health FSAs or HRAs without a prescription
- Effective January 1, 2011
  - Applies based on date medicine or drug purchased, not when submitted for reimbursement
  - Can purchase medicine on 12/31/2010, submit for reimbursement on 2/1/2011 (if FSA / HRA allows) and receive reimbursement
- Similar restrictions apply to HSAs and Archer MSAs
  - Can participants change their elections due to new rule? Probably not
  - Some "gray" items – e.g., medicated bandages

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Questions?

- Thank you for attending

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