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Health Care Reform – Recent Developments and Preparing for 2012 and Beyond

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Today's Presentation

- What we will cover
  - Summary of Benefits and Coverage
  - Preventive Care Requirements for Women
  - Claims Procedures
  - Preparing for 2012 and beyond

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Summary of Benefits and Coverage

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- Why a Summary of Benefits and Coverage?
  - Goal of Health Care Reform: give individuals more choice regarding health coverage
  - Uniform, basic information about plan coverage.
  - Make it easier for individuals to compare coverage options

Summary of Benefits and Coverage

- What Will a Summary of Benefits and Coverage Look Like?
  - Stand-alone document
  - Not more than 4 ***double-sided*** pages
  - At least 12 point font size
  - Understandable terminology
  - "Culturally and linguistically appropriate"
    - Support and Translation services if at least 10% or more of population in the county is literate only in Chinese, Spanish, Tagalog or Navajo
- Where do you find the form?
  - http://www.dol.gov/ebsa/pdf/SBCtemplate.pdf

Summary of Benefits and Coverage

- What information has to be in the SBC?
  - Cost of coverage and a description of the coverage, including cost-sharing for each category of benefits
  - Exceptions, reductions, and limitations of coverage, along with cost-sharing information regarding deductibles, co-payments and co-insurance
  - Coverage examples: Hypothetical summaries of how the plan would pay benefits in certain common medical situations:
    - Birth of a child
    - Cancer treatment
    - Managing diabetes

Summary of Benefits and Coverage

- What information has to be in the SBC? (cont.)
  - Internet address to a “Glossary” - Uniform definitions of standard insurance and medical terms
    - 44 definitions in the proposed rules, with likely more coming.
    - Will need to check your plan language against these uniform definitions
  - Internet address for formulary
  - Internet address for any provider network
  - Statement that SBC is only a summary and the plan document, policy or certificate of insurance should be consulted to determine governing provisions

Summary of Benefits and Coverage

- Who Is Entitled to Receive a Summary of Benefits and Coverage?
  - Participants and beneficiaries.
    - One SBC per address
    - Separate SBC for each available plan option
      - Two HMOs, Two PPOs? Four SBCs!
      - Differences between single and family coverage can be explained in one SBC

Summary of Benefits and Coverage

- When must Individuals receive the SBC?
  - With new enrollment kit
    - Must update if information changes before coverage begins
  - Within 7 days of receiving request for special enrollment
  - With annual open enrollment kit
  - Within 7 days of a request

Summary of Benefits and Coverage

- How do you distribute the SBC?
  - In paper form
  - Electronic form
    - Must comply with ERISA electronic distribution safe harbor rules.
      - Workforce members with ready access to computers
      - Others who consent

Summary of Benefits and Coverage

- Who Is responsible for preparing the SBC?
  - Insurers must provide SBC to health plans
  - Self-insured health plans
    - Plan sponsor OR designated administrator
    - address contractually
      - Drafting responsibility
      - Distribution responsibility

Summary of Benefits and Coverage

- When do these proposed rules go into effect?
  - HHS, DOL and IRS accepting comments until October 21, 2011
  - Require initial distribution of SBC by March 23, 2012

- What happens if we fail to distribute the SBC?
  - Willful failure to provide SBC: $1,000 for each violation
  - Each individual who fails to receive an SBC is a separate violation

Advance Notice of Plan Modifications

- Notice of material changes to health plan coverage
- No later than 60 days prior to effective date of change
- HHS to establish format
- Goes into effect March 23, 2012

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Preventive Care Requirements for Women

Preventive Care Requirements for Women

- Large list of treatments and services required without cost-sharing.
  - No co-pays, deductibles, co-insurance for in-network visits
- Requirements apply to non-grandfathered group health plans for plan years beginning on or after August 1, 2012
- Calendar-year plans - January 1, 2013
- A lot of press is leading to a lot of questions

What Services are Required?

Treatment or Service	Frequency
Well Woman visits, including preconception and prenatal care	Annually, or more often if necessary
Screening for gestational diabetes	With every pregnancy
DNA human papillomavirus (HPV) testing	No more than once every three years, if the woman is at least 30 years old
Counseling for sexually transmitted infections	Annually

What Services are Required?

HIV counseling and screening	Annually
Contraceptives (all FDA approved contraceptive methods), sterilization procedures and patient education and counseling	As prescribed for all women with reproductive capacity
Breastfeeding support, supplies and counseling, including the cost of breastfeeding equipment such as breast pumps	Coinciding with each birth
Screening/Counseling for interpersonal and domestic violence	Annually

All FDA Approved Methods of Contraception

- Six Categories
  - barrier methods
    - Non Prescription: male and female condoms, contraceptive sponge, spermicide creams, foams and jelly
    - Prescription (diaphragm and cervical cap)
  - hormonal methods
    - Estrogen and progestin oral contraceptives
    - Progestin-only oral contraceptives
    - Continuous-use oral contraceptives
    - Skin patch that utilizes estrogen and progestin to stop ovulation
    - Vaginal contraceptive ring (NuvaRing)
    - Injection of progestin that lasts three months (Depo-Provera)
  - emergency contraception a.k.a. “morning after pill” or “Plan B”
    - Prescription required for 18 and under in some states. 18+ over the counter
  - implanted devices
    - IUD
    - implantable rods of progestin under skin of a woman’s upper arm (Implanon)
  - permanent sterilization methods for women and
  - permanent sterilization surgery for men

Partial Religious Exemption

- Religious Institution
  - "Exclusively religious activities"
  - Must be a non-profit
  - Purpose of organization must be the inculcation of religious values
  - Organization must primarily employ and serve individuals who belong to same religious affiliation
- Exemption applies to contraceptives only.
  - No exemption for counseling and screening for sexually transmitted infections or HIV.

Certain Plans Not Affected

- Flexible Spending Accounts
- Stand-alone Dental Plans
- Stand-alone Vision Plans
- Grandfathered Plans

**Remember, Health Reimbursement Arrangements <u>are</u> subject to these requirements, unless they are limited scope in nature

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Claims and Claims Appeals

Claims and Claims Appeals

- Urgent care precertification decisions back to old rule
  - As soon as administratively practicable, within 72 hours (1/1/12)
  - Previous guidance had put this at 24 hours
  - Providing notices in culturally and linguistically appropriate manner (1/1/12)
  - Detailed EOBs (7/1/11—except have until 1/1/12 to include diagnosis and treatment codes)
  - Deemed exhaustion for failure to comply with new requirements (1/1/12)
- No extensions and already required:
  - Expanded scope of appeal to include rescissions
  - Duty to notify of new grounds/new information
  - Avoiding conflicts of interest
  - External review process

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Preparing for 2012 and Beyond

Stand-Alone HRAs – 2011/12

- Group health plans may not impose lifetime limits on the dollar value of health benefits, and annual limits must be within certain ranges
  - Restricted annual limits could have been waived. The Administration stopped accepting applications on September 22, 2011
- Stand Alone HRAs in effect prior to September 23, 2010 do not have to comply with annual limit requirements for plan years beginning before January 1, 2014
  - Under recent guidance, no annual waivers necessary before January 1, 2014.
  - If an employer that maintains an HRA also maintains other coverage, whether or not that coverage is integrated with the HRA, that other coverage must comply with the annual limit restrictions or obtain a waiver.
- After 2014 – will these stand-alone HRAs continue to exist?

Rate Review – 2011/12

- Rate Review Required
- Michigan: Office of Financial and Insurance Regulation (OFIR) requires all carriers to file individual health rates.
  - Historically, only BCBS MI and HMOs filed large & small group rates
  - Now, all commercial carriers must file small group and individual rates.
  - Michigan is defining a “small group” as a business with 2 to 50 eligible employees. In 2016, this will change to 2-100 eligible employees.
  - States must post carriers’ explanations for any proposed 10%+ increase on the internet and the public can comment online on the increase
  - State must forward double-digit rate increase proposals to the federal Centers for Medicare & Medicaid Services (CMS) through a new Health Insurance Oversight System (HIOS)
  - Existing health coverage, disability insurance rate are not subject
  - **?** Impact on overall and employer group rate increases

New Fees – 2012/13

- Michigan – Paid Claims Assessment Act
  - 1% of claims paid - Michigan Residents & Providers only
  - Paid by Insurer, HMO or Plan Sponsor (self insured)
  - Effective August 24, 2011
- Federal – Annual fees on non grandfathered insured and self-insured benefit plans to fund comparative effectiveness outcomes research
  - $1 per enrollee for years beginning after 9/30/2012
  - $2 thereafter

Reporting on W-2 – 2012/13

- Employers must report cost of employer-provided coverage
  - Optional for 2011
  - Required for 2012. W-2 forms required to be issued in January 2013 (2014 for under 250)
  - Not required to distribute W-2s with this information for people who terminate mid-year

Annual Quality of Care Reporting-2012/13?

- Health care quality and wellness initiatives
  - Non Grandfathered Plans required to file annual reports with HHS and disclose to participants
  - Regulations due by March 23, 2012

Automatic Enrollment – 2014?

- Employers with more than 200 employees
  - Must automatically enroll new full-time employees in one of health plans it offers (subject to waiting period)
  - Employees may opt out
- Full-Time Employee threshold not specified
  - ? 30 hours (the penalty)
  - ? 20 hours per month (affordability threshold)
- Effective Date Not Specified
  - DOL: Compliance not required until regulations are issued (by 2014)
  - ? 2014 ? Earlier

Affordability - 2014

- Large employer (Equivalent of 50 + FTE Employees) subject to assessable payment if any full-time employee is certified to receive an applicable premium tax credit or cost-sharing reduction *and* either:
  - The employer does not offer FTEs (and their dependents) the opportunity to enroll in minimum essential coverage; or
  - The employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage that either is unaffordable or does not provide minimum value
- Coverage under an employer-sponsored plan is affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.5% of the employee's *household income* for the taxable year

Affordability - 2014

- Proposed Safe Harbor: 9.5% of *wages* employer paid to an employee, instead of 9.5% of *household income*
  - Only applicable for employer shared responsibility provision
  - Does not affect employee's eligibility for health insurance premium tax credits
  - Determined after the end of the calendar year and on an employee-by-employee basis
  - Could be used prospectively
- Penalties
  - $2,000 x FTE (-30) If no minimum essential coverage
  - $3,000 x # of employees who actually receive credits/enroll in exchange (capped at above penalty)

Alternatives - 2014

- Continue existing plans
- Abandon plans
  - Penalty
  - Effect on compensation - ? Makeup
- ? Specific dollar amount/credit in cafeteria plan
  - Amount then offset by estimated premium tax assistance/credit and penalty if applicable
  - Result - 400% of poverty+ receive greatest cafeteria plan amount
  - Taxation ?
  - Discrimination ?
- ? Couple credit w/ access to private exchange offering individual coverage with benefits superior to exchange coverage
  - Lower income in public/Higher Income in private exchanges
  - ? Effectively two tiers of coverage avoiding nondiscrimination rules

Questions?

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