

# What Every CFO Needs to Know About Healthcare Reform



Jonathan Clark | February 3, 2011



## Overview

- The Patient Protection and Affordable Care Act (the “Act”) was enacted on March 23, 2010, and was amended on March 30, 2010 by the Health Care and Education Reconciliation Act of 2010, which makes changes to the Act.
- Effective dates are staggered from the date of enactment until January 1, 2014.
- New health insurance plans must comply with all requirements.
- Grandfathered plans are exempt from some of these requirements.



## Grandfathered Plans

- Grandfathered plans are all those plans that were in existence on March 23, 2010.
  - Grandfather rules apply indefinitely.
  - Special rules for collectively bargained plans.
  - Enrollment of new members or their family members after the date of enactment.
  - Other plan changes may impact grandfathered status.
  - Caution should be exercised with plans changes until guidance is issued.



## Grandfathered Plans

- Grandfathered plans still subject to insurance reforms and employer mandate as well as:
  - Dependent coverage until Age 26;
  - Preexisting exclusions;
  - Lifetime maximums;
  - Annual maximums; and
  - Rescission of coverage limitations.

# Insurance Reform Dependent Coverage



## Until Age 26 Six Months from Enactment for All Plans Including Grandfathered Plans

- Health plans must cover adult children up until age 26, regardless of student or marital status.
  - In most cases, January 1, 2011.
- Definition of an adult child.
- Grandchildren not included.
- Prior to January 1, 2014, adult children may be excluded if eligible to enroll in employer-sponsored coverage.

# Insurance Reform Dependent Coverage



## Until Age 26 Six Months from Enactment for All Plans Including Grandfathered Plans

- Preamble to Interim Final Rules issued by the IRS, DOL and Health and Human Services clarify impact on grandfathered status.
- No taxation for such coverage.
- Notice 2010-38 clarify the tax treatment of providing such coverage, as well as the ability to amend cafeteria plans retroactively to effectuate this change

# Insurance Reform

## Pre-Existing Condition Prohibition



### Six Months from Enactment for All Plans Including Grandfathered Plans

- Children under age 19 may not be excluded for pre-existing conditions.
  - Effective as of January 1, 2011 in most cases.
  - Applies to all for plan years beginning on or after January 1, 2014.



## Six Months from Enactment for All Plans Including Grandfathered Plans

- A lifetime maximum on essential benefits prohibited.
- Nonessential benefits can be subject to such a maximum.
  - The Secretary of Health and Services is to determine the scope of what is considered essential benefits.

# Insurance Reform Annual Dollar Limitations



## Six Months from Enactment for All Plans Including Grandfathered Plans

- No annual dollar limits on “essential” benefits.
  - Prior to January 1, 2014, a “restricted annual limit” on “essential” health benefits permitted.
  - The Secretary of Health and Human Services to issue guidance on definition of restricted annual limit.



## Six Months from Enactment for All Plans Including Grandfathered Plans

- Prohibition from rescinding participant health insurance coverage, except for fraud or material misrepresentation.
  - Impact mistakenly enrolled individuals unclear, or on a plan amendment that prospectively eliminates coverage.
  - With prior notification, cancellation of coverage permitted for nonpayment of premiums, fraud and termination of the plan.

# Insurance Reform Mandated Coverage for Preventive Care



## Six Months from Enactment for Plans Other Than Grandfathered Plans

- No cost sharing for:
  - preventive care services and immunizations
  - certain child preventive services; and
  - women’s preventive care and screening.



## Six Months from Enactment for Plans Other Than Grandfathered Plans

- Patient protections including:
  - Designation of primary care provider.
  - Coverage of emergency services in a hospital.
  - Designation of pediatrician required.
  - No authorization or referral required for obstetrical or gynecological care.



## Six Months from Enactment for Plans Other Than Grandfathered Plans

- Claims and appeals processes required, which must include:
  - An internal claims appeal process;
  - Notice to participants of available and external appeals and consumer assistance and ombudsmen;
  - Participant's right to file review, present evidence and testimony; and
  - Continued health care coverage during the appeals process.

# Insurance Reform

## Explanation of Coverage Requirements



### Two Years from Enactment for All Plans Including Grandfathered Plans

- Requirement to provide summary documentation to all plan participants that must:
  - state whether the plan provides minimum essential coverage; and
  - whether the plan's share of the costs is at least 60% of actuarial value.
- Limited four pages
- In addition, to ERISA's Summary Plan Description requirements.

# Insurance Reform Explanation of Coverage Requirements



## Two Years from Enactment for All Plans Including Grandfathered Plans

- Standards for this summary expected by March 23, 2011.
- 60-days advance notice of changes to the summary of benefits required.
- A new \$1,000 per participant penalty for each willful failure to provide the summary, as well as a \$100 per day per individual penalty for such a failure.

# Insurance Reform Pre-Existing Condition Limitation



## Effective as of January 1, 2014 for All Plans Including Grandfathered Plans

- For both insured and self-insured health plans, no pre-existing condition exclusions regardless of age.
  - Currently, HIPAA permits pre-existing condition limitations to be applied for up to 12 months (or 18 months for late enrollees), subject to reduction for periods of prior creditable coverage.

# Insurance Reform Other Important Changes



## Effective as of January 1, 2014 for All Plans Including Grandfathered Plans

- No eligibility waiting periods of more than 90 days.
- Existing law permitted wellness programs, but new law makes one major change by increasing level of financial incentives from 20% to 30%.
- May be increased by 50% in the discretion of the Department of Labor, Health and Human Services and the Treasury.

# Insurance Reform Other Important Changes



## Effective as of January 1, 2014 for Plans Other Than Grandfathered Plans

- Mandated benefit and design changes for new plans:
  - Coverage of essential benefits for individual and small plans for insured, individual and small group markets only.
  - Non-discrimination based on health status prohibited.
  - Expanded coverage for routine costs of clinical trials for insured and self-insured plans
  - Plans may not impose annual cost-sharing requirements and deductibles in excess of certain limitations



## Tax Increases

- Flexible spending arrangements
  - No reimbursements for non-prescription drugs
- Nondiscrimination requirements expanded to include fully-insured plans
  - Section 105(h) of the Tax Code
  - Two nondiscrimination tests: coverage and benefit levels
  - Excise tax per participant if plan fails



## More Tax Increases

- Health flexible spending arrangements
  - Salary reduction contributions limited to \$2,500
- Medicare Part D subsidy provided to employers
  - Deduction no longer permitted



## Large Employers (50 or more FTEs) – Penalties

- Not offering health coverage
  - Monthly penalty = \$166.67 x number of full-time employees in excess of 30
- Offering inadequate coverage
  - Coverage is too expensive for employees
    - Employee cost exceeds 9.5% of household income, or
    - Employee share of total allowed cost of benefits is more than 40%



## Large Employers (50 or more FTEs) – Penalties

- Monthly penalty is lesser of
  - \$250 x number of full-time employees who receive a tax credit or cost-sharing reduction
  - \$166.67 x number of full-time employees in excess of 30



## “Cadillac Tax”

- 40% nondeductible tax on the annual value of health plan costs for employees that exceed:
  - \$10,200 for single coverage
  - \$27,500 for family coverage in 2018.
- One survey concluded average 2010 cost of medical coverage for active single and family plans is \$5,184 and \$14,988, respectively.
- That same survey concluded 60% of large employer plans are likely to become subject to the excise tax, after taking into account reasonable healthcare inflation.

# Questions & Answers

