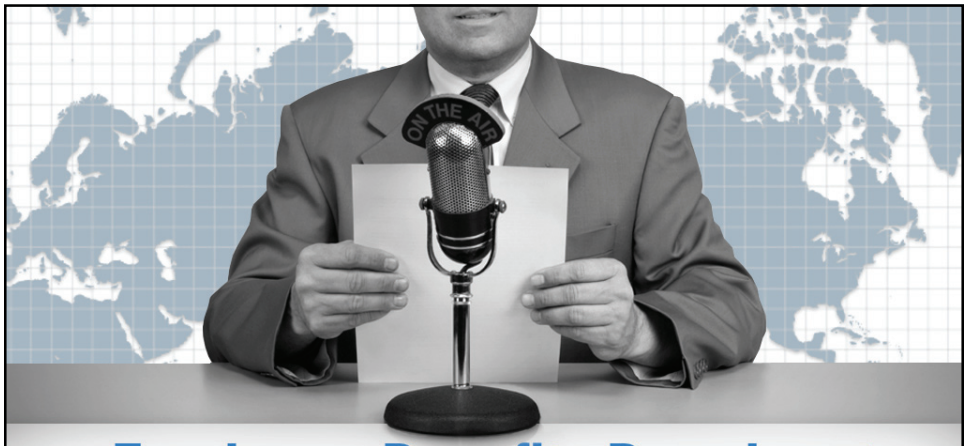

Employee Benefits Broadcast

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Employee Benefits Broadcast

Today's Topics

- **In the Headlines:** The Patient Protection and Affordable Care Act - What You Should be Considering Now
  - Retiree-Only/Excepted Benefits
  - Exceptions for Grandfathered and Collectively Bargained Health Plans
  - New Dependent Child Coverage Regulations
  - ACA Regulations: Annual & Lifetime Plan Limits
  - Pre-existing Condition Exclusions and First Dollar Preventive Care Coverage
  - Limitations on Rescissions, Patient Protections, and Internal Claims and Appeals Processes & External Reviews

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Headline News

Retiree-Only/Excepted Benefits

Samuel F. Hoffman

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Headline News

Retiree-Only/Excepted Benefits

- ACA Health Insurance reform provisions to not apply to health plans with fewer than 2 current employees or certain ‘excepted benefits’.

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Headline News

Retiree-only/Excepted Benefits

- Exemption technically only applies to ACA's ERISA and Code provisions, not ACA's PHS Act provisions; therefore, could still apply to insured plans.
- But, HHS will not enforce against carriers and DOL/IRS/HHS are 'encouraging' states not to enforce against policies covering retiree-only/excepted health benefits.
  - Employers should not have a problem if they are allowed by their local state authorities to purchase such a retiree-only/excepted benefit policy without ACA insurance reform provisions.

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Headline News

Retiree-Only/Excepted Benefits

- Retiree-only health plans are not subject to ACA's health insurance reform provisions.
  - For example, life time limits are still allowed in retiree-only health plans.
  - Retiree-only HRAs remain a viable benefit option.
- Health Plan benefits that are offered to both current active and retired former employees are subject to the ACA's health insurance reform provisions even as applied to the retired former employees.

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Headline News

Retiree-Only/Excepted Benefits

- Excepted benefits are not subject to ACA's health insurance reform provisions:
- Excepted benefits always include:
  - AD&D insurance
  - LTD insurance
  - Workers Compensation
  - Auto insurance

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Headline News

Retiree-Only/Excepted Benefits

- The following excepted benefits are not subject to the ACA's health insurance reform provisions under the circumstances noted below:
  - Dental-only if coverage is not an 'integral part' of a medical plan; i.e., participant has right to decline dental and still take medical and participant must pay extra premium for such dental coverage.
  - Vision-only if coverage is not an 'integral part' of a medical plan (same definition as dental-only).
  - Medi-gap policy if provided under a separate contract, policy or certificate of coverage.
  - Health FSAs if other medical coverage is offered to employees and the FSA generally does not reimburse for more than the lesser of 2x's the employee's deferral or the employee's deferrals plus $500.

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Headline News

Exceptions for Grandfathered and Collectively Bargained Health Plans

Belinda S. Morgan

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Headline News

What is a "grandfathered" plan?

- Health care coverage that existed 3/23/2010 that continues to cover at least one person since that date
- Grandfathered status will continue so long as no impermissible changes are made to the coverage
- Grandfathered status determined for each benefit option provided (HMO, insured, self-insured, etc.)

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Headline News

Grandfathered coverage isn't subject to certain ACA requirements:

- Preventative care coverage
- Nondiscrimination requirements for fully-insured group health plans
- HHS reporting requirements
- New appeals process
- Right to select primary care physician
- Clinical trial participation
- Limits on out-of-pocket costs
- Automatic enrollment

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Headline News

ACA requirements applicable to grandfathered coverage:

- No pre-existing condition exclusions
- No excessive waiting periods
- No lifetime limits/restricted annual limits until 2014
- Limited coverage of dependents until age 26 (but must fully cover such dependents starting in 2014)
- No retroactive rescission, except for fraud
- Must develop & use uniform coverage statements
- Reduction of coverage costs for insured plans
- Record retention/notice requirements

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Permitted changes to grandfathered plan:

- Adding new employees (both new hires and employees not currently covered) and dependents of such persons
- Changes in premiums
- Changes to comply with federal or state requirements
- Changes to TPAs

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Headline News

Prohibited changes to grandfathered plan:

- New policy, certificate or contact of insurance
- Eliminate all or substantially all benefits to diagnose or treat a particular condition
- Increase a P's percentage cost-sharing or co-insurance requirement by any amount
- Decrease employer contribution rate by more than 5% for any tier of coverage (single, family, etc.)

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Headline News

Prohibited changes to grandfathered plan, cont.:

- Increase a P's deductible, out-of-pocket limit, or other fix-cost cost-sharing (other than a co-pay) by more than the "maximum percentage increase" (i.e., medical inflation % + 15%)
- Increase a P's co-pay requirement by more than the greater of (i) $5 (increased by medical inflation) or (ii) the maximum percentage increase
- Certain changes to annual limits
- Transfer new employees to a plan to take advantage of its grandfathered status (anti-abuse rules)

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Headline News

Changes effective after 3/23/2010 will not affect a plan's grandfathered status if made pursuant to:

- A binding contract entered into on or before 3/23/2010
- A state insurance filing made on or before 3/23/2010
- Written plan amendments adopted on or before 3/23/2010

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Headline News

Transition Rule

- Grace period for plan sponsors to revoke prohibited changes made or adopted after 3/23/2010 but before June 14, 2010, that would otherwise cause plan to lose grandfathered status
- The plan will retain grandfathered status if the changes are revoked or modified effective as of the first plan year beginning on or after 9/23/2010 (2011 plan year for calendar year plans)

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Headline News

Rules for Collectively Bargained Plans

- All self-funded collectively bargained plans must comply with ACA's requirements for grandfathered plans, regardless of when CBA terminates
- Otherwise impermissible changes made to an insured collectively bargained plan will not cause it to lose grandfathered status until CBA expires – this rule does not apply to self-funded plans
- In addition, insured collectively bargained plans may change health insurance issuers at any time while the CBA is in effect & not lose grandfathered status at the termination of the CBA (does not apply to changes in issuers made after the CBA terminates)

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Headline News

New Dependent Child Coverage Regulations

IRS Regs. §54.9815-2714T
DOL Regs. §2590.715-2714
DHHS Regs. §147.120

Lloyd J. Dickinson

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Headline News

Covering Children to Age 26

- Effective Date
  - Plan Years beginning on or after 9/23/2010
  - No extended effective date for collectively bargained plans
  - A separate regulation indicates fully insured collectively bargained plans will be treated as “grandfathered” until the last CBA in effect 3/23/2010 expires

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Headline News

Covering Children to Age 26

- A plan that covers children of the participant:
  - May not have a maximum cut-off less than attainment of age 26
  - May only define "child" in terms of the relationship between the child and the parent

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Headline News

Covering Children to Age 26

- As a consequence, may not deny or restrict coverage due to
  - Financial dependency
  - Residence with participant (or anyone else)
  - Student status
  - Employment status
  - Marital status
  - Any combination
  - Or any other way

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Headline News

Covering Children to Age 26

- Coverage may be denied due to other employer coverage, but only:
  - Until the plan year beginning on or after 1/1/2014 and
  - If "grandfathered" and
  - If employer-sponsored
- And even if this denial applies:
  - Cannot deny coverage based upon another parent's group health plan

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Covering Children to Age 26

- This appears to leave open for denial, in addition to the child's own employer's plan, the child's spouse's employer's plan, if spousal coverage is available.

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Headline News

Covering Children to Age 26

- No requirement to cover children, but
- If children are covered, new definition applies
- Cannot be treated differently from similarly situated children
  - No additional premiums, exclusions, co-pays, etc for a 24 year old compared to a 12 year old
  - Cannot limit options, e.g., limit to HMO where others have more choices

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Headline News

Covering Children to Age 26

- There is no definition of child in the Act or the regulations
- IR Code §157(f)(1) defines child to include step-children, in addition to adopted and foster children
- Presumably, the plan could exclude foster children or stepchildren, but that is not clear
- If foster or stepchildren are covered, residence and dependency cannot be a requirement

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Headline News

Covering Children to Age 26

- In addition to children who have "aged-out" this appears to affect coverage of minor stepchildren, since their coverage often involves residency and/or tax dependency
- Again, no obligation to cover stepchildren, but if they are covered, residence, dependency, etc. cannot apply.
- More guidance may be coming

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Headline News

Covering Children to Age 26

- Does not require coverage of grandchildren or spouses of children

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Headline News

Covering Children to Age 26

- Transitional Rule
  - Requires special notice and enrollment for those who “aged-out” or were denied coverage due to age
  - Treated as if continuously covered
  - Does not address stepchild issue

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Headline News

Covering Children to Age 26

- Notice of the enrollment right:
  - Must be provided no later than the effective date
  - Must provide an enrollment period of at least 30 days
  - May be sent to the participant

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Headline News

Covering Children to Age 26

- The Notice Must Include a Statement:
  - Children who were denied or were not eligible for coverage
  - Because of an under age 26 cut off
  - May now enroll
- Model Notice (and other guidance) is available at:
  - http://www.dol.gov/ebsa/healthreform/index.html

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Covering Children to Age 26

- COBRA (36 mo.) is available when the child "ages out" again

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Headline News

ACA Regulations: Annual & Lifetime Plan Limits

Robert E. Goldstein

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Headline News

ACA Regulations: Annual & Lifetime Plan Limits

- General rule: group health plans can't impose annual or lifetime limits on the dollar value of *essential* health benefits (but may on all other benefits)

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Headline News

ACA Regulations: Annual & Lifetime Plan Limits

- Until further guidance, essential health benefits include:
  - ambulatory patient services
  - emergency services
  - hospitalization
  - maternity and newborn care
  - mental health and substance use disorder services
  - prescription drugs
  - rehabilitative services and devices
  - laboratory services
  - preventive and wellness services and chronic disease management; and
  - pediatric services

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Headline News

ACA Regulations: Annual & Lifetime Plan Limits

- For policies that don't now have limits, new rules shouldn't affect future premium rates
- For policies w/ lifetime maximums of $2 million, an industry trade group estimates that premium increases will be less than 1%

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ACA Regulations: Annual & Lifetime Plan Limits

- A plan may exclude all benefits for a condition
- But if any benefits are provided for a condition, then the prohibition regarding annual/lifetime limits applies

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ACA Regulations: Annual & Lifetime Plan Limits

- The elimination of limits applies to both insured and self-insured plans

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Headline News

ACA Regulations: Annual & Lifetime Plan Limits

- Pending the issuance of regulations, in determining what are “essential health benefits,” a good faith interpretation of the term will be acceptable
- Until new guidance issued, it appears that a plan may be able to limit the number of visits or impose per procedure dollar limits; as now drafted, the regulations do not address this issue

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Headline News

ACA Regulations: Annual & Lifetime Plan Limits

- Phase-in of annual limits until 2014
  - For plan or policy years beginning on or after 9/23/2010 but before 9/23/2011: $750,000 minimum
  - For policy or plan years beginning after 9/23/2011 but before 9/23/2012: $1.25 million minimum
  - For policy or plan years beginning after 9/23/2012 but before 12/31/2013: $2 million minimum
  - For policy or plan years beginning after 1/1/2014: no dollar limit

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ACA Regulations: Annual & Lifetime Plan Limits

- Because these are minimums, a plan may choose a higher limit or no limit during the transition period
- HHS may waive compliance with the unlimited annual limits if it determines that compliance likely could result in significant decreases in access to benefits or significant increases in premiums; HHS is expected to soon issue rules for requesting these waivers

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Headline News

ACA Regulations: Annual & Lifetime Plan Limits

- Notice and enrollment requirements
  - If prior claims exceeded the plan's lifetime limits, but employee is otherwise still eligible, the plan must notify the employee that the plan limits no longer apply
  - If the employee is no longer enrolled, the plan must offer the person the right to re-enroll (person must then be treated as if he were a new employee)
  - The person must be offered all of the benefit packages available to, and cannot be required to pay more than, similarly situated individuals who did not lose coverage as a result of imposition of lifetime limits under the plan
  - The Dept of Labor has prepared a model notice that may be used by plans to notify affected individuals of their reenrollment rights
  - The plan must inform the person that they have at least 30 days in which to enroll

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Headline News

ACA Regulations: Annual & Lifetime Plan Limits

- The prohibition of lifetime limits as well as annual limit restrictions applies even to grandfathered group health plans
- The notice and enrollment rights must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010; coverage must also begin by that date

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ACA Regulations: Annual & Lifetime Plan Limits

- The regulations provide that the new lifetime and annual rules do not apply to health care flexible spending account plans, health savings accounts, or retiree-only health reimbursement arrangements
- Effective date of new annual and lifetime limits: plan years beginning on or after September 23, 2010

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Headline News

Preexisting Condition Exclusions

Katherine L. Aizawa

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Headline News

What is a Preexisting Condition Exclusion (PCE)?

- Limitation, exclusion or denial of a benefit
- Due to a condition present before either the first day of coverage or the date of the denial
- Regardless of whether or not any medical advice, diagnosis, care or treatment was recommended or received
- Prior condition disclosed in enrollment questionnaire, physical exam, or review of past medical records

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Headline News

ACA Requirements - Effective for 2011 Plan Year

- A plan cannot impose a preexisting condition exclusion on any covered individual who is under age 19
- Applies to employees and dependents
- Grandfathered plans must comply

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Headline News

Example of How to Coordinate with HIPAA PCE Rule

- October 15, 2010: Frank and Lois, his 16 year old daughter, join plan.
- Before joining, Frank and Lois had a significant break of more than 63 days where they had no health plan.
- Lois was treated for asthma in the 6 months before October 15 and the plan has a 12-month PCE for asthma.
- For remainder of 2010, Lois's asthma treatments are not covered.
- Effective January 1, 2011, plan has to cover Lois's asthma treatments.

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Headline News

ACA Requirements - Effective for 2014 Plan Year

- A plan cannot impose a preexisting condition exclusion on **any** covered individual

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Headline News

First Dollar Preventive Care Coverage

Katherine L. Aizawa

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Headline News

- Grandfathered plans are exempt
- Effective January 1, 2011 for calendar year plans
- Expires on July 12, 2013, or earlier if announced by Federal government

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Headline News

What Are Preventive Care Services?

- http://www.HealthCare.gov/center/regulations/prevention.html
- Evidenced based items or services with an A or B rating
  - ✓ Colonoscopies between ages 50 and 75
  - ✓ Stop smoking programs
- Routine immunizations for children, adolescents and adults
  - ✓ Measles, mumps, influenza
- Evidenced informed care and screenings for infants, children and adolescents
- Evidence informed care and screening for women; guidance expected to be issued no later than August 1, 2011

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Headline News

Preventive Care Cost Sharing Rules

- "Cost sharing" is copays, coinsurance or deductibles
- Whether or not cost sharing can be applied to preventive care depends upon if:
  - ✓ care is billed separately from the office visit and
  - ✓ the primary reason for the office visit

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Headline News

Preventive Care Cost Sharing Rules Cont'd

- **When cost sharing can be applied to an office visit**
  - ✓ Preventive care is billed separately (or is "tracked as individual encounter data separately"*) from office visit
    - Plans that use capitation or similar pay arrangements that do not bill individually for items/services
  - ✓ Preventive care is not billed separately and primary purpose of office visit is not the preventive care

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Headline News

Preventive Care Cost Sharing Rules Cont'd

- **When cost sharing <u>cannot</u> be applied to an office visit**
  - ✓ Preventive care is <u>not</u> billed separately (or is not tracked as individual encounter data separately) from office visit and primary purpose of visit is the preventive care

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Preventive Care by Out-of-Network Providers

- Plan is not required to cover preventive care provided by an out-of-network provider
- If covered, Plan can impose cost sharing

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Headline News

Reasonable Medical Management Allowed

- Plan/insurer can use for frequency, method, treatment to set coverage limits
- For listed preventive care for which cost sharing is waived and which have no recommendations about frequency, method, or treatment

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Headline News

Plans Can Be More Generous

- Plans/insurers have the option to cover preventive care which is not on list
- Cost sharing can apply to such covered care

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Headline News

New Recommended Preventive Care Services/Items

- Plans must cover new services the first plan year beginning one year after a service/item appears on the list
- List is found at http://www.HealthCare.gov/center/regulations/;revention.html
- List will be updated and will include the date on which a new service/item is listed

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Headline News

"Unlisted" Preventive Care Services/Items

- Plans/insurers can opt to continue coverage or impose cost sharing for any item/service that ceases to be a recommended preventive service
- Warning: ACA requires plan/insurer to provide 60 days advance notice to enrollees before effective date of any material change

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Headline News

Limitations on Rescissions

Leigh C. Riley

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Headline News

Limitations On Rescissions

- Applies to fully-insured and self-insured group health plans
- Applies to grandfathered plans
- Effective for plan years beginning on or after September 23, 2010
- Sets “floor” – for fully insured or non-ERISA plans, State law may further restrict rescissions

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Headline News

Limitations On Rescissions

- Rescission means a **retroactive** termination of coverage
- Not considered rescission to cancel coverage prospectively or retroactively terminate for failure to pay premiums
- May rescind only for:
  1) fraud [*material false statement with an intent to deceive, reliance by plan and damages*] or
  2) intentional misrepresentation of material fact

"as prohibited by the terms of the group health plan coverage"

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Headline News

Limitations On Rescissions – Notice

- Must provide at least 30 days advance notice prior to rescinding
  - Because prospective termination is OK, can immediately cut off coverage
- Gives individuals opportunity to contest or find alternative coverage
- Notice provided to each individual who would be affected
  - All family members?
- No model notice provided

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Headline News

Patient Protections

Leigh C. Riley

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Headline News

Patient Protections

- "The Patient Bill of Rights" applies to fully-insured and self-insured group health plans, **but not grandfathered plans**
  1) Primary provider choice (only applies to plan with network of providers)
  2) No referral for OB/GYN services (only applies to plan with network of providers)
  3) Emergency services
- Effective for plan years beginning on or after September 23, 2010

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Headline News

Primary Provider Choice

- If plan requires designation of primary care provider, must allow:
  - each individual to designate any participating primary care provider
  - each child to designate any in-network pediatrician

  who is available to serve as that individual's primary care physician
- Must provide notice to participant with SPD or other description of benefits

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Headline News

Primary Provider Choice – Model Notice

[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].

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

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Headline News

No Referral For OB/GYN Services

- If plan requires designation of primary care physician and covers OB/GYN services, cannot require authorization or referral to OB/GYN in-network provider (including non-physician)
- Must provide notice to participant with SPD or other description of benefits

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Headline News

OB/GYN Services – Model Notice

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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Headline News

Emergency Services

1) Cannot require pre-authorization
2) Cannot exclude if provided out-of-network
3) Cannot have more restrictive administrative requirement or limitation for out-of-network than in-network
4) Out-of-network must be subject to same co-pay and co-insurance as in-network
   - Can require different deductible, but out-of-network emergency payments must count towards general out-of-network deductible

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Emergency Services

5) Covered without regard to any other term or condition, except for
   - Exclusion of, or coordination of, benefits
   - Application of waiting period
   - Application of cost sharing

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Headline News

Emergency Services

6) For out-of-network, plan must reimburse the highest of:
   - negotiated in-network provider rate (or median if multiple rates)
   - normal rate for out-of-network, such as "usual, customary and reasonable amount"
   - Medicare Part A or B reimbursement amount

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Headline News

Internal Claims and Appeals Processes & External Reviews

Leigh C. Riley

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Headline News

Internal Claims And Appeals Processes

- Applies to self-insured and fully-insured group health plans
- **Does not apply to grandfathered health plans**
- Effective for plan years beginning on and after September 23, 2010

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Headline News

Internal Claims And Appeals Processes

- Adopts existing ERISA claims and appeals procedures with 6 changes
  1) Adverse benefit determination includes rescissions
  2) Urgent care benefit determination must be made w/in 24 hours (instead of 72)
     - Exception for lack of information
  3) Must disclose to claimant sufficiently in advance of decision on appeal to allow claimant to respond:
     - Any new or additional evidence considered, relied upon, or generated by the plan
     - Any new rationale for the denial

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Headline News

Internal Claims And Appeals Processes

4) Expanded information in claim or appeal denial notice
   - Date of service
   - Name of health care provider
   - Claim amount (if applicable)
   - Diagnosis code/treatment code and meaning of these codes
   - Denial code and meaning of the code
   - Standard used to deny the claim, if any (e.g., description of medical necessity standard)
     - If appeal notice, discussion of the decision
   - Description of appeal process, including how to initiate
   - Availability of, and contact info for, health insurance consumer assistance or ombudsman
- DOL promised to provide model notice soon

Headline News

Internal Claims And Appeals Processes

5) Criteria to avoid conflicts of interest
   - Cannot hire or reward decision-makers based on denials
6) Failure to **strictly adhere** allows claimant to jump to external remedy (including lawsuit)
   - For ERISA plans, presumed no deference given to plan administrator decision

Headline News

External Review Processes

- Determine whether State external review requirements, if any, apply
  - Fully-insured plans (insurance company responsible)
  - Non-ERISA plans
- If State external review requirements do not apply, or if they do not provide certain minimum consumer protections, then Federal laws apply
- For plan years beginning before July 1, 2011, State external review processes deemed compliant

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Headline News

Federal External Review Processes

- Applies to adverse benefit determinations, other than eligibility/participation
- Federal external review process standards not finalized, but will cover such items as:
  - Which claims are subject to external review
  - How external review can be initiated by claimant
  - Who can be the external reviewer
  - Additional notice requirements about the external review process

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Headline News

Culturally And Linguistically Appropriate Notices

- Plan < 100 participants on 1st day of plan year = upon request, must provide notice in non-English language if 25% or more of participants are literate in the same non-English language
- Plan > 100 participants on 1st day of plan = upon request, must provide notice in non-English language if lesser of 500 or 10% of plan participants are literate in the same non-English language
- For either of above:
  - must include prominent statement if such non-English language of availability of non-English notice
  - if receive request, everything thereafter must be in non-English language
  - customer assistance must be available in non-English language

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Employee Benefits Broadcast

Questions

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Employee Benefits Broadcast

Mark Your Calendar

- The final session of the 2010 Employee Benefits Broadcast Series will take place on:
  - October 26, 2010

Employee Benefits Broadcast

Thank You

- A copy of the PowerPoint presentation and a multimedia recording will be available on Foley's website within 24 to 48 hours:

  http://www.foley.com/news/event_detail.aspx?eventid=3022

- We welcome your feedback. Please take a few moments before you leave the web conference today to provide us with your feedback:

  http://www.zoomerang.com/Survey/WEB22AZPQHDJJ8

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