The Patient Protection and Affordable Care Act (PPACA)

Health Care Reform

Effects on the Wood County Employee Health Benefits Plan

Employee Health Benefits Committee
August 19, 2010

Health Care Reform

- Federal Law (PPACA) and State Law
- Focus only on provisions that apply to our Plan
  - Governmental, self-insured, non-ERISA plan
- Additional clarification as available

Includes:

Timelines
Grandfathered Status
2010 Changes – Eligibility
Projected Impact on Plan
Implementation Process
Action Items

Patient Protection and Affordable Care Act

- H.R. 3590: Public Law No: 111-148
- Largest Bill in History
- Various Implementation Dates:
  - Initial Effective Date: January 1, 2011
    (Plan year on or after September 23, 2010)
  - Eight Year Implementation Timeline: marathon not sprint
  - Collective Bargaining: Bill supersedes negotiations
- Applies to health and prescription coverage only

State Legislation: H.B. 1

- Passed in 2009
- Effective January 1, 2011 for Health and Prescription coverage only plan
- Changes Eligibility

PPACA Timeline

Year	Action	Applies to Grandfathered Status
2010	▪ Change in federal tax definition of dependent to the end of the calendar year in which dependent turns 26	Yes
	▪ Break time/private room for nursing moms	Yes
2011	▪ Dependent coverage to 26 using new definition for eligibility	Yes
	▪ No lifetime dollar limits on essential health benefits	Yes
	▪ Restricted annual dollar limits on essential health benefits	Yes
	▪ No pre-existing condition limitations for children up to age 19	Yes
	▪ No rescissions – 30 day notice required	Yes
	▪ Voluntary long-term care "CLASS"	Yes
	▪ Disclosure of plan data	No
	▪ Appeals process notice	No
	▪ Flexibility in provider choice and emergency room	No
	▪ No charge for certain wellness benefits	No
	▪ Minimum medical loss rule (not for self insured plans)	Yes
	▪ Mental Health Parity (non PPACA)	Yes

PPACA Timeline

Year	Action	Applies to Grandfathered Status
2012	▪ Employers must distribute uniform benefits summaries to participants ▪ Employers must provide 60-day advance notice of material modifications (notice TBD) ▪ Form W-2 reporting for 2011 health coverage	**Yes** **Yes** **Yes**
2013	▪ Research fees begin ▪ Notice of availability of Health Insurance Exchange	**Yes** **Yes**
2014	▪ Health insurance exchanges ▪ Free-choice vouchers (Employer penalties – 30 hour rule: No) ▪ Additional reporting and disclosure ▪ Dependent coverage to age 26 for any covered employee's child ▪ No annual dollar limits on essential benefits ▪ No pre-existing condition limits ▪ No waiting period over 90 days ▪ HIPPA wellness limit increases ▪ Annual cost sharing and deductible limits	**Yes** **Yes** No **Yes** **Yes** **Yes** **Yes** No **Yes**
2018	▪ High Cost Coverage Reporting	
TBD	▪ Auto – Enrollment Notice: Identify minimum coverage (Single Health/Prescription if no election to opt out)	

“Grandfathered” Status

Group health plans that were in force on March 23, 2010, have “grandfathered” status.

Permissible Changes:
No loss in “Grandfathered” status

- Increased premium
- Changes required to comply with federal or state law
- Changes to voluntarily comply with provisions of PPACA or to increase benefits
- Changes to a third party administrator
- Adding, changing or deleting enrollees
- Voluntarily adding benefits

Impermissible Changes:
Will cause loss in “Grandfathered” status

- Terminate entire current benefit package
- Elimination of benefits in current plan
- Decrease in employer/employee rates
- Increase in deductible
- Increase in coinsurance
- Increase in out-of-pocket maximum
- Increase in co-payment (service fees)
- Changes in annual limits

Unknown at this time…

- Changes to prescription drug formulary
- Changes to self-insured plan network

Loss of Grandfathered Status

- Terminate Entire Current Benefit Package
  - Elimination of plan
- Elimination of Benefits in Current Plan
  - Benefits to diagnose or treat a particular condition
- Decrease in Employer/Employee Rates
  - Employer or employee contributions toward the cost of any tier of coverage for any class of similarly situated individuals are decreased by more than 5% below the contribution rate (the percentage of employer contributions towards the total cost of coverage) for the coverage period that includes March 23, 2010.
  - Current Premium: 90% Employer – 10% Employee
- Increase in Deductible
  - Fixed-amount cost sharing requirements (e.g., deductibles) are increased more than medical inflation (CPI-U from March 23, 2010) plus 15%
  - Current Deductible: $150/$450 – In Network

ACTION ITEMS

- Consideration of federal restrictions for future plan design changes
- Note grandfathered status in Plan Document (PD) and Summary Plan Description (SPD)
- Revise PD and SPD to provide federal contact information

Loss of Grandfathered Status

- Increase in Co-Insurance
  - 80%-20% in-network, 60%-40% out-of-network
- Increase in Out-of-Pocket maximum
  - Fixed-amount cost sharing requirements are increased more than medical inflation (CPI-U from March 23, 2010) plus 15%
  - Current Maximum: $250/$750 – In Network
- Increase in Co-Payment
  - Fixed-amount co-payments (e.g. service fees) are increased more than the greater of medical inflation (CPI-U) plus 15% or $5
  - Current Co-Payment: $10 Dr.; $35 ER
- Changes in Annual Limits
  - If the plan did not have an overall annual or lifetime limit, annual dollar limits cannot be added.
  - If the plan had an overall lifetime dollar limit, but no overall annual dollar limit, the plan cannot adopt an overall dollar limit that is lower than the dollar value of the lifetime limit.
  - If the plan had an overall annual dollar limit, the plan cannot decrease the dollar value of the annual limit.
  - Current Lifetime Limit: $1 M

ACTION ITEMS

- Remove lifetime from essential benefits
- Review annual limits for change
  - $500 Physical/Wellness benefit (includes Child Health Supervision Services - CHSS)
- Add annual limit of $1 million on non-essential benefits
- Update PD and SPD on all other changes

No Rescissions

- Prohibits the rescission of health coverage except in the case of fraud or intentional misrepresentation of a material fact who is otherwise eligible.
- Applies to self-insured plans.
- Does not prohibit coverage from being cancelled on a prospective basis
- Does not prohibit coverage from being cancelled retroactively if the cancellation is attributable to a failure to pay required premiums or contributions
- Requires 30 days advance notice of a rescission, when still permitted

ACTION ITEM

- Revise Plan Document and Summary Plan Description

It is not intended to restrict the right of a group health plan to remove from coverage any individual who is ineligible because he or she does not satisfy the plan's eligibility provisions.

No Pre-Existing Condition Exclusions up to Age 19

- Prohibits the exclusion of coverage of specific benefits associated with a pre-existing condition
- Prohibits a complete exclusion from the plan if based on a pre-existing condition
- Leaves unchanged the existing rule under Health Insurance Portability and Accountability Act (HIPAA) that permits an exclusion of benefits for a condition if the exclusion applies regardless of when the condition arose relative to the effective date of coverage
- Applies to grandfathered plans, except for grandfathered individual policies

ACTION ITEM

- Revise Plan Document and Summary Plan Description

No Lifetime Dollar or Annual Dollar Limit on Essential Benefits (TBD)

- PPACA provides that Health and Human Services will define what constitutes Essential Health Benefits. *
- Good faith interpretation is acceptable until further guidance is provided.
- Cannot impose lifetime dollar limits on individual coverage, but the following per-beneficiary limits are permitted:
  - Impose annual dollar limits that cap essential health benefits at or above $750,000, $1.25 million and $2 million over the next three consecutive plan years
  - Can impose lifetime limits on specific non-essential benefits coverage

ACTION ITEM

- Work with Meritain on clarification
- Review annual limits for changes, e.g., $500 physical/ wellness benefit
- Add annual limit on essential benefits of $1 million

* Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services; including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Changes to Dependent Eligibility

- Coverage available birth to age 26 (Adult child to 26th birthday)
  - Biological son or daughter
  - Adopted son or daughter (includes placement for adoption)
  - Step son or daughter
  - Eligible foster child
- Cannot condition eligibility on
  - Student status
  - Marital status
  - Residence with employee
  - Financial dependence on employee
  - Coverage by other parent
- No requirement to cover
  - if "eligible" for other employer sponsored group health plan
  - the spouse of dependent
  - the child of dependent

Federal Rules

Applies to Health and Prescription Coverage Only

ACTION ITEMS

- Change eligibility rules in Plan Document and SPD
- Coverage changes effective first of month following permitted eligibility changes (TBD)

Changes to Dependent Eligibility

- Coverage available for until age 28 if
  - Unmarried
  - Natural child, step child, or adopted child of employee
  - Resident of Ohio or a full-time student at an accredited public or private institution of higher education
  - Not employed by an employer that offers any health benefit plan under which the child is eligible for coverage
  - Not eligible for coverage under Medicaid or Medicare
- Other Considerations
  - Older age child does not have to live with the parent, be financially dependent upon the parent or be a student.
  - Federal tax status changed to “end of the year in which they turn 26”
  - May charge adult child premium

State Rules

Applies to Health and Prescription Coverage Only

ACTION ITEMS

- Implement funding for State eligible Adult Children (ages 26 & 27)
- Create Adult Child Premium
- Review rules for Section 125 Special Enrollment Rights
- Meet with internal/external accountants

Tax Implications for Employees

- Employer is required to report value of health care on W-2 for 2011 calendar year
- Federal to end of calendar year turn 26: IRS Notice 2010-38 issued April 27
- Status of reporting state's adult child coverage (TBD)
- Pretax limit to $2,500 in 2013
- Employer penalties for non-grandfathered plans

Projected Impact on Rates for Health and Prescription Based on Federal Changes

Change to Plan*	% of Rate Increase	
Source	AON	Employee Benefit News
Lifetime Maximum	.5 to 1%	
Dependent Eligibility to Age 26	1 to 4%	
Removal of Pre-Existing Condition up to age 19	< .5%	
Minimum Requirements	.5 to 2%	
Estimated % of Increase	7.5% Max	13% Max
Increased Cost based on 2009 Plan Year	$434,243	$735,355

*Does not account for medical inflation, carrier rate changes, etc.

2009 Plan Costs (Health & RX): $5,656,584

Projected Impact on Eligibility for Health and Prescription Based on Federal Changes

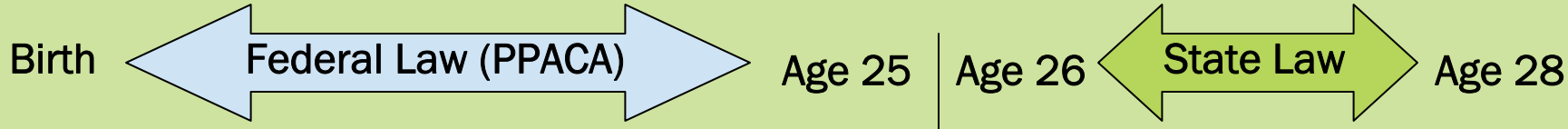
Year	Dependents Age 19 – 23 Removed from Coverage
2010	25
2009	28
2008	23
2007	29
2006	28
2005	27
2004	13

Estimated Eligible Overage Dependents*: 173 +

Does not account for other eligibility status changes for those age 19 and under, e.g., stepchildren, tax exemptions, non-qualified medical child support notices.

*Dependents were removed due to loss of eligibility because of marriage, employment, tax exemption status, residency, financial status, student status, national medical child support notices, etc.

Changes for Dependent Eligibility: Health and Prescription



ELIGIBLE: Biological son or daughter Adopted son or daughter (includes placement for adoption) Stepson or daughter Eligible for foster care NOT ELIGIBILE: if "eligible" for other employer sponsored group health plan the spouse of dependent the child of dependent	ELIGIBLE: Natural, step, or adopted child of employee Resident of Ohio or a full time student Not employed by an employer that offers any health benefit plan Not eligible under Medicare or Medicaid Adult Child Rate Applies

Dependent Eligibility: Vision and Dental

Birth — Current Plan Rules — Age 18 | Age 19 — Plan Rules — Age 23

- Natural, legally adopted children or children placed in anticipation of adoption who are:
  - Unmarried
  - Not employed on a regular full time basis
  - Not covered under the Plan as an employee
  - Dependent on the covered employee or the covered employee's Spouse for more than 50% of their financial support
  - Dependent claimed for tax exemption purposes under Section 152 of the Internal Revenue Code
- Includes a stepchild or child under legal guardianship of a covered employee or covered employee's spouse who:
  - Meets all the requirements listed above
  - Lives in the covered employee's home for more than half of each calendar year in a regular parent-child relationship
  - Is wholly dependent on the covered employee for financial support
  - Is claimed by the employee as a dependent for tax exemption purposes under Section 152 of the Internal Revenue Code

- Full time student at an accredited school until the end of the calendar year in which they reach the limiting age of 23
- Full-time student coverage continues only between semesters/quarters if the student is enrolled as a full-time student in the next regular semester/quarter.
- Student Certification Process

Implementation Process

- Provide mandated 30 day notice (Transition Rule) before January 1, 2011, to enroll in Plan
  - Those who reached lifetime maximums
  - Those who meet new eligibility rules
    - HIPAA Special Enrollment rules apply
- Coordinate this with current Open Election Period November 15 to December 15, effective January 1
  - Distributing written SPD to members by November 1
  - Required signature receipt of SPD

Implementation Process

- Develop eligibility verification process to determine eligibility
  - "Eligible" for other employer sponsored group-like coverage
- Changes to the Annual Certification Process in 2010 and on-going
  - Student Certification/Spousal/OBRA, etc.

The Plan Document supports requests for proof of eligibility at any time.

Examples of Current Documentation Requested: Student Certification, National Medical Support Notices, Divorce Decrees, Tax Forms for Spousal Certification, Letters from Employers documenting gain or loss of eligibility/employment

Other Action Items

- Require Insurance Group Rep participation at annual meeting on October 20 at 9:30 a.m. in the Commissioners' Hearing Room
- Require Employee participation in annual meetings on November 17 & 18
- Summary of information to be posted on website and future newsletters
- Offer question and answer period sessions
  - Tentatively: November 23 at Office Building at 10 a.m.
    November 30 at Health Dept at 10 a.m.

Feedback on Action Items

- Recommendation:
  - Offer New Hire Insurance Orientation for Employee and Insurance Group Rep as pilot
    - e.g., 2nd and 4th Wednesday of month
- Encourage use of electronic application to offer logic on eligibility
- Encourage communication of SPD or link to website during interview/selection process