HUMAN RESOURCE ASSOCIATES

HR Consultants to Management

PERSONNEL NOTEBOOK

For Your Most Important Resource

HEALTH CARE REFORM

Part I

What Do We Have to Do and When Do We Have to Do It?

After more than a year of intense politicking, the controversial health care reform legislation is now the law of the land. Although most of us have come down firmly on which side we favor, (it's either the American thing to do, or it's the start of socialism), the fact is we really don't know all we need to about this law or even if it will remain the law of the land. We do know it comes to us with two names. The primary law is called The Patient Protection and Affordable Care Act (PPACA). The lesser law (in that it makes minor changes to the primary act) is called The Health Care and Education Reconciliation Act (HCERA). Some of this goes into effect immediately and some doesn't go into effect until as late as 2018.

Every week since its passage, it seems that new surprises keep popping up from among this legislation's 1,900 pages. As one politician put it, "We have to pass the bill to find out what's in it." As much of the law comes into effect over the next several years, we will likely have many more surprises and new interpretations as it unfolds. In addition, 20 states have passed state laws against the enforcement of the health care law. Many have joined with the National Federation of Independent Businesses in filing a lawsuit seeking to declare the law unconstitutional, in part because it forces Americans to buy a consumer product they may not want, or pay a fine. A hearing date has been set for the lawsuit.

Whatever happens with the lawsuit, it will not likely stop enforcement of the law this year. So what do we know about the law, or, better yet, what do we have to do and when do we have to do it? Here are the highlights.

2010

January 1 — Employer Tax Credit: Employers with less than 25 full-time equivalent employees, (equivalent means that every 2,080 hours equals one employee whether full-time, part-time, or temporary; hours for seasonal employees are not counted) may be eligible for a tax credit of from 35 percent to 50 percent of the costs. Nonprofit organizations may be eligible for 25 percent to 35 percent.

March 23 — Breastfeeding Breaks and Facilities: All employers are required to provide reasonable, unpaid break time for nursing mothers to breastfeed their babies up to one year of age. This includes providing a suitable place (not a bathroom) in which to do so. Companies with fewer than 50 employees may be excused from compliance if they can establish that it causes significant difficulty or expense.

June 21 (and ending January 1, 2014) — **Early Retirees Coverage:** Employees who retire before they are age eligible for Medicare, are at least 55 years of age, and have exhausted their COBRA benefits, and their dependents, may obtain coverage from their former employer's insurance carrier for up to 80 percent of their medical services costing from $15,000 to $90,000. The insurance carriers must apply for this reimbursement which may not be used for profit or to lower the employer's cost of the plan. The amounts received must be used to lower participant's premiums, co-payments, and other out-of-pocket expenses.

July 1 — Grants for Wellness Plans: Employers with fewer than 100 employees who work at least 25 hours a week will be eligible for grants to offset some the costs incurred for qualified wellness programs. Note that wellness costs must be separated from health care costs since the grants only apply to wellness programs. These programs must be available to all employees, but employee participation must be voluntary. Financial rewards may be provided to employees who choose to participate, but awards may no longer be tied to premium reductions or cost-sharing amounts. Such programs must include the following components:

- A health awareness component, which may consist of health education, private screenings, and health assessments.
- An employee engagement component, which provides for the active engagement of employees through work site assessments and program planning, and on-site delivery, evaluation, and improvement efforts.
- A behavioral change component, which encourages employees to adopt healthy lifestyles through counseling, seminars, online programs, and self-help materials. These programs may be aimed at tobacco use, obesity, stress management, physical fitness, nutrition, substance abuse, depression, and mental health promotion.
- A supportive environment component, which includes having company policies that promote healthy lifestyles by banning tobacco use, making nutritious food available in cafeterias and vending machines, minimizing stress and promoting positive mental health, and encouraging employees to be physically active during and after work hours.

September 23 — (For plan years beginning September 23 or later) **Grandfathered Plans:** Those companies that were already providing health care coverage on March 23, 2010, are exempt from many of the regulations that follow. Their benefit plans are called "grandfathered plans." They may continue to enroll new employees in their plans. New regulations are being prepared to further define such plans and their requirements. However, even grandfathered plans must still comply with all of the following listed requirements:

- Coverage for children until age 26
- No pre-existing health exclusions
- No lifetime maximums
- No annual maximums after 2014
- No rescission of coverage

Coverage for Children up to Age 26: All benefit plans must offer coverage to employees' children up to age 26. The children do not have to be in school, live at home, or even be dependents of the employees. They may even be married and living in another state. However,

their children (employees' grandchildren) need not be covered. Plans may also charge higher premiums for dependent coverage but may not charge more because of the higher age. Also, if an employee's child was previously dropped from coverage because of age, the employer must now notify the employee of the opportunity to gain coverage. Note that grandfathered plans must provide such coverage but *not* if these children are eligible to be covered by another plan other than the parent's plan.

No Lifetime Limits: Group health plans may no longer impose lifetime limits on benefits. They may, however, impose annual limits based on the dollar value of the essential health benefits they provide. (The dollar amounts will be determined later by the federal government.)

Those essential health benefits to which annual limits may still be applied are identified as:

- Preventive services with no deductibles, wellness services and chronic disease management
- Emergency services without prior authorization or network affiliation
- Ambulatory patient services
- Hospitalization
- Maternity and newborn care
- Rehabilitative and habitual services
- Pediatric services, including dental and vision,
- Prescription drugs
- Laboratory services
- Mental health and substance abuse services, including behavioral health treatments

Note that this does not mean that employers must provide these benefits. It means that if an employer does provide them, they may still requires annual limits on the amount that will be provided for them.

In any case, all annual limits must end beginning in 2014.

No Pre-Existing Conditions: Group health plans may not impose pre-existing exclusions on enrollees who are under the age of 19. All pre-existing conditions must disappear by 2014.

May Not Cancel Coverage: Except in cases of fraud, neither insurance carriers nor employers may rescind or cancel coverage being provided to enrollees.

No Cost Sharing for Preventive Care: Plans must provide preventive health services (immunizations, screenings, preventive care) with no cost sharing for children or women. Adult males may be required to pay. Grandfathered plans do not have to comply.

No Discrimination Favoring Higher Paid Employees: Group plans (but not self-insured plans since they are already covered) are prohibited from limiting eligibility for coverage to executives and other high-paid employees. If the plans do so discriminate, the amount considered to be excessive will be fully taxable.

Other Coverage Requirements:

- Plan participants are allowed to choose any primary care provider.
- Plans participants may not be required to obtain prior authorization or referrals for visits to obstetricians or gynecologists.
- Obstetricians and gynecologists must be treated as primary care providers.
- Plans must provide emergency care services without prior authorization and with the same cost sharing in or out of network.
- Plans must provide coverage for cost of participation in a clinical trial.

2011

January 1 — No More Reimbursement for Over-the-Counter Drugs From Health Savings Accounts (HSA): Employees may no longer be reimbursed for over-the-counter drugs from their HSAs, Flexible Spending Accounts (FSAs), or Archer Medical Savings Accounts (MSAs).

Tax Increase on Unused HSAs and MSAs: The tax on distribution from a HSA or an MSA that is not used for qualified medical expenses will increase to 20 percent.

Health Benefits to Be Included on W-2s: Employers are required to report on the employee's W-2 statement, the total cost of employer-provided, group health coverage that is otherwise not included in the employee's gross income.

CLASS Act: The Community Living Assistance Services and Support (CLASS) Act will provide a new national insurance program for purchasing community living assistance services. This program provides individuals who have functional life limitations with the tools that will allow them to maintain their personal and financial independence to live in their community. This is accomplished through financing strategies for community living assistance services that will alleviate burdens on family caregivers. Employers are encouraged to participate in the CLASS Act by adopting enrollment processes that will automatically enroll employees into the CLASS Act.

Simple Cafeteria Plans for Small Businesses: The IRS will allow simple cafeteria plans for small businesses (defined as employers with an average of 100 employees or less during one of the previous two years). The allowance will include a safe harbor from the non-discrimination requirements. If a business qualifies, it can retain the small business status until it employs an average of 200 or more employees for one year.

March 23, 2011 — Simplified Language Benefit Policies: All group plans (including self-insured and grandfathered plans) must be written in a manner that explains the summary of benefits and of the coverage that is clear and easy to understand. It must describe any cost sharing, exceptions, reductions, and limitations on coverage. It must include examples or anecdotes to illustrate common benefit scenarios. Enrollees must be provided with the policy contract number and a phone number to call for questions. Also included must be a Web site where the group certificate is posted. In the event of any plan changes, the enrollees must be given notice 60 days in advance. Failure to comply with this provision may lead to a fine of $1,000 per enrollee. Effective March 23, 2012, each enrollee must be provided a copy of this summary.

July 1 — Simplified Language Health Coverage Administration: A document establishing a single set of operating rules for eligibility verification and claims status must be adopted to take effect on January 1, 2013.

2012

March 23 — Annual Quality of Care Reports: Group plans and health insurance issuers must create a structured program designed to assume responsibility for the outcomes of the enrollee's health benefits. The program must be a strategic, comprehensive system of activities that is intended to improve the health and wellness of enrollees. Such activities include:

- Effective case management
- Care coordination
- Chronic disease management
- Medication and care compliance initiatives

- A comprehensive discharge planning program to prevent hospital readmissions
- Post-discharge planning and reinforcement by qualified health care professionals
- Improved patient safety and reduced medical errors through appropriate use of clinical practices, evidence-based medicine, and health information technology.
- Improved quality of medical reporting

Plans and insurers must report annually whether the benefits under the health coverage satisfy these requirements.

July 1 — Simplified Language Health Coverage Administration: Rules for electronic transfer of funds and health care payment and remittance must be adopted to take effect on January 1, 2014.

2013

January 1 — Medicare Tax Increase: Medicare part A (hospital insurance) tax rate on wages increases from 1.45 percent to 2.3 percent on earnings of more than $200,000. Assorted other tax increases related to Medicare will also become effective.

FSA Contribution Limit: Contributions to an FSA for medical expenses are limited to $2,500 per year.

Elimination of Tax Deduction for Part D Medicare: The tax deduction for employers that receive Medicare part D retiree subsidy is eliminated.

March 1 — Employers Are Required to Inform Employees of New Insurance Exchange: With the creation of the new state health insurance exchange, employers are required to inform all existing and new employees (upon hire), in writing, of the existence of their state's exchange and how they may contact it to request assistance. If the employer and employee meet requirements (too small to provide minimum coverage requirements or financially unable to pay premiums), the employee may obtain insurance through the exchange.

In part II of Health Care Reform, we will review the mandate for individuals to acquire health insurance, the penalties for individuals and employers, and automatic enrollment requirements up through 2018.

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