CONNER STRONG & BUCKELEW

National Healthcare Reform Update

Webinar: Wednesday, June 29, 2011
11:00 am – 12:00 pm EDT

Today's Speakers

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National Healthcare Reform

The Patient Protection and Affordable Care Act ("PPACA" or the "Affordable Care Act"), as amended by the Health Care and Education Affordability Reconciliation Act of 2010

- Passed March 2010
- Government agencies continuing to release regulations and guidance with more to come over the coming months and years
- Massive government bureaucracy needed to administer the law
- According to the Congressional Research Service, it is impossible to know the number of agencies, boards and commissions that will be created under healthcare reform.

Your New Health Care System

President

Congress

IRS

Treasury Department

PCORI

IPAB

Secretary
Health & Human Services

CMS

Medicare

Medicaid/ CHIP

Essential Health Benefits Package

Government Health Benefit Exchanges

Health Insurance CO-OP

Physicians

Patients

Labor Department

Justice Department

Social Security Administration

Office of Personnel Management

CDC

NIH

GAO

Employers

Individuals

Health Insurance Companies

Health Industry

Individual Mandate Buy Health Insurance

Employer Mandate Provide Health Insurance

Insurance Mandates

New Government

- Rationing Potential
- Involvement in Health Insurance Market
- Other Expansions
- Represents Bundles of Additional Entities
- Mandates
- Taxes & Monetary Fees/ Penalties/Cuts
- Trust Fund (Rationing Potential)
- Other New Trust Funds/ Monetary Benefits

Expanded Government

- Government with Expanded Authority/ Responsibility
- Government Financial Entity with New Inflows/ Outflows
- State/Territory with Expanded Authority/ Responsibility

Private

- Private Entity with New Mandates/ Regulations/ Responsibilities
- Unchanged Private Entity
- Special Interest Provisions

New Relationships

- Regulations/ Requirements/Mandates
- Reporting Requirements
- Oversight
- Money Flows
- Consultation/Advisory/ Info Sharing
- Structural Connections (Includes Existing)

Patient Protection & Affordable Care Act, P.L. 111-148;
Health Care & Education Reconciliation Act, P.L. 111-152
Prepared by: Joint Economic Committee, Republican Staff
Congressman Kevin Brady, Senior House Republican
Senator Sam Brownback, Ranking Member

National Healthcare Reform

Agenda

- Repeal Efforts and Other Challenges
- Wellness Programs, Preventive Services, and Essential Benefits
- Recent Guidance on Mandates and Other Reforms
- What to Expect Through 2013
- 2014 and Beyond
- Notices, Communications, and Other Reporting and Disclosures
- Key Next Steps for Employers
- Resources

Repeal Efforts and Other Challenges

Two Phases of the Law

- Immediate/short term provisions such as the age 26 and annual/lifetime limits
  - **likely to survive repeal efforts**

- 2014 individual mandate/health insurance exchange provisions
  - **what full repeal efforts are all about**
  - free choice voucher provision recently repealed

Delay/Repeal

- The President is unlikely to sign legislation making big changes to the law, so there is no real possibility of repeal in the short term
- Supreme Court refused to take up individual mandate challenge
  - Court is likely to ultimately take case next term and decision is not likely before June 2012
- In the meantime, certain provisions subject to delay (nondiscrimination for self insured benefit, claims/appeals standards, W-2 reporting delay)
- Some additional provisions will likely be repealed piecemeal (CLASS Act?)
  - 1099 reporting and free choice vouchers have been repealed
- Future guidance expected on many upcoming reforms including uniform notice requirements, auto enrollment, exchanges, etc.

Preparing for 2014

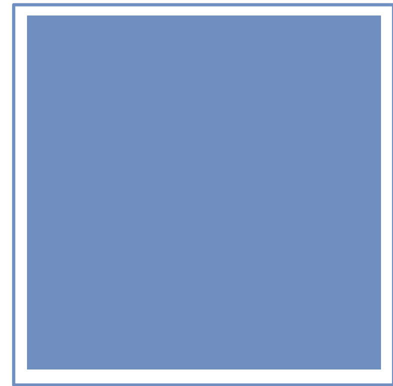
- Several recent studies have made assorted predictions about what employers will do after health reform fully kicks in come 2014.
  - McKinsey study at odds with other studies as to projected effects on employer sponsored plans
  - Many studies find that most large employers remain committed to offering employer-sponsored benefits (further decrease in retiree medical benefits likely)
  - Begin looking at key considerations for 2014 and beyond
  - Employers and employees must provide minimum essential coverage starting in 2014 or pay penalties to the federal government
  - Employers will need to analyze the value of continuing to directly offer healthcare benefits compared with paying a penalty
  - Employers to consider redesigning their health plans to be sure that by 2018 their plans do not qualify for the excise “Cadillac” tax for high-value plans
- Will see changes in care delivery and reimbursement (ACOs, disease management, wellness, lifestyle coaching, etc.)

Healthcare Waivers

- Obama administration recently announced an early end to the healthcare waiver program - no new waiver applications will be considered after September 22.
- Approvals or renewals received by the September 2011 deadline will be good through 2013 - starting in 2014, the main coverage provisions of the law will take effect and the waivers will no longer be needed.
- The waivers address a provision of the law that phases out annual dollar limits on health coverage (plans cannot impose a limit below $750,000).
- Temporary waivers have been granted to "limited benefit" plans or "mini-med" plans often offered to lower paid workers which have annual limits well below the restricted annual limits.
- Plans qualify for waivers by proving that the new minimum standards would significantly raise premiums or lower coverage rates.
- Without waivers, those plans would have been forced to terminate or increase premiums significantly, leaving more people uninsured.

State Waivers

- Under the law, state waivers would be available starting in 2017 (three years after the healthcare reform law's effective date)
- States can apply for a waiver (for up to 5 years, with authority for extensions) from the individual mandate, employer "free rider" assessment, "essential health benefits," exchanges, and cost-sharing provisions
- Allows states the flexibility to implement their own alternative state health care programs, provided that the state's programs are at least as comprehensive and affordable as the coverage under the federal provisions.
- Must also result in at least as many residents being covered with health insurance as they would under the health reform law and may not result in an increase in the federal deficit.
- Obama supports permitting states to obtain waivers starting in 2014, three years before the law currently permits in 2017.



Wellness Programs, Preventive Services, and Essential Benefits

Wellness Programs

- Because of health reform, 18% of employers have adopted or expanded their use of wellness initiatives in the last year; 27% plan to do so in the next year. 38% are expanding the use of financial incentives to encourage health behaviors; 27% are adopting or expanding disease management offerings.
- Almost every kind of wellness initiative will be governed by at least one set of legal rules (complex network of federal and state laws)
- Group health plans often provide incentives for wellness by providing premium discounts or additional benefits to reward healthy behaviors through a wellness program
- Wellness programs are often structured to offer cost-sharing "rewards" (giving participants a discount off a "standard" cost-sharing amount for engaging in desired behaviors) rather than imposing a "penalty,“ (a surcharge on the "standard" cost-sharing amount)

Examine provisions carefully - Penalty provisions (such as cost-sharing surcharges) may implicate the six changes that defeat grandfather status and also may violate other nondiscrimination rules

Preventive Services

- Non-grandfathered plans are required to provide coverage for certain "Recommended Preventive Services" (such as mammograms, colonoscopies and immunizations) without cost-sharing.
- Under a non-grandfathered plan, participants will not have to pay a co-payment, co-insurance, or any deductible to receive preventive health services, such as recommended screenings, vaccinations, and counseling.
- If a health plan uses a network of providers, the health plan is only required to provide these preventive services through an in-network provider. The health plan may allow these services from an out-of-network provider, but may charge a fee.
- The complete list of recommendations and guidelines that must be covered by plans will be continually updated to reflect both new recommendations and guidelines and revised or removed guidelines.

Essential Benefits

Regulators are focused on how to define “essential benefits” — the basic medical services that health plans must cover under the law.

- foundation for the coverage to be provided through the state healthcare exchanges in 2014.
- key concept in determining an employer's responsibility to provide health coverage and what limits may or may not be imposed on that coverage

Essential benefits are not defined beyond the following ten general categories listed in the statute:

- ✓ Ambulatory Patient Services
- ✓ Emergency Services
- ✓ Hospitalization
- ✓ Laboratory Services
- ✓ Maternity and Newborn Care
- ✓ Mental Health and Substance Use Disorder
- ✓ Pediatric Services, Including Oral and Vision Care
- ✓ Prescription Drugs
- ✓ Rehabilitative and Habilitative Services and Devices
- ✓ Preventive and Wellness Services and Chronic Disease Management

Essential Benefits

- Some services are triggering debate, such as fertility treatments, unlimited length of stay in mental health facility, "lifestyle" medications such as Viagra, chiropractic care, hearing aids, organ transplants, acupuncture, organ transplants and hospice care, unlimited physical therapy, and habilitative services.
- Until further guidance is issued, employers must make a good-faith effort to reasonably interpret essential benefits and apply the interpretation consistently.
- At the request of HHS, the Institute of Medicine is undertaking a study that will make recommendations on the criteria and methods for determining and updating the essential benefits package.
- Will consider appropriate balance among categories of care, the health care needs of diverse segments of the population, and nondiscrimination based on age, disability, or expected length of life.
- This fall, HHS will collect public comment and hear directly from all Americans who are interested in sharing their thoughts on this important issue.

Recent Guidance on Mandates and Other Reforms

Grandfathered Plans

- Under PPACA, group health plans must determine their grandfathered status and then determine the plan mandates that apply to each plan
- Expected that most plans will lose grandfathered status over time.
- Plans cease to be grandfathered when an amendment that causes the plan to lose grandfather status becomes effective, and not based on when it is adopted. So if an amendment resulting in loss of grandfathered status is adopted on 7/1/11, for a change to plan terms that will become effective for the plan year beginning 1/1/12, the plan would cease to be a grandfathered plan on 1/1/12.
- Pros of maintaining status:
    - Exempt from, or special treatment under, certain health reform provisions (preventive care, appeals, emergency services, provider choice, age 26 exception for other coverage)

Grandfathered	Non-Grandfathered
For plan years beginning on and after September 23, 2010 (January 1, 2011 for calendar year plans)	
▪ No annual limits on essential benefits (Secretary may allow restricted annual limits on benefits through January 1, 2014)	
▪ No lifetime limits on essential benefits	
▪ No rescissions (except for fraud or misrepresentation)	
▪ No pre-existing condition exclusions for individuals under 19 years old	
▪ If the plan covers dependents, must offer coverage to adult children up to age 26	
▪ Until 2014, adult children to age 26 coverage is not required if the dependent is eligible for another employer-sponsored health plan other than that of a parent	▪ Cannot deny coverage to adult children up to age 26 if the dependent is eligible for another employer-sponsored health plan other than that of a parent
	▪ No cost sharing for immunization or preventive care
	▪ No discrimination in favor of highly compensated individuals for insured plans
	▪ Must provide appeal process for coverage determinations including external review
	▪ Must allow individuals to choose pediatrician for child's primary care physician
	▪ Must allow females to choose gynecologist or obstetrician without referral
	▪ Must allow emergency services without preauthorization and treat as in-network
Plan Year 2014	
▪ No annual limits on essential benefit	
▪ No pre-existing condition exclusions (regardless of age)	
▪ Waiting periods limited to 90 days	
▪ Can no longer deny coverage to adult children up to age 26 if the dependent is eligible for another employer-sponsored health plan	▪ No discrimination against individual participating in clinical trial, and must cover routine costs for items or services furnished in connection with clinical trial
	▪ No discrimination based on health status
	▪ No discrimination on health care providers acting within the scope of their license
	▪ Must follow cost sharing and deductible limits

Grandfathered Plans

- Recent Guidance
  - *Notice:* If grandfathered, the plan must include disclosure as to its grandfathered status whenever a summary of benefits is provided, such as at initial eligibility for benefits, during an open enrollment period, or during other enrollment, renewal, or coverage modification periods. It is not necessary to provide disclosure language in every communication (e.g., an EOB).
  - *Carrier Change:* New amendment clarifies that an insured group health plan does not lose grandfathered status merely by changing issuers or insurance contracts. The amended rule generally applies prospectively only to contracts entered into after November 15, 2010.

Final regulations to be published "in the near future"

Early Retiree Reinsurance Program (ERRP)

- Establishes a temporary $5 billion dollar early retiree reinsurance program for employer plans
- Began accepting applications June 21, 2010
- The temporary $5 billion program was designed to end on the earlier of January 1, 2014 (when the state-based health insurance exchanges are scheduled to be operational) or when program funds are exhausted.
- Due to a projected lack of available funds, the ERRP program stopped accepting applications on May 5, 2011.
- ERRP funds likely to run out before the end of 2011.

Nondiscrimination

Non-grandfathered and new plans must comply with new nondiscrimination rules

- Confirm insured plans are not discriminatory (under rules once applicable to self-insured plans only)
- Perform testing of insured plans

Compliance with the insured plan nondiscrimination rule not required until years after March 11, 2011 (the earliest effective date would be January 1, 2012 for calendar year plans, but in any event not until after regulations or other administrative guidance has been issued).

Until that time, sanctions for failure to comply with the rules will not apply.

Claims and Appeals

Establish internal and external appeals procedures

- Implement appropriate procedures (guidance and model forms related to claims, appeals and external reviews for non-grandfathered health plans have been released)
- Concerns for self insured health plans
- Update open enrollment materials
- Coordinate with vendors and update vendor contracts as necessary

  Enforcement grace period: DOL will not take any enforcement action during the enforcement grace period, against non-grandfathered group health plans that fail to comply fully with some of the new internal claims and appeals standards.

  New, updated model notices recently released to address the new guidance

Form W-2 Reporting

- Requires reporting of “aggregate cost” of “applicable employer-sponsored coverage” on Form W-2
- Both employer and employee portions of cost included
- Aggregate cost to be determined under rules similar to COBRA
- Requirement applies to 2012 W-2s (issued to employees in 2013). Therefore, employers will not be required to report the cost of health coverage until January 2013.
- For certain smaller employers (those filing fewer than 250 W-2s) the requirement is optional for 2012 W-2s (and continues as optional until further guidance is issued) Therefore, small employers will not be required to report the cost of health coverage until at least January 2014.

What to Expect Through 2013

Through 2013

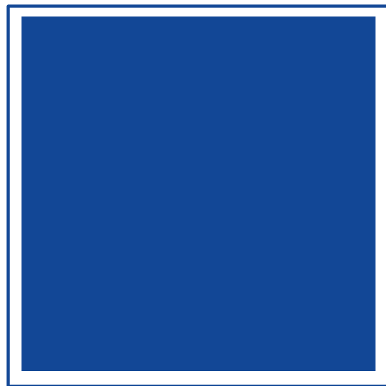
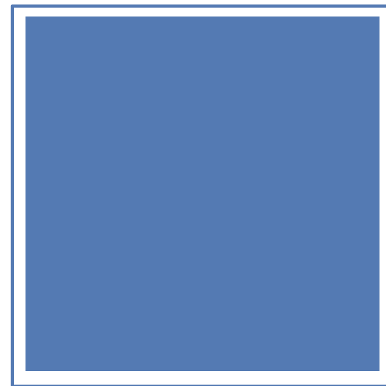
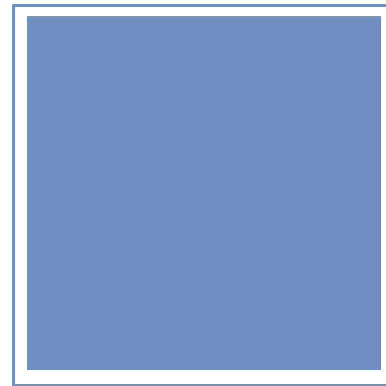
- New plan summary (required in 2012?)
  - plan administrators must distribute new summary of health information to all enrollees/ applicants at initial enrollment and annually in addition to the SPD
- Quality of care reporting (required in 2012?)
  - plans must begin disclosing to HHS and enrollees information on plan benefits that improve health, case management, disease management and wellness.
- Cap on Flexible Spending Account contributions (for tax years beginning after December 31, 2012)
  - limits employee salary deferral contributions to health FSAs to $2,500 per year.

Through 2013

- W-2 reporting of employee health coverage (applies to 2012 W-2s issued to employees in 2013)
  - reporting of aggregate cost of applicable employer-sponsored coverage
- New-hire auto-enrollment requirement (by 2014?)
  - until implementing regulations are issued, employers are not required to comply with the automatic enrollment requirement. It is expected that automatic enrollment rulemaking should be completed by 2014.
- Nondiscrimination guidance for insured plans (by 2012?)
  - the earliest effective date would be January 1, 2012 for calendar year plans, but in any event not until after regulations or other administrative guidance has been issued

Through 2013

- Medicare payroll tax (in 2013)
  - Medicare Hospital Insurance (HI) tax rate rises from 1.45% to 2.35% on employees' earned income above $200,000 (single return) or $250,000 (joint return); affects only employee-paid portion of payroll tax (no employer match payment required on 0.9% increment).
- Personal medical deduction (threshold will rise to 10% in 2013 for all taxpayers except those aged 65 or older; for these folks, the 10% rule is effective in 2016)
  - The threshold for claiming medical expenses on itemized tax returns is raised to 10% from 7.5% of income. The threshold remains at 7.5% for the elderly through 2016.

2014 and Beyond

2014 and Beyond

- State health insurance exchanges for small businesses and individuals open (initially to individuals and small employers with 100 or fewer employees, unless the state opts to limit this to organizations with 50 or fewer employees). Beginning in 2017, states would have the option to expand the exchange to larger employers.
- Most people will be required to obtain health insurance coverage or pay a fine if they don't
  - increasing tax penalties for noncompliance equal to greater of flat dollar amount (e.g., $95 in 2014) or percent of income (e.g., 1.0% in 2014).
- Employer government reporting begins on employee health coverage to enforce individual and pay-or-play mandates.

Pay or Play

- Certain employers must provide qualified low and moderate income employees with “free choice vouchers” (REPEALED)
- In 2014, some large businesses will be required to “pay or play”
  - Larger employers (generally over 50 full time employees) that don't offer coverage or offer “substandard” coverage will face penalties if their workers get subsidized coverage through the exchange.
  - "Substandard" coverage - a policy that doesn't cover at least 60% of an employee's total medical costs or whose premiums cost more than 9.5% of the worker's income.
- Employers with 50 or more full-time equivalent employees that don‘t offer coverage in 2014 will have to pay an assessment ($2,000 for each full-time employee) to help offset the cost of health insurance if their employees are receiving help from the federal government to purchase insurance.

Pay or Play

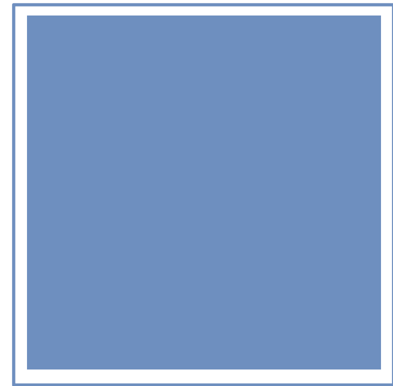
- Employers that offer substandard or unaffordable plans may also face penalties if their employees are receiving federal subsidies (as much as $3,000 for each full-time worker who gets a tax credit for coverage through the exchange).
- Employers may still impose a waiting period for coverage without being subject to a penalty, but this waiting period may not exceed 90 calendar days.
- Employers generally do not have to pay an assessment for:
  - Employees working less than 30 hours per week.
  - Employees hired for less than 120 days, seasonal employees, and retail workers employed exclusively during the holiday season.
  - The first 30 FTEs for which employers must otherwise pay a free rider assessment.
  - Employees in eligibility waiting periods less than 90 days.

Pay or Play

- It is not yet clear how to calculate whether an employee is employed on average at least 30 hours of service per week, particularly with regard to employees who are not employed on an hourly basis.
- Regulators have released a notice giving employers an advance look at how it plans to formulate guidance on the shared responsibility provisions. Specifically, the notice outlines possible approaches employers could use to determine who is a full time employee and issues related to the 90-day limit for waiting periods.
- The notice does not constitute guidance. Instead, it describes potential approaches, which could be incorporated in future proposed regulations, to certain discrete issues, particularly the issue of who is a full time employee, and invites interested parties to provide comments on the proposed approach.
- Employer concern as to how the full overhaul will affect them – uncertainty is the general sentiment
- Wait and see mentality on how businesses will respond to the pay or play provisions effective in 2014

High-Cost Plan Excise Tax

- Effective in 2018 - nondeductible excise tax of 40% imposed on plan administrators (including self-insured plans) for certain high cost plans
- Applies to plans where the combined annual employer/employee premiums exceed the threshold of $10,200 for self-only coverage and $27,500 for family coverage.
- Tax applies to the amount of the premium in excess of the threshold so the first $27,500 of a family plan and $10,200 for individual coverage is exempt from the tax.
- Additional threshold amount of $1,650 for singles and $3,450 for families is available for retired individuals over the age of 55 and for plans that cover employees engaged in high-risk professions (e.g., law-enforcement professionals, EMTs, construction and mining).
- Dental and vision coverage is excluded when calculating this excise tax, but other health coverage is aggregated including PPO, HMO, HDHP, HSA, FSA, HRA, etc.



Notices, Communications, and Other Reporting and Disclosures

Coverage Mandate to Age 26 - Notice

- Notice applies to grandfathered and non-grandfathered insured and self insured plans
  - Must be given at least 30 days prior to enrollment deadline for the first plan year on or after September 23, 2010
  - Retroactive enrollment to the first day of the plan year is permitted

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the first plan year beginning on or after September 23, 2010.] For more information contact the [insert plan administrator or issuer] at [insert contact information]. (See http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc)

Lifetime Limit – Notice

- Grandfathered and non-grandfathered insured and self-insured group health plans may not impose lifetime dollar limits on individual coverage
- Notice applies to all grandfathered and non-grandfathered plans subject to health care reform that have lifetime limits on benefits
  - Notice must be given to all employees who lost coverage due to reaching the lifetime limit
  - Notice must be given at least 30 days prior to enrollment deadline for the first plan year on or after September 23, 2010
  - Retroactive enrollment to the first day of the plan year is permitted

> The lifetime limit on the dollar value of benefits under [Insert name of group health plan or health insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator or issuer] at [insert contact information]. (see http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc)

Grandfathered Plan – Notice

- Provide disclosure regarding grandfathered status in all plan materials describing the benefits, including contact information.

This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.] See http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc)

Recission

- Grandfathered and non-grandfathered insured and self-insured group health plans may not retroactively rescind coverage after enrolling a participant, except in the event of fraud or intentional misrepresentation of material fact
    - Plans must provide a 30 days advance written notice to each participant who would be affected by a rescission

ERRP Notice

- For retiree group health plan sponsors participating in Early Retiree Reinsurance Program
- Must provide a form notice to plan participants notifying them that the sponsor is participating in the ERRP

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

[If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.]

Claims and Appeal

- New and non-grandfathered plans
- Enrollees whose claims are denied must receive notices about a plan's procedures for internal appeals and external reviews of these decisions.
- Model notices (revised in June 2011) are available for initial and final internal adverse benefit determinations and for final external review decisions.
- Regulators also intend to post model SPD language to explain new internal and external appeal review process.
- Effective for plan years starting on or after September 23, 2010, but enforcement grace period applies to certain internal claims and appeals requirements.

Physician Designation - Notice

- New and non-grandfathered plans must give notice of option for designating a primary care physician
  - Participants have right to designate any participating PCP including a pediatrician or OB/GYN
  - Notice must be given no later than the first day of the first plan year on or after or after September 23, 2010 (notice must also be provided in SPD)

- For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:
- [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 plans and issuers that require or allow for the designation of a primary care provider for a child, add: For children, you may designate a pediatrician as the primary care provider.
- For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

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]. (See http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc)

Disclosure of Plan Data

- New and non-grandfathered plans
- Plans must provide certain government agencies and the public with information related to enrollment and disenrollment; claims payments, denials, processing and appeals; cost sharing; financial information; and covered individuals' rights.
- Regulators must develop "plain language" standards for this disclosure, but guidance is not yet available.

Quality-of-Care Report and Employee Notice

- New and non-grandfathered plans
- Plans must annually file a report and provide enrollees a notice describing quality-of-care initiatives, including wellness programs; health-improvement activities; and efforts to prevent hospital readmissions, improve patient safety or reduce medical errors.
- Regulators are required to "develop" the reporting requirements no later than March 23, 2012.
- The due date for the first reports and notices is uncertain.

Mini-med Plans (waiver) Notice

- Group health plans offering “mini-med” plans
- As a condition of receiving a waiver from the annual limits requirements, group health plans offering "mini-med" plans must provide a notice informing current and eligible participants that the plan does not meet the minimum annual limits for essential benefits and that it has received a waiver.
- The notice is required to include the dollar amount of the annual limit along with a description of the plan benefits to which the limit applies.
- Model notice language (as revised) is available.
- The annual limit waiver application process will terminate on September 22, 2011.

Auto Enrollment Notice

- Employers with more than 200 full-time employees
- Employers are required to automatically enroll new full-time employees in the employer's health plans and continue enrollment of current employees.
- Employees automatically enrolled must be notified of the opportunity to opt out of coverage.
- Until implementing regulations are issued, employers are not required to comply with the automatic enrollment requirement.
- It is expected that automatic enrollment rulemaking should be completed by 2014.

Form W-2 Health Coverage Reporting

- All employers offering group health plans and/or contributing to HSAs or HRAs.
- For tax years starting on and after January 1, 2012, employers must report the value of each employee's health coverage on Form W-2, although the amount will remain tax-free.
- The W-2s due in early 2013 will be the first required to report coverage costs for the prior calendar year.
- Special small employer rule provides for even further delayed reporting date.

Summary of Benefits

- All group health plans
- By March 23, 2012, group health plan sponsors must provide a benefits summary during annual open enrollment and when someone first becomes eligible for coverage.
- The summary is required to be short, contain non-technical language and cover "essential health benefits" and other topics.
- Regulators are expected to provide guidance about the required benefit summary shortly (original deadline was March 23, 2011).

Material Modification Notice

- All group health plans
- If a group health plan makes any material modification in any of the terms of the plan involved that is not reflected in the most recently provided summary of benefits, the plan must provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective. The effective date of this provision has been unclear. Recent guidance clarifies that plans need not give this notice until after they begin issuing benefit summaries.
- Group health plans are not required to comply with the 60-day prior notice rule until they are required to provide the summary of benefits (the agencies have not yet issued those standards).

Health Insurance Exchange Notice

- All employers, regardless of health plan offering
- Before the expected start of health insurance exchanges in 2014, all employers will have to provide employees a notice explaining the coverage available from the exchanges and the tax credits to offset costs for certain employees.
- More guidance is expected.

Employer Report of Health Coverage Offerings

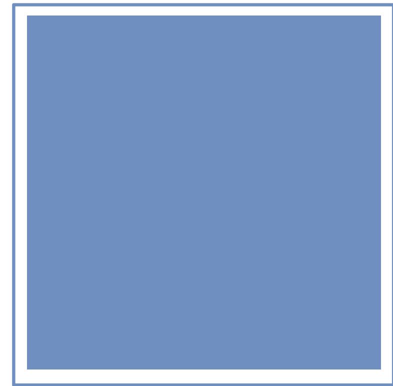
- Employers with more than 50 full-time equivalent (FTE) employees; certain other employers offering group health plan coverage
- Starting in 2014, any employer (or an insurer on an employer's behalf) that has more than 50 full-time employees or requires employees to pay more than 8% of wages for coverage must file an annual report with the IRS describing the health coverage(s) offered.
- By January 31st of the year after an annual report is filed, employees covered in the report must receive a notice with details reported on their coverage.

Employer Report of Individual Health Coverage

- Employers offering self-funded group health coverage
- Starting in 2014, employers with self-funded health plans must report to the IRS about their plans and covered participants.
- Covered individuals must receive notices with information about their own benefits reported in the IRS filing.
- For insured coverage, the insurer is responsible for the IRS report and individual notices.

Notice of High-Cost Coverage Subject to Excise Tax

- Employers and others liable for excise tax.
- Starting in 2018, any employer sponsoring ‘high-cost coverage” triggering the law’s 40% excise tax must notify the IRS and the health insurer (for insured coverage) or plan administrator (for self-insured coverage) and provide information on each party’s associated tax liabilities.



Key Next Steps for Employers

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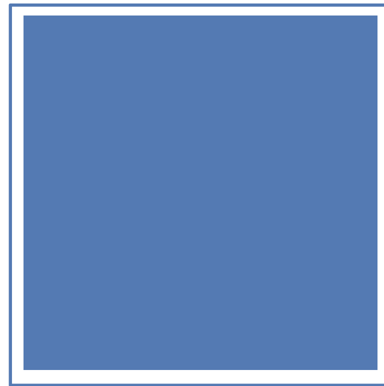
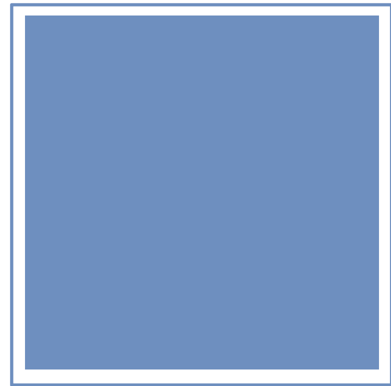
- Take immediate action (if not already completed) to examine the changes and how they impact your particular group health plan.
    - Determine your plan year – immediate changes to plans take effect for plan years that begin following six months after enactment (January 1, 2011 for calendar year plans).
    - Consider whether your plans are grandfathered and which provisions will not apply to those grandfathered plans (ongoing determination required).
    - Address the number of reforms that are effective for plan years that begin six months after the enactment date (January 1, 2011 for calendar year plans).

Key Next Steps for Employers

- Make changes (if not already done) to plan design and communication and plan materials as needed prior: adult child coverage, lifetime/annual maximums, preexisting condition exclusions, the prohibition on rescissions, the restriction on reimbursement for over-the-counter drugs, and the higher penalty for misusing health savings accounts.
- Keep an eye on emerging regulatory interpretations and longer-term strategic changes.
- Stay informed on major aspects of health care reform that will take effect in 2014.

Employers will need to be prepared in early 2013 to start implementing necessary changes required in 2014. Consider transitioning with smaller moves rather than making significant changes all at once.

Resources

Resources

Government Agency Web Sites

- HHS consumer health care website. "Web portal" required under health care reform providing information for consumers about both public and private health coverage options available in their states.
- HHS Center for Consumer Information & Insurance Oversight (CCIIO) website. Provides access to HHS regulations, fact sheets, FAQs, letters, news releases, and other resources regarding health care reform.
- DOL Affordable Care Act website. Provides links to health care reform regulations, other guidance (including model notices), research studies and surveys, archived webcasts, and additional resources.

Resources

More Government Agency Web Sites

- IRS Affordable Care Act website. Provides information on health care reform's tax provisions, as well as links to related guidance, Q&As, IRS forms, tax tips, and other resources.
- IRS Small Business Health Care Tax Credit website. Information about the small employer tax credit under the health care reform.
- Early Retiree Reinsurance Program (ERRP) website. Regulations, reference materials, announcements, and other information about the ERRP (temporary program to reimburse employment-based plans for a portion of the costs they incur providing health coverage to early retirees).

Resources

More Government Agency Web Sites

- White House health reform website. Provides news and other information about health care reform.
- U.S. Department of Justice "Defending the Affordable Care Act" website. Collects selected decisions in cases challenging health care reform's constitutionality

Conner Strong Publications (Webinars, Email blasts, Perspectives, Health Reform Guidebook)