Patient Protection and Affordable Care Act – Effect on Employee Benefits

Steven Kreisberg

July, 2010

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PPACA Effects

- Creates greater access to benefits
- Creates patient protections to eliminate coverage gaps
- Creates benefit mandates to promote long term cost restraint and higher value

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Provisions that Apply to All Plans: Plan years beginning after September 23, 2010

- Dependent Care Coverage to Age 26
- Elimination of lifetime dollar benefit limits
- Phase-out of annual dollar benefit limits
- No pre-existing condition limits for children
- Medical Loss Ratios (insured plans)

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Provisions Effective January 1, 2014

- No eligibility period for benefits greater than 90 days
- No pre-existing condition exclusions
- Elimination of annual dollar benefit maximums

Dependent Coverage to Age 26

- Dependent coverage must include children up to age 26, regardless of financial dependency, residence, student status, or employment (assuming dependent coverage is offered)
- Age based surcharges are not allowed
- Plans cannot vary benefits based on the age of the child
- Until 1/1/2014, a grandfathered plan does not have to offer coverage to adult child who has employment based coverage

Lifetime Benefit Limitations Eliminated

- No lifetime benefit dollar limitations on "essential benefits" for plan years beginning September 23, 2010 or later

- "essential benefits" to be determined by HHS.

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Annual Benefit Limitations Phased Out

- $750,000 for plan years that begin on or after Sept. 23, 2010 but before Sept. 23, 2011;

- $1.25 million for plan years that begin on or after Sept. 23, 2011, but before Sept. 23, 2012; and

- $2 million for plan years that begin on or after Sept. 23, 2012, but before Jan. 1, 2014

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Pre-existing Conditions

- Prohibits preexisting condition exclusions for children under age 19 for plan years beginning on or after September 23, 2010

- Prohibits preexisting condition exclusions for adults for plan years beginning on or after January 1, 2014

- Will affect new enrollees in some plans

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Grandfathering

- A “grandfathered” plan is a plan in existence on March 23, 2010
- Grandfathered plans are exempt from some of the mandates - but not all
- Plans lose grandfathered status if they make significant changes

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Rules That Do Not Apply to Grandfathered Plans

Plan Years beginning on or after Sept 23, 2010:

- Preventive care with no cost-sharing (defined in recent regulation)

- Patient protections that allow plan participants to select their own primary care provider and pediatrician. OB/GYN services may not be subject to pre-authorization. Prior authorization and higher cost sharing for out of network emergency services are prohibited.

- Internal and external appeals minimum requirements

- Quality reporting requirements

Losing Grandfathered Status

- Elimination of all or substantially all benefits to diagnose or treat a particular condition.
- Any increase in a percentage cost-sharing requirement (coinsurance).
- Any increase in fixed-dollar cost-sharing (e.g. deductibles, out-of-pocket expenses – not copayments) in excess of the rate of medical inflation since March 23, 2010, plus 15 percentage points
- Any increase in copayments in excess of the greater of a) the rate of medical inflation, plus 15 percentage points, or b) $5.00, increased by medical inflation

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Losing Grandfathered Status

- Any decrease in the employer contribution towards the cost of any tier of coverage by more than 5 percent of the contribution rate in effect on March 23, 2010
- For fully insured plans, a change in the health insurance carrier – even if benefits remain essentially unchanged.
- Unaddressed: provider networks, formularies, implementation of gatekeepers

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Rules That Do Not Apply to Grandfathered Plans

Plan years beginning on or after Jan 1, 2014:

- Maximum out-of-pocket limits and deductibles (based on HSA maximums)
- Coverage may not be denied for routine care that the plan would otherwise provide because an individual is enrolled in a clinical trial
- Provider nondiscrimination based on scope of license
- Wellness incentives/penalties on individuals can be increased to 30% (or more) of costs
- Additional information reporting

Account Based Plans

- Effective 1/1/2011: Health Reimbursement Arrangements (HRAs), Flexible Spending Arrangements (FSAs), Health Savings Accounts (HSAs) can only reimburse over-the-counter drugs if there is a prescription

- Effective in 1/1/2013, health FSAs are limited to $2,500 per year

More Information

www.afscme.org/healthcare

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Federal Health Care Reform at the State of Nevada Public Employees' Benefits Program

Tuesday, July 20, 2010

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Today's Topics

- Disclaimer
- PEBP
- The Health Care Reform Frenzy

Today's Topics

- Grandfathering
- Pre-existing Conditions
- Wellness
- W-2 Subsidy Reporting
- Coverage of "Children" to Age 26
- Life-time maximums
- Early Retiree Reinsurance Program

I am NOT

- **An Actuary**

I am NOT

- **An Accountant**

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM
PEBP
Health Matters.

I am NOT

- **A Consultant**

I am

The Public Employees' Benefits Program (PEBP)

- Health Insurance Program for State of Nevada Employees (60%) and Retirees (40%)
- 74,000 lives
  - Self-funded PPO (50,000)
  - Fully Insured HMOs (24,000)
- $400 million budget (excluding reserves)
- 9 Member Board
- July 1 – June 30 Plan Year

The Public Employees' Benefits Program (PEBP)

- Considered full-time if work more than 80 hours per month
- Covers nearly all wellness procedures
- Has an appeal process
- Auto enrolls new employees
- 90 day waiting period
- Claims loss ratio approx 103-108%; expense ratio approx 5%

The Health Care Reform Frenzy

- Bills prior to March 23, 2010
- H.R. 3590; H.R. 4872
- Regulations
- Webinars
- Staff Meetings
- Board Meetings
- State Lawsuits

Grandfathering

- **PEBP does not plan to pursue grandfathering status**
  - **Northern HMO- New Deductible**
  - **Too many notice requirements**
  - **State subsidization cuts expected**
  - **Very little benefit**
    - **Wellness**
    - **“Children” with other employer based coverage**
    - **Pre-existing conditions**

Pre-Existing Conditions

- NRS 287.0205; 287.0475 excludes pre-existing conditions for reinstated retirees
- For Nevada local governments- PEBP will submit BDR
- Outside of Nevada- may need to update state law
- Review local laws and MPD
- Change (for PEPB) effective July 1, 2011

Wellness

- PEBP has $2,500 wellness benefit per member per year
- Average use: $150 per year
- Discussions regarding limiting number of wellness services
- Change (for PEPB) effective July 1, 2011

W-2 Subsidy Reporting

- Amounts paid by employer must be reported on W-2 for CY 2011
- Assessment subsidy v. actual subsidy
- Multiple employers/paycenters
- Change (for PEPB) effective January 1, 2011 (goal); required end of 2011

Coverage of “Children” to Age 26

- Currently PEBP covers to age 19; 23 if FTS
- FHCR:
  - Mandatory coverage up to age 26
  - Voluntary (IRS Code) coverage up to age 27
- PEBP will cover up to age 26 effective July 1, 2011, regardless of employment status
- Estimated cost 1.0% - 1.5% ($2.5 - $3.8 M)

Life-Time Maximums

- PEBP covers up to $2 Million per member
- PEBP will eliminate life-time maximums effective July 1, 2011
- Estimated cost 0.3% - 0.5% ($0.8 - $1.3 M)

Early Retiree Reinsurance Program

- Regulations issued May 5
- Effective June 1
- Application Available June 29
- PEBP mailed application July 12
- Reimbursement infrastructure not expected to be available until at least October
- Program ends January 1, 2014 (or when $5 Billion runs out)

Early Retiree Reinsurance Program

- Allows for reimbursement of 80% of the cumulative costs between $15,000 and $90,000 incurred in a plan year
  - Up to $60,000
  - Must be paid (payment lag)
  - For retiree share, must have “prima facie evidence” of payment
- Retirees age 55 and older not Medicare eligible
  - And their dependents, regardless of age

Early Retiree Reinsurance Program

- PEBP expects reimbursement for approximately
  - 10,000 retirees and dependents (PPO)
  - 4,000 retirees and dependents (PPO)
- Expected reimbursement
  - $1.6 M for the first plan year (one month)
  - $16.9 M for the second plan year (ending June 30, 2011)

Early Retiree Reinsurance Program

- **Maintenance of effort**
  - **Discussions regarding whether to submit application**
  - **Based on the plan year in effect on March 23, 2010**
  - **Based on aggregate amounts paid by plan sponsor/employer for the plan year**
- **Must have data sharing agreement with TPA/PBM/HMO**

Early Retiree Reinsurance Program Application

- Similar to RDS application
  - Plan sponsor information
  - Authorized representative
  - Account manager
  - Bank account information
  - Plan sponsor agreement
- Does not require initial retiree list
- Does not require annual application

Early Retiree Reinsurance Program Application

- **Must indicate:**
  - **Programs and Procedures for Chronic and High Cost Conditions**
    - **Musculoskeletal**
    - **Heart Disease**
    - **Cancer**
    - **Chronic Obstructive Pulmonary Disease**
    - **Diabetes with Complications**
    - **Organ/Tissue Transplant**
  - **How fund will be used**
  - **Expected amount of reimbursement**

Resources

- **US HHS Federal Health Care Reform Regulations and Guidance:**
  - **http://www.hhs.gov/ociio/regulations/**

- **Presentation to PEBP Board by Aon Consulting (includes timelines)**
  - **http://www.pebp.state.nv.us/informed/brdpkts/5-6-10Packet.pdf (see Agenda Item IV)**

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Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

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