

Health Care Reform and its Affect on Single-Employer and Collectively Bargained Plans

Information and Assistance
To Help You
Comply with the Law



Hello. My name is Emilie. On behalf of EBS-RMSCO, I will be reviewing health care reform and how it will affect single-employer and collectively bargained group health plans with you.

I'm glad that you have joined me today with an interest in obtaining more information on this important subject.

Now let's get started and let me tell you how EBS-RMSCO can assist you in complying with these sweeping reforms.

Background

- Affordable Care Act passed on March 23, 2010
- Single-employer group health plans and group health plans that are written pursuant to collective bargaining agreements (“CBA”) are subject to the rules and regulations of the Affordable Care Act
- Applies to insured and self-funded plans



On March 21, 2010, Congress passed the Patient Protection and Affordable Care Act (known as the Affordable Care Act) which was signed into law on March 23, 2010. The Act is intended to provide a minimum level of healthcare coverage for eligible individuals in the United States.

The Affordable Care Act, and its conforming amendments, apply to single-employer group health plans and group health plans written pursuant to collective bargaining agreements and it applies both to self-funded plans or plans funded through the purchase of insurance.

Let me tell you about some of the important implications to you and your plan.

Scope of Law

- Some minor exceptions/differences for CBA plans compared to single-employer plans.
- CBA plans must be mindful of the accelerated compliance dates they may not be accustomed to.
- CBA plans must comply with most provisions of the health reforms no later than the plan year that follows September 23, 2010 (no delayed compliance date).



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With some minor exceptions, collectively bargained plans will be treated the same as single-employer plans for the purposes of the health care reform.

In the past, collectively bargained plans have been given more time to comply with these types of laws but this is not the case here. **Collectively bargained group health plans are required to comply with the health reforms on the same dates that single-employer plans are required to comply. There is no delayed compliance date.** The Affordable Care Act includes several health reforms. For example, plans must extend coverage to adult dependents until they reach age 26 and they must remove annual and lifetime dollar maximums. The compliance date for these reforms will not be delayed like collectively bargained plans are accustomed to.

Now, let's go into more detail about some of the reforms that we have some guidance on.

Grandfather Rule

Insured Plans

- Insured CBA plans with bargaining agreements ratified prior to March 23, 2010 will be considered grandfathered until the termination of the latest CBA. Can not lose grandfather status while current CBA is still in effect.
 - Such plans are allowed to make changes until the latest CBA terminates without losing grandfather status
- After the latest CBA terminates, the normal grandfather rules will apply
- These groups will need to do a comparison of the terms of the plan on March 23, 2010 to the terms of the plan on the date the latest CBA terminates to determine whether the plan will retain its grandfather status.



On June 17, 2010, the Departments of Treasury, Labor and Health and Human Services collectively released guidance in the Federal Register regarding the grandfather rule for group health plans under the Affordable Care Act. Understanding this rule is a very important aspect in determining which health reforms your plan must comply with.

The law defines a grandfathered health plan as “coverage provided by a group health plan, or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010.”

Plans that retain their grandfathered status will only have to comply with a portion of the health reforms set out in the law. I will go into more detail on these reforms later. For now, I want to discuss the grandfather rule, how it affects collectively bargained plans, and how it differs between fully-insured and self-funded plans.

Fully-insured, collectively bargained plans with bargaining agreements that were ratified prior to March 23, 2010 will be considered grandfathered until the termination of the latest of the collective bargaining agreements. They can not lose their grandfather status while the current collective bargaining agreement is in effect, even if changes are made during that period.

Under the law, these plans are allowed to make changes to their benefits until the latest of the collective bargaining agreement terminates without losing grandfather status. They must keep in mind during this time period that after that last agreement terminates, the normal grandfather rules will apply. Clients will need to determine at that time whether the plan will retain its grandfather status based on a comparison of the plan terms between March 23, 2010 and at the end of the latest agreement.

Grandfather Rule

Self-Funded Plans

- Self-funded CBA plans are treated the same as single-employer group health plan for the purpose of the grandfather rule
- Can not make significant changes even while the CBA is in effect
- Could lose grandfather status while CBA is still in effect if significant changes are made
- Materials that are distributed to participants must disclose the plan is a grandfathered plan and; therefore, not subject to some of the additional consumer protection provisions of the Affordable Care Act.
- If grandfather status lost, required to comply with all additional health reforms



In contrast, self-funded, collectively bargained plans do not follow the same grandfather rules as fully-insured plans. They are treated the same way as single-employer plans in that they are not allowed to make significant changes to benefits at anytime after March 23, 2010, even while the collective bargaining agreement is in effect, or they may jeopardize their grandfather status.

Plan Sponsors are required to disclose to participants that the plan is grandfathered and; therefore, not subject to some of the additional consumer protection provisions under the Affordable Care Act.

If grandfather status is lost, the plan would be required to comply with all the additional health reforms that non-grandfathered plans must comply with, which I will discuss next.

Health Reforms under the Public Health Service Act

- CBA plans must comply with the same health reforms as single-employer plans.
- No delayed compliance date for plans written pursuant to CBAs.
- Must comply on the same date that single-employer plans must comply.



The Affordable Care Act amended the Public Service Act to require plans to comply with health reforms to improve health care and access to coverage. Both single-employer and collectively bargained group health plans are required to comply with these health reforms which I will describe in more detail in the next slides.

Normally, collectively bargained plans are given additional time to comply with regulations that require benefit changes. Plan Sponsors will not have that luxury with these health reforms. Collectively bargained plans, whether they are fully-insured or self-funded, grandfathered or non-grandfathered, must comply with the health reforms on the same dates that single-employer plans must comply.

The grandfathered status of the plan will determine which of the reforms they must comply with. Since EBS-RMSCO handles only self-funded clients, I will concentrate on the health reforms that will affect those plans.

Health Reforms under the Public Health Service Act

Grandfathered and non-grandfathered single-employer and CBA plans must comply with the following health reforms:

Provision	Effective Date	Notice Requirement?
Prohibition of pre-existing condition exclusions or other discrimination based on health status for enrollees under age 19	9/23/10 and 1/1/14	N
Prohibiting discrimination against individual participants and beneficiaries based on health status	9/23/10	N
Prohibition on excessive waiting periods	1/1/14	Y
No lifetime or annual limits	9/23/10	N
Prohibition on rescissions	9/23/10	Y
Extension of dependent coverage	9/23/10	Y
Development and utilization of uniform explanation of coverage documents and standardized definitions	3/23/12	No guidance yet



The good news is that Grandfathered health plans are not required to comply with all of the health reforms; however, there are still several changes that Plan Sponsors must make.

Plans may not impose a pre-existing condition exclusion or discriminate based on a health factor beginning after September 23, 2010. Grandfathered and non-grandfathered plans are only required to remove the pre-existing condition exclusion on enrollees under age 19 until January 1, 2014. Beginning on that date, the pre-existing clause must be removed for all participants.

Plans are prohibited from setting eligibility rules based on factors such as health and evidence of insurability.

Plans will no longer be able to apply waiting periods in excess of 90 days.

The health reforms also prohibit plans from establishing lifetime limits and annual limits on the dollar value of benefits. Prior to 2014, plans may establish certain restricted annual limits that are defined in regulations released by the Federal government.

Group health plans may not rescind coverage after coverage begins except in cases of fraud or intentional misrepresentation.

Group health plans that provide dependent coverage must continue to make such coverage available to children until they turn 26 years old. One important distinction here is that until January 1, 2014, grandfathered plans may exclude coverage for a dependent that has an offer of employer-sponsored coverage aside from coverage through a parent. I will discuss this provision in more detail a little later on in the presentation.

The Federal government will be developing model language for a uniform summary of benefits and explanation of benefits for use by plans that can be inserted into plan materials and handed out to participants. The explanation of coverage must describe any cost sharing, exceptions, reductions, and limitations on coverage, and give examples to illustrate common benefit scenarios. Plans will also be required to provide notice of any material modification to the terms of their plan to participants no later than 60 days prior to the effective date of the change.

Health Reforms under the Public Health Service Act

Non-grandfathered, single-employer and CBA plans must comply with all of the prior slide's health reforms **plus** the following:

Provision	Effective Date	Notice Requirement?
Nondiscrimination in health care	9/23/10	N
Coverage of preventive health	9/23/10	N
Provision of additional information	9/23/10	Y
Appeals process	9/23/10	Y
Patient protections	9/23/10	Y



Again, all of the health reforms I have just reviewed apply to both grandfathered **and** non-grandfathered plans. The next few provisions I will discuss **only apply to non-grandfathered plans**. It is important to remember that if your plan loses its grandfathered status, it will have to comply with all the provisions listed here **and** the provisions I just went over.

The first provision listed here prohibits discrimination by a group health plan against health care providers acting within the scope of their license and applicable State laws.

Group health plans will be required to cover preventive services, immunizations, and screenings without any cost sharing.

There is also a provision of additional information that a non-grandfathered plan would be required to adhere to. This provision requires group health plans to disclose to the Federal government and to the State insurance commissioner, certain enrollee information such as claims payment policies and practices and enrollee rights. This provision also requires plans to provide information to enrollees on the amount of cost-sharing on a specific item or service. We are awaiting guidance on this provision.

Plans would be required to provide an effective internal appeals process of coverage determinations and claims and implement an external review process that meets standards established by the Federal government.

And, finally, group health plans must permit an individual to select a participating primary care provider or, pediatrician in the case of a child. The Plan will also be required to provide direct access to obstetrical or gynecological care without a referral. The law also prohibits prior authorization or increased cost-sharing for out-of-network emergency services.

Plans, including collectively bargained plans must comply with these reforms as early as this year.

Extension of Dependent Coverage

- The Affordable Care Act requires plans that cover dependents to extend coverage under the group health plan to adult children until they turn age 26. Covered dependents include: biological children, adopted children, stepchildren, and foster children. The child:
 - Is not required to reside with the employee/parent(s)
 - Does not need to be enrolled in college
 - Can be married
 - Is not required to be a tax dependent of the employee/parent(s)
 - Has to have the same benefits/same price as other similarly situated children under the plan
- The Internal Revenue Code was amended so that benefits and contributions for these adult children will be non-taxable.



One of the health reforms that the Federal government has released guidance on is the provision regarding the extension of dependent coverage. The Affordable Care Act requires plans that cover dependents, including collectively bargained plans, to extend coverage for children until they reach age 26. The children are not required to live with the parents, they do not have to be enrolled in college, they can be married, and they are not required to be a tax dependent in order to be covered under the plan. Any qualified adult child must be offered all of the benefit packages that are available to a child that did not lose coverage because of losing dependent status. Also, the child can not be required to pay more for coverage than any other child that is covered under the plan as a dependent.

In order for medical benefits and member and employer contributions to retain their favorable tax status, the Internal Revenue Code was amended to make benefits and contributions non-taxable for any child who is under age 27 as of the end of the taxable year. This amendment was dated retroactively to March 30, 2010 for those plans that wished to comply with this section of the health reforms early.

Extension of Dependent Coverage

- This provision does not require plans to cover a spouse of an adult child or children of an adult child.
- Until January 1, 2014, grandfathered plans may exclude coverage for a dependent that has an offer of employer-sponsored coverage aside from coverage through a parent.
- Plans must offer a Special Enrollment opportunity for affected children. For plan years beginning on or after September 23, 2010, plans must give children who qualify an opportunity to enroll that continues for at least 30 days regardless of whether the plan offers an open enrollment period. This enrollment opportunity and written notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.
- No delayed compliance date for plans written pursuant to CBAs.
- Must comply by the first day of the plan year immediately following September 23, 2010. Plans may also choose to comply early.



This provision does not require plans to cover a spouse of an adult child, nor does it require a plan to cover children of a dependent child. Also, as I mentioned before, until January 1, 2014, grandfathered plans may deny coverage to an adult child that has employer-sponsored coverage available to them aside from coverage through a parent.

It is important to note that there is no delayed compliance date for collectively bargained plans for the extension of dependent coverage; therefore, such plans must comply with this reform by the first day of the plan year that immediately follows September 23, 2010.

Early Retiree Reinsurance Program

- Single-employer and CBA plans are eligible to apply for the Early Retiree Reinsurance Program (“ERRP”) provided they are “employment-based plans” as defined in the ERRP regulation.
- An “employment-based plan” includes a “group benefits plan providing health benefits that is maintained by private employers ...or a multi-employer plan (as defined by ERISA)”.
- Funds are available to insured and self-funded plans.
- Plans may begin filing applications at the end of June.
- For more detailed information on this temporary program, refer to www.ebsrmsco.com under the Health Care Reform tab.



Single-employer and collectively bargained plans are both eligible to apply for and receive funds from the Early Retiree Reinsurance Program that was included in the Affordable Care Act. This temporary program, beginning on June 1, 2010, will make it easier for employers to provide coverage to early retirees. The Act includes \$5 billion in financial assistance to employers to help them maintain coverage for early retirees between the ages of 55 and 64 who are not yet eligible for Medicare.

The Act provides that “employment-based plans” that provide coverage to early retirees may apply for reimbursement under the program. An “employment-based plan” includes a “group benefits plan providing health benefits that is maintained by private employers... or a multi-employer plan as defined by ERISA”; therefore, collectively bargained plans are also eligible to participate.

Limited funds will be available to insured and self-funded plans. Plan Sponsors may begin filing applications at the end of June.

For more detailed information on this program and a copy of the application, please refer to our website at www.ebsrmsco.com under the Health Care Reform tab.

Client Impact

Plan Design

- CBA plans must be mindful of the accelerated compliance dates they may not be accustomed to.
- Review Plan Documents and Summary Plan Descriptions for compliance with health reforms
- Plans will need to prepare the proper amendments or summary of material modifications to their plans to implement any changes required to comply with the health reforms



Collectively bargained plans should be mindful of the fact that there is no delayed compliance date for which they are accustomed to so they will be required to comply much earlier than they normally have in the past. Plan Sponsors should review their plan materials very carefully for compliance with the health reforms.

Plan Sponsors will also need to prepare the proper amendments or summary of material modifications to their plans to implement any changes required to comply with the law.

Client Impact

Next Steps

- Plan Sponsors should notify EBS-RMSCO of any changes they wish to make to their plan design and provide us with the proper amendments or summary of material modification to their plan
- Plan Sponsors are also required to make proper notification to participants
- If the plan remains grandfathered, Plan Sponsors must disclose the grandfathered status on communication materials. (A copy of the model language is on our website www.ebsrmsco.com under the Health Care Reform tab)
- If a Plan Sponsor chooses to apply for the ERRP, they should begin preparing the application now and submit it as soon as the Federal government begins accepting them. Applications will be processed on a FIFO basis.



Plan Sponsors are asked to notify their Account Executive or Client Service Representative of any changes they wish to make to their plan design in order to comply with the health reforms. Plan Sponsors are also required to notify participants of these changes. If the plan retains its grandfathered status, Plan Sponsors must include a notice in plan materials stating that the plan is grandfathered and information on who to contact with questions. A copy of the model language provided in the regulation is located on our website at www.ebsrmsco.com under the heading Health Care Reform.

If a Plan Sponsor chooses to apply for the Early Retiree Reinsurance Program, they should begin preparing the application as soon as possible so that they can submit it as soon as the government begins accepting them. Applications will be accepted on a first in, first out basis.

Thank You



ASK US
If You Have Any Questions



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Thank you for joining me today. There are many new requirements included in this sweeping legislation and we know that it can be very confusing. Should you have any additional questions, please contact your Account Executive or Client Service Representative.

Remember that EBS-RMSCO is here to help!