

**Federal Health Care Reform:
Group Health Plans and Health Insurance Coverage
Relating to Collectively Bargained Public Sector Health Insurance Plans in Ohio**

October 2011

In 2010, Congress passed legislation to address health insurance reform through two pieces of legislation. The first, the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148), was signed into law by President Obama on March 23, 2010, expanding Medicaid eligibility, providing incentives for employers to provide health insurance, providing certain employees and employers with support for health insurance premium payments, prohibiting the denial of coverage for children on the basis of pre-existing conditions, establishing health insurance exchanges and providing additional support for medical research, among other things.

One week later, President Obama signed the Health Care and Education Affordability Reconciliation Act (HCEAR) (P.L. 111-152) into law, which made several technical changes to PPACA, also included a rider on financial aid for college students. The focus of health reform can be seen in the titles of the PPACA legislation:

1. Insurance Market Reforms
2. Medicaid Reforms
3. Medicare Reforms
4. Disease Prevention and Public Health
5. Workforce Supply
6. Fraud and Abuse, Transparency, Physician Self-Referral
7. Biologics and Drug Purchasing
8. Class Act
9. Revenue Generation and Tax
10. Amendments to Titles 1-9

This Bulletin narrows the focus of federal health care reform to those aspects that impact employer-based health insurance, i.e., PPACA Titles 1, 9 and 10.

To begin with, aspects of the federal health care reform law (PPACA and HCEAR) apply differently to grandfathered and non-grandfathered plans. A group health plan¹ or health insurance coverage is a grandfathered health plan with respect to individuals enrolled on March 23, 2010, their family members, and other new employees (whether newly hired or newly enrolled) thereafter. A grandfathered plan can be insured or self-insured. Grandfathered plan status is determined separately with respect to each benefit package. According to the “Keeping the Health Plan You Have: The Affordable Care Act and “Grandfathered” Health Plans” fact sheet available

¹ The term ‘group health plan’ includes both insured and self-insured group health plans. The treatment of dental and vision benefits require an explanation which is beyond the scope of this brief Bulletin. Please see *FAQs About the Affordable Care Act Implementation* at http://www.hhs.gov/ociio/regulations/implementation_faq.html.

from the federal government at <http://www.healthcare.gov>, grandfathered plans can lose their status in a number of ways.

“Compared to their polices in effect on March 23, 2010, grandfathered plans:

- Cannot significantly cut or reduce benefits. For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.
- Cannot raise co-insurance charges. Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20% of a hospital bill). Grandfathered plans cannot increase this percentage.
- Cannot significantly raise co-payment charges. Frequently, plans require patients to pay a fixed-dollar amount for doctor’s office visits and other services. Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next 2 years, it will lose its grandfathered status.
- Cannot significantly raise deductibles. Many plans require patients to pay the first bills they receive each year (for example, the first \$500, \$1,000, or \$1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points. In recent years, medical costs have raised an average of 4-to-5% so this formula would allow deductibles to go up, for example, by 19-20% between 2010 and 2011, or by 23-25% between 2010 and 2012. For a family with a \$1,000 annual deductible, this would mean if they had a hike of \$190 or \$200 from 2010 to 2011, their plan could then increase the deductible again by another \$50 the following year.
- Cannot significantly lower employer contributions. Many employers pay a portion of their employees’ premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers’ share of premium from 15% to 25%).
- Cannot add or tighten an annual limit on what the insurer pays. Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).”

To maintain grandfathered status, a plan or health insurance coverage (1) must include in any plan material provided to participant or beneficiaries describing the benefits under the plan or health insurance coverage, that the plan or health insurance coverage believes that it is a grandfathered health plan within the meaning of section 1251 of the PPACA, and (2) must provide

contact information for questions and complaints. In addition, a plan or health insurance coverage which takes the position that it is grandfathered must maintain records documenting the terms of the plan in effect on March 23, 2010, and any documents necessary to verify, clarify or explain grandfathered status. These retained records must be kept for as long as the plan relies on its grandfathered status and must be made available for examination by participants, beneficiaries and federal and state agencies upon request.

In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010, the coverage is grandfathered at least until the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates. Collectively bargained plans (both insured and self-insured) that are grandfathered health plans are subject to the same requirements as other grandfathered health plans, and are not provided with a delayed effective date for PHS Act provisions with which other grandfathered health plans must comply. Thus, the provisions that apply to grandfathered health plans apply to collectively bargained plans before and after termination of the last of the applicable collective bargaining agreement. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage that amends the coverage solely to conform to federal health care reform law is not treated as a termination of the collective bargaining agreement.

Certain group health plans and health insurance coverage existing as of March 23, 2010 are subject to provisions of federal health care reform for plan years beginning on or after September 23, 2010. This includes the following:

2010

- Requires plans offering coverage in the group and individual markets (including grandfathered plans but excluding self-insured plans) to report to the Secretary the amount of premium revenues spent on clinical services, activities to improve quality, and all other non-claims costs as defined by the National Association of Insurance Commissioners and certified by the Secretary of HHS. Beginning in 2011, large group plans that spend less than 85 percent of premium revenue and small group and individual market plans that spend less than 80 percent of premium revenue on clinical services and quality must provide a rebate to enrollees (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011). In addition, each hospital operating within the United States shall publish a list of standard charges for items and services provided by the hospital. (PPACA, Title 1, Subtitle C, Section 2718).
 - On July 7, 2011, the Department of Health and Human Services (DHHS) released a list of states and territories with effective review programs in the private small group and individual markets. Ohio will use a state process in both markets.² On September 1, 2011, states and DHHS began reviewing proposed premium increases for 2012.

² See http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html.

- Group health plans and health insurance issuers offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage for children under age 19 (PPACA, Title 1, Subtitle C, Section 2704). This provision is applicable to grandfathered plans and non-grandfathered plans.
- Group health plans and health insurance issuers offering group or individual health insurance coverage cannot rescind an enrollee's coverage except in cases of fraud or intentional misrepresentation (PPACA, Title 1, Subtitle A, Section 2712). This provision is applicable to grandfathered and non-grandfathered plans.
- Group health plans and health insurance issuers offering group health insurance coverage may not establish (1) lifetime limits on the dollar value of benefits for any participant or beneficiary or (2) unreasonable annual limits on the dollar value of essential benefits for any participant or beneficiary. Until then, plans may only establish restricted limits prior to January 1, 2014 on essential benefits as determined by the Secretary of DHHS. (PPACA, Title 1, Subtitle A, Section 2711). This provision is applicable to grandfathered and non-grandfathered plans.
 - For plan years beginning on or after September 23, 2010 but before September 23, 2011, the annual limit cannot be less than \$750,000; for plan years beginning on or after September 23, 2011 but before September 23, 2012, the annual limit cannot be less than \$1,250,000; and for plan years beginning on or after September 23, 2012 but before September 23, 2014, the annual limit cannot be less than \$2,000,000.
 - The term 'essential benefits' includes at least the following ten general benefit categories: 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; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Such essential benefit (EHB) packages are meant for the uninsured individuals and employees of small businesses (< 100 employees).
 - Congress asked the DHHS to recommend a process for defining an EHB package, which turned the job over to the Institute of Medicine (IOM). On October 7, 2011, the IOM released its recommendations on how to develop a process to establish and update an EHB package.³ The IOM report focuses this process on evidence-based services and health care service prioritization, setting a target for EHB wherein the plan pays 70 percent of covered medical and drug charges.

³ See http://www.nap.edu/catalog.php?record_id=13234.

- Group health plan and health insurance issuers offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual: (1) health status, (2) medical condition (including both physical and mental illnesses), (3) claims experience, (4) receipt of health care, (5) medical history, (6) genetic information, (7) evidence of insurability (including conditions arising out of acts of domestic violence), (8) disability, and (9) any other health status-related factor determined appropriate by the Secretary of the Public Health Service (PPACA, Title 1, Subtitle C, Section 2705). This provision is not applicable to grandfathered plans.
- Health plans must provide certain types of preventive care without participant cost-sharing (the regulations passed subsequent to the law indicate that network plans don't have to offer preventive care out of network). This provision is not applicable to grandfathered plans. Preventive care services include:
 - Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force.
 - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
 - With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
 - With respect to women, additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009 (PPACA, Title 1, Subtitle A, Section 2713).
- Children up to age 26 are eligible to receive coverage under a parent's plan (PPACA, Title 1, Subtitle A, Section 2714) unless they have access to coverage under an employer plan; this restriction ends in 2014. This dependent eligibility expansion is applicable to non-grandfathered plans. Grandfathered plans don't have to offer coverage to eligible dependents if those dependents have access to coverage through another employer.
 - The definition of a dependent includes the employee's son or daughter, stepchild, legally adopted child, legally placed foster child, or covered child of a domestic partner.
 - Once this mandate applies, plans can no longer include eligibility conditions for any minor or adult child < age 26 based upon the child's student status, marital status, employment, financial support base or residency status. The law does not require

employers to cover a dependent's spouse or children, and children are allowed on the plan even if the parent provides partial or full support. In fact, the dependent does not have to reside with the parent or even live in the same state as the parent. However, until 2014, grandfathered plans do not have to provide coverage if the child is covered under another employer-sponsored plan.

- Employer contributions and patient costs cannot be based upon the child's age, and the employer's contribution structure for other dependents must be extended to eligible adult children.
 - A new special enrollment period must be available children who were denied, never had coverage or whose coverage ended for plan years starting after September 23, 2010. Children on COBRA because they 'aged out' of the plan must be given an opportunity to enroll as a dependent.
 - The value of employer-provided coverage for children through the end of the year in which they reach 26 will not be taxable to employees.
- The Secretary of the Public Health Service is responsible for developing guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs (PPACA, Title 1, Subtitle A, Section 2713) and standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage (PPACA, Title 1, Subtitle A, Section 2715). This latter section of law also requires health plan administrators that make any material modification in any of the terms of the plan or coverage involved that is not reflected in the most recently provided summary of benefits and coverage to notify enrollees within 60 days prior to the date on which such modification becomes effective.
 - Two additional programs are to be established by the Secretary of the Public Health Service beginning approximately June 23, 2010 through January 1, 2014. The first program is a high risk health insurance pool program for the uninsured (PPACA, Title 1, Subtitle B, Section 1101), while the second is a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to employers that provide early retirement health insurance benefits (PPACA, Title 1, Subtitle B, Section 1102).
 - In May 2010, the Ohio Department of Insurance announced that it was seeking proposals to implement a temporary high risk pool in Ohio; the contract was awarded to Medical Mutual of Ohio on June 25, 2010. Coverage began September 1, 2010, and money from the federal government (\$152 million) may be enough to cover 5,000 of Ohio's estimated 17,000 uninsured that could qualify for the program. Those who are accepted into the program will be enrolled in Medical Mutual of Ohio's SuperMed PPO program, and will pay premiums that are set according to the county in which the enrollee lives. The program is expected to end by 2014, when individual health insurance exchanges are slated to begin.

- By May 2010 each of Ohio's non-uniformed retirement systems that serve Ohio's public school employees had indicated that they would apply for the retiree reinsurance program. By August 2010, the applications of the Ohio Public Employees Retirement System of Ohio (OPERS) and the School Employees Retirement System of Ohio (SERS) had been accepted. In October 2010, STRS received information from the federal government that the first of their two applications for the retiree reinsurance program had been accepted.
- Health insurance exchanges will be established to provide access to fully-insured individual or group health insurance coverage (PPACA, Title 1, Subtitle D, Parts 1 - 4) on or before 2014.
 - Ohio's Exchange was being developed by the Ohio Department of Insurance and the Ohio Health Care Coverage and Quality Council, but the Ohio Department of Insurance disbanded the Council in 2011. According to the ODI website, "Many efforts of the HCCQC are now being led by the Office of Health Transformation."⁴
 - On August 30, 2010, Ohio applied for a health exchange planning grant. On October 1, 2010, DHHS awarded grants to states to assist in the planning and establishment of the exchange (not operating funds). Each state will seek final approval from the U.S. Department of Health and Human Services for implementation of its exchange 1/1/2012 – 12/31/2013. DHSS must determine by January 1, 2013 if a state will be able to operate a qualified exchange (If a state does not, the federal government will operate it). Each state shall establish an American Health Benefit Exchange by January 1, 2014; each state Exchange must be self-sustaining by January 1, 2015.
- Self-funded health plans which have opted out of special enrollment periods, limitations on preexisting condition exclusion periods, and prohibitions against discriminating against individual participants and beneficiaries based on health status under the Health Insurance Portability Act (HIPAA) may no longer continue to do so for plans beginning on or after September 23, 2010. Plans such as these that are maintained pursuant to a collective bargaining agreement ratified before March 23, 2010 will not have to come into compliance until the first day of the first plan year following the expiration of the last plan governed by the collective bargaining agreement.
- Employers that have more than 200 full-time employees and that offer employees enrollment in 1 or more health benefits plans must automatically enroll new full-time employees in one of the plans offered (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer. 'Automatic' and current enrollees have the ability to opt out of the plans once they receive advance notice of their opt-out rights from their employer (PPACA, Title 1, Subtitle C, Part 2, Section 1511). Once state health exchanges are

⁴ See <http://www.insurance.ohio.gov/Pages/hccqc.aspx>.

established, employers are required to provide an employee, at the time of hiring (or, with respect to current employees, not later than March 1, 2013), written notice—

- Informing the employee of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance;
- If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986 and a cost sharing reduction under section 1402 of the Patient Protection and Affordable Care Act if the employee purchases a qualified health plan through the Exchange; and
- If the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

2011

- The PPACA will provide employers with technical assistance, consultation, tools, and other resources in evaluating employer-based wellness programs, and in training employers on how to evaluate employer-based wellness programs (PPACA, Title IV, Subtitle D, Section 4303).
- For tax years beginning on or after January 1, 2011, reimbursements for health flexible spending arrangements (health FSAs) or health reimbursement arrangements (HRAs), and distributions from health savings accounts (HSAs) or Archer medical savings accounts (Archer MSAs), will be modified to include amounts paid for medicine or a drug only if such medicine or drug is a prescribed drug or is insulin; reimbursements for over-the-counter (OTC) drugs under these plans will no longer be allowed unless the OTC drug is prescribed (PPACA, Title 9, Subtitle A, Section 9003). This provision is applicable to grandfathered and non-grandfathered plans.
- Distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses will be taxed up to 20 percent of the amount used, up from 10 percent prior to PPACA.

2012

- A uniform schedule of benefit and coverage statement and a standardized glossary are made available from health insuring companies, life and health companies, and third party administrators that provide health insurance benefits to individuals and those covered by employer-based health insurance coverage (PPACA, Title 1, Subtitle A, Part A, Subpart II, Section 2715). This requirement applies to both insured and self-insured

plans, grandfathered and non-grandfathered plans, ERISA plans and plans that are not covered by ERISA, in particular, non-federal governmental health plans.

- A proposed rule on the benefit and coverage statement was released by the Health and Human Services Department, the Employee Benefits Security Administration, and the Internal Revenue Service on August 22, 2011. A template for the uniform schedule of benefit and coverage statement is at <http://www.healthcare.gov/news/factsheets/2011/08/labels08172011b.pdf>.

2013

- Employers must begin to report the total cost of medical benefits on employees' Form W-2 in tax year 2013 (the form W-2 issued for the 2012 calendar year) (PPACA, Title 9, Subtitle A, Section 9003). It is intended to be informational only, and is not a tax on health benefits. The value of the benefit will not be added to the taxpayer's gross income.
 - On March 29, 2011, the Treasury Department and Internal Revenue Service released interim guidance related to this part of the law. The guidance reiterates that the reporting is for informational purposes only. That is, the inclusion on a Form W-2 of the cost of health benefits does NOT make those benefits taxable to the employee.
- Beginning January 1, 2013, PPACA would limit the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year increased annually by a cost of living adjustment (PPACA, Title 9, Subtitle A, Section 9005(i)).

2014

- Beginning January 1, 2014, U.S. citizens and legal residents will be required to have qualifying health coverage (there is a phased-in tax penalty for those without coverage, with certain exemptions) (PPACA, Title 1, Subtitle F, Part 1, Section 1501).
- Assess employers with 50 or more employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee, excluding the first 30 employees from the assessment. PPACA exempts employers with fewer than 50 employees from any of the above penalties, and requires employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400 percent of the federal poverty level (FPL) whose share of the premium exceeds 8 percent but is less than 9.8 percent of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing

free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange (PPACA, Title 1, Subtitle C, Part 2, Section 1513).

- Limit the waiting period for health plan benefits to 90 days or less (PPACA, Title 1, Subtitle C, Section 2708). This provision is applicable to grandfathered and non-grandfathered plans.

2018

- An excise tax of 40 percent on insurance companies or plan administrators will be levied for any health coverage plan to the extent its cost is above the threshold of \$10,200 for single and \$27,500 for family coverage. These thresholds could be higher if plan costs increase more than expected between 2010 and 2018. The threshold will be indexed at CPI-U plus 1 percentage point in 2019 and CPI-U in years thereafter. An adjustment to the thresholds is available for employers whose health costs are higher due to the age or gender of employees (HCERA, Subtitle E, Section 1401). This tax is expected to be passed on to employers, who are expected to pass it on to employees. This provision is applicable to grandfathered and non-grandfathered plans.

As expressed in the PPACA and the HCEAR, federal health care reform took 907 pages to write as legislation. The regulations and implementing guidelines constitute thousands of pages and will take years to fully develop. Over 150 boards and commissions were created through the legislation in order to apply and monitor its implementation. The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) estimated that enacting both pieces of legislation would produce a net reduction in federal deficits of \$143 billion over from 2010 through 2019 as a result of changes in direct spending and revenues.

For those who would like additional information on federal health care reform, please visit <http://www.healthcare.gov/>. Questions regarding this *Bulletin* should be directed to Gregg Gascon in the Collective Bargaining and Research Division at gascong@ohea.org.

COLLECTIVE BARGAINING & RESEARCH DIVISION (CBaR)

OHIO EDUCATION ASSOCIATION | Box 2550, Columbus OH 43216-2550 | 614/228-4526 or 800-282-1500