McGraw Wentworth

REFORM Update

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McGraw Wentworth will continue to clarify various aspects of health care reform in our *Reform Updates*. This *Update* reviews the following topics:

- Changes to Medicare Part D
- Auto-enrollment for employers with more than 200 full-time employees
- Government studies on large group market
- National voluntary long-term care program
- Accommodating breast-feeding mothers

While some of these issues won't affect employers immediately, these key elements of health care reform will affect organizations within the next few years.

Changes to Medicare Part D

Health care reform changes to Medicare Part D may at some point affect employer-sponsored group health plans. The goal is to reduce beneficiaries' out-of-pocket Medicare Part D costs, specifically in the coverage gap or "donut hole."

The closing of the donut hole will happen over time and be handled differently for brand name and generic drugs. Brand name drug cost reductions will be funded by additional discounts offered by pharmaceutical manufacturers and also government subsidies that are provided directly to PDPs (approved Prescription Drug Plans). The coverage of brand name drugs in the donut hole will change as follows over the next ten years:

Year	Manufacturer Discount	Gov't Subsidy to PDP	Beneficiary Pays
2010	n/a	n/a	100% less $250 rebate
2011	50%	n/a	50%
2012	50%	n/a	50%
2013	50%	2.5%	47.5%
2014	50%	2.5%	47.5%
2015	50%	5%	45%
2016	50%	5%	45%
2017	50%	10%	40%

Year	Manufacturer Discount	Gov't Subsidy to PDP	Beneficiary Pays
2018	50%	15%	35%
2019	50%	20%	30%
2020	50%	25%	25%

The donut hole will also be gradually closed for generic drugs, but this will be accomplished solely through government subsidies paid to PDPs. The changes for generic drug coverage in the donut hole for the next 10 years will be as follows:

Year	Gov't Subsidy to PDP	Beneficiary Pays
2010	n/a	100% less $250 rebate
2011	7%	93%
2012	14%	86%
2013	21%	79%
2014	28%	72%
2015	35%	65%
2016	42%	58%
2017	49%	51%
2018	56%	44%
2019	63%	37%
2020	75%	25%

Beginning in 2011, the base Medicare Part D premium will increase for anyone with a significant adjusted gross income. The increase depends on the adjusted gross income amount (for joint filers, the income amounts listed below should double):

Adjusted Gross Income	Percentage Increase in Base Part D Premium
$85,000 or less	No adjustment
More than $85,000 but equal to or less than $107,000	35%
More than $107,000 but equal to or less than $160,000	50%
More than $160,000 but equal to or less than $214,000	65%
More than $214,000	85%

While these changes directly affect Medicare Part D enrollees, they may also affect employer-sponsored health plans. Employer plans must determine whether their prescription drug coverage is equivalent to or better than the standard Medicare Part D plan. If the employer benefits are as good as or better than Medicare Part D, the coverage is considered creditable. Employers are required to notify Medicare-eligible participants of the prescription plan's creditable coverage status annually.

Health care reform changes are likely to increase the value of the standard Part D benefit and thus may affect creditable coverage status.

Auto-Enrollment Rules for Large Employers

Health care reform amended the Fair Labor Standards Act to require employers with more than 200 full-time employees to enroll new full-time employees in a health plan automatically. The auto-enrollment provisions are sparse, but key details include:

- Employers must automatically enroll new full-time employees in one of the health plans the employer offers (subject to any lawful waiting period).
- Employers must also continue to enroll current employees in the health benefits plan.
- An employer must notify new employees of the opportunity to opt-out of any automatic coverage.
- This section of the law does not supersede any state law, unless a state law prevents an employer from instituting the automatic enrollment program.

The health reform laws do not include an effective date for this provision. Generally, when an effective date is not included, the rule is effective on the date the statute passes. However, in this case, the statute indicates the government will issue regulations on the specifics of auto enrollment and those regulations will include an effective date.

Government Studies on Large Group Market

The government will begin collecting data on health plans to submit to various Congressional committees.

The first project will be an annual report on self-insured plans. No later than March 23, 2011, the Secretary of Labor will prepare an annual report using Form 5500 data. The report will include general information, such as:

- Plan type, number of participants, benefits offered, funding arrangements and benefit arrangements.
- Financial information on self-funded benefit plans, information on assets, liabilities, contributions, investments and expenses.

The second project is a study of fully insured and self-funded group health markets to:

1. Compare characteristics of employers, health plan benefits, financial solvency, capital reserve levels, and the risks of becoming insolvent.
2. Determine the extent to which the new health insurance market reforms will discourage employers from using the large group market or encourage small or midsize employers to self-fund.

The Secretary of HHS will work jointly with the Secretary of Labor to collect information and analyze:

1. Whether self-funded group health plans are less expensive and whether lower costs are due to more efficient plan administration and lower overhead or to claim denial and limited benefit packages.
2. Claim denial rates, plan benefit fluctuations, and the effect of the limited recourse options on consumers.
3. Any potential conflict of interest between self-insured enrollees' health care needs and self-insured employers' financial contribution or profit margin and the effect of the conflict on administering the health plan.

A report on the results of this data collection is due no later than March 23, 2011.

What is not clear is exactly how the government intends to collect this information. Clearly the health insurance carrier or a self-funded plan's third party administrator will need to provide some of the information. However, these entities may need information directly from employers, in which case, employers will need to respond to those requests.

None of the mechanics on how these studies will be conducted is currently included in the health reform acts. Future guidance will likely provide more details.

National Voluntary Long-Term Care Program

The health reform act also includes the Community Living Assistance Services and Supports Act (CLASS Act). CLASS is a voluntary insurance program designed to:

1. Provide a new financing strategy to help people with disabilities maintain their personal and financial independence and live in the community.
2. Establish an infrastructure to help support community living assistance services.
3. Alleviate the burdens on family caregivers.
4. Provide support for people choosing to remain independent and live in the community rather than live in an institution.

Health reform includes only the very broad details on this new program to be administered by the Secretary of Health and Human Services. The program will provide some basic long-term care benefits and provide some financial assistance to help people continue to live at home. The program will have no underwriting requirements. Employers choosing to offer this government program will be permitted to collect premiums through payroll deductions. Employers have the option of adopting an auto-enrollment process, but they must allow employees to opt-out. If employers decide not to offer the voluntary plan, anyone eligible can choose to enroll in the program directly with the government. To be considered eligible, a person must:

1. Be 18 years or older.

2. Have earned taxed wages or paid taxes on self-employment income.
3. Be actively employed.

It appears anyone eligible can enroll during an initial enrollment period. Those choosing not to enroll when first eligible can enroll during a subsequent open enrollment period (no timeframe specified). Anyone deciding to disenroll from the program must wait for the next open enrollment period.

Premium amounts depend on age or income level and can be adjusted annually. Anyone making less than poverty level income can pay a nominal premium. If coverage lapses for more than 90 days, premiums can be re-calculated. Premiums will not increase when a participant turns 65 or has paid premiums for 20 years.

The premiums are treated the same as long-term care insurance for tax purposes. If employers allow employees to elect coverage under the plan, the premiums will need to be taken from an employee's pay post-tax. Long-term care insurance is tax-deductible only in very limited circumstances. Employees should consult their tax advisors to determine whether part of the premium is tax deductible.

Two types of long-term care benefits are available. First, part of the premium paid is set aside in a Life Independence Account which allows:

- Financial help to pay for any needed home modifications, accessible transportation, respite care, personal assistance services and so on.
- Institutionalized Medicaid beneficiaries to keep 5% of the account for personal needs and Medicaid to keep the remainder to offset the cost.
- Participants in home- or community-based services to keep 50% of their account with the remainder offsetting the cost to the state.
- Cash benefit received to be disregarded in determining eligibility for a needs-based program such as Medicaid.
- Funds to pay for a family caregiver.

The second benefit resembles a more traditional long-term care insurance product. To qualify for these benefits, a participant needs to meet the trigger for care. The trigger is based on the inability to perform the six activities of daily living (ADLs), which include eating, toileting, transferring, bathing, dressing and continence. To be eligible for benefits, a participant must require substantial supervision for at least two of the six ADLs. Benefits are paid in cash and will be at least $50 a day. Payments will also vary based on the number of ADLs the participant cannot perform without assistance.

A participant must pay into the plan for at least five years before benefits are available. Participants must also meet some additional requirements relating to income and premium payment lapses.

The program will coordinate with traditional long-term care coverage. It appears that insurance carriers will be able to offer long-term care options through the exchange.

While the effective date for this program is January 1, 2011, it is pretty clear that, based on the magnitude of this program, the effective date is simply not practical. It will likely take a couple of years to fully develop the official parameters of the program, the eligibility system, the payment process and the claims payment process. More details will be coming.

Accommodations for Breast-Feeding Mothers

Health care reform also amended the Fair Labor Standards Act. Employers will have to provide nursing mothers:

- A reasonable break time to express milk for up to one year after the child is born. The break time needs to be allowed whenever the mother needs to express milk.
- A place, other than a bathroom, shielded from public view and free from intrusion by co-workers or the public, to express milk.

The employer is not required to pay an employee receiving reasonable break time for the sole purpose of expressing milk.

An employer with fewer than 50 employees is not required to comply with this section if the requirements would impose an undue hardship by causing the employer significant difficulty or expense when considering factors such as employer size, financial resources, and the nature of the employer's business.

Although the details of this requirement are sparse, the requirements were effective as of March 23, 2010. Employers have scrambled to find space and create policies to accommodate nursing mothers.

Our next *Reform Update* will cover the federal limit on medical FSAs, loss of tax-favored status of the retiree drug subsidy, quality information reporting requirements, tax to fund comparative effectiveness studies, health insurer executive compensation limits, and Medicare payroll tax increase for specific employees.