McGraw Wentworth

REFORM Update

Issue Nine June 2010

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In order to highlight key issues for plan sponsors within a voluminous, two-act health care reform law, McGraw Wentworth released eight *Reform Updates* over the past ten weeks. Our steady rollout approach allows time for issuance of the needed clarifying regulations (at least some of them), clustering of date sensitive or interrelated aspects of the laws, and, hopefully, bite-sized and understandable information. We will continue this process over the coming months as additional guidance becomes available. All of the *Reform Updates* can be found at our website, www.mcgrawwentworth.com.

Issue - *Date*	Topics Covered
#1 - *March 22*	• Patient Protection and Affordable Care Act (PPACA) • Key Provisions and Glimpse Of The Future
#2 - *March 31*	• Health Care and Education Reconciliation Act of 2010 (HCERA) • Key Provisions and Overview of Changes to PPACA
#3 - *April 12*	• National High Risk Pool, Temporary Early Retiree Reinsurance Program, Small Business Tax Credit , Change Tax-Favored Status of OTC Drugs • Non-Grandfathered Key Group Health Plan Mandates
#4 - *April 26*	• Grandfathering Discussion and Group Health Plan Mandates • W-2 Reporting, Section 105(H) Non-Discrimination Rules on Self-Funded Plans, Increase to Excise Tax on Non-Medical HSA Distributions
#5 - *May 3*	• IRS Notice 2010-38 – Taxation of Coverage Provided to Age 26 Dependents • Section 125 Amendments - Pre-Tax Premium Deductions and Allowance of Expenses Under Medical FSA for Adult Non-Dependent Children
#6 - *May 10*	• Employer Responsibilities for 2014 – “Pay or Play” Provisions • Additional Employer Administrative Requirements • Update on Early Retiree Reinsurance Program – New Information Released

Issue - *Date*	Topics Covered
#7 - *May 18*	• Early Retiree Reinsurance Program
#8 - *May 26*	• Extension of Coverage to Children to Age 26

In this *Update*, we will cover the following topics that will impact employers and health plans:

- Coverage requirements for clinical trials
- Federal rate review requirements and minimum loss ratios
- Small employer cafeteria plan requirements
- Web-based information portals (state requirement)
- Health plan summary communication requirements
- Annual fee imposed on brand name prescription drug manufacturers
- Important clarifications for HSAs

At this time, our information on these topics come from the Health Care Reform acts that provide only a summary of requirements – clarifying regulations will be needed to answer many important questions.

Covering Clinical Trials

Health Care Reform requires non-grandfathered health plans cover individuals participating in approved clinical trials on the first day of the first plan year on or after January 1, 2014. In theory, the effective date may be delayed for "grandfathered plans" but we are waiting for additional guidance to determine how grandfathering impacts effective dates.

Group health plans and health insurers:

- May not deny an individual the ability to participate in a clinical trial that meets certain requirements
- Must not deny, limit, or impose additional conditions on coverage for **routine patient costs** in connection with clinical trial (items and services typically covered when not in clinical trial)
- Cannot discriminate against an individual due to participation in clinical trial
- Will not be required to cover any investigational item, device, or service
- Will not be required to cover items or services provided solely to satisfy data collection and analysis needs or items not used in the direct clinical management of patient
- Will not be required to cover a service clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

- Will be able to require qualified individuals participate in a clinical trial using a network provider as long as provider will accept individual as a patient.
- Will not be required to cover clinical trial out-of-network, but only if plan does not cover treatments out-of-network
- Need only cover *approved clinical trials* - a Phase I–IV trial conducted for the prevention, detection, or treatment of cancer or other life-threatening conditions as follows:
    - Federally funded or approved by NIH, CDC, AHCRQ, CMS, cooperative group or center of DOD, VA or DOE, or qualified non-governmental entity identified by NIH grant guidelines
    - Study or trial conducted under FDA approved investigational new drug application
    - Drug trial exempt from FDA approved investigational new drug application
- *Qualifying individuals* must be eligible to participate in a trial for treatment of cancer or other life-threatening medical conditions and must be referred by a network provider who believes patient would benefit from trial or individuals can provide medical and scientific information to support they will benefit from participation

Though the requirements to cover routine patient costs appear relatively straightforward, it would be helpful for the government to provide examples of expenses that would be considered routine patient costs. For now, employers may need to rely on their carriers and TPAs to assist with this plan change.

Federal Rate Review and Minimum Loss Ratios

Effective January 1, 2011, insurance carriers (individual and group market) will have new loss ratio measurement rules and new reporting requirements to the Federal government.

The rules indicate that loss ratios will be measured by dividing the total amount of money spent on health care services for plan participants (including both clinical care and activities that improve health care quality) by the total amount of premium revenue. Large group health insurance carriers (101 or more lives) must maintain loss ratios of at least 85% and individual and small group carriers (100 lives and below) must maintain loss ratios of at least 80%. Any carrier failing to meet the minimum loss ratios may be compelled to rebate a portion of the premium.

Carriers must submit a report to the HHS Secretary explaining how incurred loss (i.e., incurred claims) plus the loss adjustment expense (i.e., change in IBNR or contract reserves) compare to total earned premiums. The report will include the percentage of total premium revenue (net of risk adjustment, risk corridors, and payments of reinsurance) that such coverage expends on:

1. Reimbursement for clinical services (health care services) provided to plan participants
2. Activities that improve health care quality
3. All other non-claims costs (excluding Federal and State taxes and licensing or regulatory fees) - along with an explanation of nature of such costs

The carrier information will be made available to the public on a website to be developed by HHS. Based on the insurance carrier information, the government will make a determination as to whether the carrier has achieved the required loss ratio targets. If targets are not achieved, the rebate calculation is based on the percent below target multiplied by the total premium revenue (less Federal and State taxes and licensing or regulatory fees).

The government is working closely with the NAIC to develop the accepted methodology for calculating the minimum loss ratio and also potential rebate calculations.

Though these requirements will not directly affect employers, organizations that purchase fully insured health benefits need to be aware that insurance carriers will be required to provide the required reporting and achieve the specified loss ratios.

Small Employer Cafeteria Plan Requirements

Health Care Reform establishes a SIMPLE cafeteria plan available only to small employers. The new SIMPLE arrangement is designed to help small employers meet the IRS Section 125 requirements when allowing employees to pay for health plan premiums on a pre-tax basis – these requirements include both plan documentation and non-discrimination rules (Section 125 plan rules can be found in our 2010 *Benefit Advisor*, Issue 4 at http://mcgrawwentworth.com/resources_benefitsadvisor.html).

Small employers often struggle to pass IRS non-discrimination tests designed to prevent plans from favoring highly compensated and key employees. A SIMPLE plan automatically satisfies the non-discrimination requirements of Section 125. Small employers now have two options for offering a qualified Section 125 plan: meet the traditional requirements and pass the non-discrimination tests **or** meet the requirements of a SIMPLE plan.

Unfortunately, SIMPLE may not be as easy as the name implies. First, an employer must have an average of 100 or fewer employees on business days during either of the two preceding years (IRS controlled group rules apply when defining employer). Special rules allow “growing firms” to continue using a SIMPLE plan after crossing the 100 lives threshold. If an employer is eligible, the plan must meet two requirements to be considered a SIMPLE plan:

1. ***Eligibility:*** All employees (with some exceptions) must be eligible to participate with each employee able to elect any benefit available under the plan (subject to any terms or conditions affecting all participants). Exceptions to “all employee” rule include:
    a. Not attained age 21 by end of plan year
    b. Worked fewer than 1,000 hours in preceding plan year
    c. Not completed one year of service with the employer at any day in plan year
    d. Covered by collective bargaining agreement
    e. Meet requirement of Section 410(b)(3)(C) - non-resident alien working outside U.S.

2. ***Minimum Contribution***: Employer must pay a minimum level of contribution for each non-highly compensated employee (not highly compensated and/or not key employee) that may be used to purchase any qualified benefit offered under the plan. Minimum contribution can be a fixed amount or a matching contribution, but must use the same methodology for all non-highly compensated employees.

This new SIMPLE plan option does not replace the safe harbor for premium-only plans in the current Section 125 regulations. Small employers should consult the administrator of their cafeteria plan to determine if it makes sense to adopt a SIMPLE plan or maintain their current Section 125 arrangement.

Web-Based Information Portals

Health Care Reform requires HHS to develop a website called a web portal that individuals and small businesses can use to access information about insurance coverage available in their state. At a minimum, the portal must include information on eligibility, availability, premium rates, cost sharing, and the percentage of premium revenue expended on non-clinical costs relating to the plan options offered. The web portal must be available to the public as of July 1, 2010.

HHS issued an interim final rule detailing the information carriers, states, high risk pools, and association plans will be required to provide. In addition, the interim rules recognize the practical reality that not all the information requested will be available before July 1st by setting forth a staged approach in data collection. General information about products is expected on July 1st, with detailed pricing and benefits information due September 3rd and expected to be available on October 1st.

Once the portal is fully developed, it should provide helpful information on securing individual and small group health coverage across the country.

Health Plan Summary Communication Requirements

Health Care Reform includes a new communication requirement for employers - a four-page summary of benefits for plan participants. The technical effective date is the first day of the first plan year following September 23, 2010, but the government is scheduled to produce a model notice by March 23, 2011 and employers are given until March 23, 2012 to distribute the new summary.

The health plan summary must:

- Be presented in a culturally and linguistically appropriate manner
- Be written in at least 12 point font
- Be provided to all applicants and enrollees at initial enrollment and annual open enrollment
- Be provided by plan administrator (self-funded plans) or insurance carrier
- Be provided in a paper or an electronic format

- Include all of the following information:
  - Uniform definitions of standard insurance and medical terms
  - Coverage explanation including cost sharing for essential benefits
  - Coverage exceptions, reductions and limitations
  - Cost-sharing provisions (copays, deductibles, coinsurance)
  - Renewability and continuation of coverage provisions
  - Examples illustrating common benefit scenarios
  - Whether minimum essential coverage is provided and a statement that the plan ensures its share of the total allowed cost of benefits in not less that 60%
  - Statement that the coverage document should be consulted for more detailed information
  - Contact information if the individual has questions and any website addresses associated with the carrier, TPA or your site where the SPD is maintained

The summary appears to require so much information that it would exceed a four page limit - it will be interesting to see the model notice HHS releases. For ERISA plans, this summary of coverage requirement is over and above the requirement to provide an SPD.

The fine for failing to provide this summary is substantial (up to $1,000 **for each willful failure**). More details will be needed to define a willful failure. Employers will need to wait for the model notice and any clarifications the government makes via regulations.

Annual Fee on Pharmaceutical Drug Manufacturers

An annual fee will be imposed on brand name pharmaceutical drug manufacturers and importers beginning in 2011. The fee will be determined based on percentage of brand name prescription sales from the previous year. The government will determine the amount of fee based upon sales reports drug manufacturers and importers are required to provide to the government.

The funds collected from this annual fee will be transferred to the Medicare Part B trust fund.

This fee will not directly affect most employers; however, it may impact the pricing of brand name medications under your group health plan.

Clarification on Dependents and HSAs

Health Care Reform requires group health plans that cover dependent children to extend coverage to children up to age 26 effective the first day of the first plan year following September 23, 2010. For employers with CDHPs/HSAs, it is important to understand how this change will impact your arrangement. The CDHP is required to extend benefit coverage to children up to age 26 under the qualifying high deductible health plan. However, Health Care Reform did not change HSA rules in terms of determining qualifying dependents for tax-favored medical expenses under the HSA. HSAs are governed by Section 223 of the IRC and that section of the code refers to Section 152 to define dependents eligible for tax-favored distributions from HSAs for medical expenses.

Health Care Reform did not change Section 152: it added to Section 105 and 106 that addresses when employer contributions to, and benefits paid from, a health plan are considered tax-favored. The addition allowed employers to provide health benefits tax-favored to adult children. The IRS also amended Section 125 to allow expenses for adult children to be eligible under health care reimbursements accounts or medical FSAs.

Unless the IRS changes Section 223, the more limited definition of dependent would apply to the HSAs. For employers with these plans, it is important your employees understand that adult dependent children are eligible for coverage under the qualifying high deductible health plan but their expenses may not be eligible for tax-favored treatment when reimbursed from the HSA.

Our next *Reform Update* will address the impact of union agreements on effective dates, changes to Medicare Part D, auto-enrollment for employers with more than 200 employees, new reporting requirements, national voluntary long term care program and accommodations needed for breast feeding mothers.