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Healthcare Reform Update

Since the PPACA and the HCEARA passed, our goal has been to bring you information as interpreted by legal counsel, Steptoe & Johnson LLP. This issue focuses on two important aspects of the legislation:

1. Impact to Self-Insured Plans
2. Impact to "Mini-Med," or Limited, Benefit Plans

As always, feel free to contact your Van Gilder team with any questions you might have. Please remember, this information is not intended to serve as legal advice.

Issues Regarding Self-Insured Plans

1. Section 1301(b)(1)(B) of the PPACA contains provocative language that could literally be read to exempt self-funded group plans from all of Title I of the bill...all the mandated plan benefits and design changes, for example. Yet it doesn't seem to make sense that this would be the case. I wonder what Steptoe's take is on any self-funded vs. fully insured distinction to be made, based on that section. My sense is that the language merely means a self-funded plan can't play in the Exchanges, as offering qualified health benefits. But I am scratching my head.



We read the Section 1301(b)(1)(B) self-insured plan exception to only – in that provision at any rate – exempt self-insured plans from eligibility to participate in the Exchanges. Section 1301 is outlining parameters for "qualified health plans" that are "qualified" to participate in Exchanges. The specific provision exempts self-insured plans from being considered to be "health plans." The Subtitle A market reforms and other reforms folded into other portions of the Act generally apply to "group health plans" from which self-insured plans are not excluded under this

definition. Again, this is an area in which regulatory clarification/verification will be sought at the earliest opportunity.

2. Do all provisions of the healthcare reform measure that address health insurance coverages apply to self-insured groups? If not, which do/do not?

By and large, almost all of the provisions included in the bill apply to self-insured plans on the same terms and conditions as they do to other similarly situated group plans. The primary exceptions are that self-insured plans are exempt from the Medical Loss Ratio provisions and from the premium increase review provisions (although they do have to make information filings listing their costs under the MLR provisions). Self-insured plans also have an independent obligation to file a new report with HHS.

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3. Can you please confirm that a self-funded plan will be required to pay 60% of an employee's coverage and the employee can't be required to pay more than 9.5% of their salary?

There are a few things to be aware of regarding self-insured employers' contributions toward coverage. First, a large employer may be penalized for providing "unaffordable" coverage to its employees, if it has an employee that ends up obtaining a federal subsidy to buy individual coverage from the Exchange. Starting in 2014, "unaffordable" coverage will be defined as employer coverage for which the premium costs more than 9.5% of family income for the least expensive plan or a plan for which the employer is responsible for less than 60% of the total cost of coverage, if the employee has a family income below 400% of the Federal Poverty Level. While an employer is free to provide coverage that is "unaffordable" by this standard, the employer will face a \$3,000 penalty for each employee offered such unaffordable coverage who obtains a federal subsidy to buy coverage through the Exchange.



Also keep in mind that if employees with family income below 400% of the Federal Poverty Level are offered coverage by an employer that would cost between 8 and 9.5% of their

family income in premiums for the least expensive employer-provided plan, such employees are eligible for the "Wyden" vouchers and can take the employer's plan contribution and apply it to an Exchange plan on a tax-exempt basis. Under the voucher provisions, if the Exchange plan costs less than the employer's plan contribution, the employee keeps the difference.

Second, for non-grandfathered plans in the small group market (100 or fewer employees) starting in 2014, the reform law will cap the amount of out-of-pocket expense (e.g., coinsurance, copayments, deductibles, but not premiums, balance billing for non-network providers or

spending for non-covered services) for employees at an amount equal to the high deductible health plan out-of-pocket limits for health savings accounts, and will also cap deductibles at \$2,000 for self-only coverage and \$4,000 for any other type of coverage, which amounts will be subject to indexing tied to growth in average nationwide premiums. (FAQ added/updated 5-17-10)

4. Is a self-funded account subject to this mandate if they made no changes to their plan at renewal? This should mean they are "grandfathered"?

If the question refers to the market reforms, a plan that was in existence on March 23, 2010 and made no changes at plan renewal is likely grandfathered, although we must await guidance from HHS on the definition of "grandfathering" to answer this question with certainty. Grandfathered plans are required to implement some of the new market reforms, specifically:

- No lifetime coverage limits for essential benefits (effective 2010) (PPACA §§ 1001 and 10101 (adding PHSA § 2711); HCEARA § 2301(a))
- No annual coverage limits on essential benefits (from 2010 to 2014, except as may be permitted by HHS; after 1/1/2014, annual limits are completely prohibited) (PPACA § 10101 (a)(2) (adding PHSA § 2711); HCEARA § 2301(a))
- No pre-existing conditions exclusions (only applies to children younger than 19 from 2010 until 2014 and applies to all thereafter).
- A ban on policy rescissions except in cases of fraud (effective 2010) (PPACA § 1001 (adding PHSA § 2712))
- Extension of dependent coverage until the dependent turns 26 years old (from 2010 until 2014, "grandfathered" group coverage need not be extended to a dependent that is directly eligible for employer-provided coverage). And,
- A bar on imposing waiting periods on plan participation in excess of 90 days (effective 2014). (FAQ added/updated 5-17-10)



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Limited Benefits (e.g. “Mini-Med) Plans

1. Our division administers about 110,000 limited medical lives. For these groups it is their PRIMARY coverage. There are many internal limitations and there are NO catastrophic benefits. I have attached a brochure as an example of some of the plan types. I know that Company X and Company Y have about a \$500 Million block of this business as well. Do we have any idea how limited medical is going to be affected?

This is a good question. Until the Health Reconciliation Act, all existing coverage plans were “grandfathered” and were thus insulated from mandatory compliance with most of the new requirements. That would have allowed such limited benefit plans to remain in place. The Reconciliation Act mandates that many of the key market reforms – including the elimination or restriction of lifetime and annual insurance coverage limits for essential benefits and the mandatory offering of free preventive services, for example – will apply to any plan year that begins after September 23, 2010 (or so) to all health insurance coverage. (H.R. 4872 § 2301(a)). We are still evaluating this issue and we will seek regulatory relief/clarification, but those provisions may essentially eliminate the ability to offer such limited plans on a cost-effective basis going forward.

2. Do we know what role, if any, mini-med plans will have moving forward?

This is an issue that we are still evaluating and regulatory relief/clarification is needed, but those provisions may essentially eliminate the ability to offer such limited plans on a cost-effective basis going forward.

3. Since mini-med plans are not considered traditional health plans, would people of such plans be subject to the penalty for not having credible coverage?

The individual mandate is satisfied if an individual is enrolled in any employer-provided health coverage. Mini-med plans – to the extent that they will still exist after the mandates take place in 2014 – would satisfy this requirement.

4. Do you have any summaries regarding the impact on limited benefit plans and what can be offered?



The impact will turn on how HHS interprets the application of the annual benefits to limited benefits plans. HHS has the discretion to allow annual limits until 2014; after 2014, it appears that limited benefit plans will not be permitted but we are working through the regulatory process in an effort to address that issue. For existing plans, there is no requirement regarding the scope of benefits that must be offered; the issue is that – for the benefits that are offered, the legislation imposes the prohibitions on annual and lifetime limits.

5. One of our clients is concerned by the “annual limits” language as they are all over mini-med plans. The annual limits language is outlined in Sec. 2711, but can you clarify how it relates to mini-medical plans.

This is an issue that we are still evaluating and regulatory relief/clarification is needed, but this provision may essentially eliminate the ability to offer such limited plans on a cost-effective basis going forward. Please see above responses for more details.

This document is comprised of questions received from Council members and answered by The Council’s attorneys at Steptoe & Johnson LLP. All section references are to the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) (“PPACA”) or the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) (“HCEARA”), as indicated in each response. Many of the changes in the legislation are in the form of amendments to the Public Health Service Act. References to that Act in this document will be to PHSA. Please keep in mind that the information provided here is not intended to be, and should not be construed, as a legal opinion or advice. It is recommended that you consult with your own attorney or other adviser relating to your specific circumstances or those of any organization you advise.