Benefit Insights

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Guidance Tells How to Maintain-or Lose-Grandfathered Status Under the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act enacted a package of health insurance reforms for group health plans, including benefit mandates and health insurance market reforms. "Grandfathered plans" - plans in effect on March 23, 2010 (the date of enactment) are exempt from certain-but not all-of the law's provisions.

The Internal Revenue Service, Department of Labor's Employee Benefits Security Administration and Department of Health and Human Services have jointly issued an interim final rule regarding grandfathered plans, in particular, what changes to grandfathered plans will and will not affect a plan's status.

Among the Act's provisions that do not apply to grandfathered plans are the following:

- The requirement that preventive care services, including immunizations and screenings, are covered with no cost-sharing for plan participants.
- Requirements under Sec. 105(h) of the Internal Revenue Code that plan provisions do not discriminate in favor of highly compensated employees.
- Maintenance of claims and appeals processes that include external review.
- Certain benefits requirements involving provider choice, emergency services and clinical trials.

According to the interim final rule, if a grandfathered plan does any of the following, it will lose its grandfathered status:

- Eliminate all or substantially all benefits to diagnose or treat a particular condition. This includes the elimination of an element necessary to treat the condition (for example, if a plan provides counseling and prescription drugs for a mental health condition, and eliminates the counseling benefit while maintaining the prescription drug benefit, it will be considered to have eliminated substantially all benefits for the condition and lose its grandfathered status).
- Increase coinsurance rates, to any extent at all, for plan participants.
- Increase participant copayment levels by more than the greater of $5 (adjusted annually for inflation) or a percentage equal to medical inflation plus 15 percentage points.
- Increase a fixed-dollar cost-sharing requirement other than a copayment-such as a deductible-by more than medical inflation plus 15 percentage points.
- Lower employer cost-sharing by more than 5 percentage points (for example, decreasing employer cost-sharing while increasing the percentage of employee cost-sharing from 10% to 20%).
- Add or tighten limits on what an insurer pays (for example, capping or lowering the annual dollar amount covered by a plan for specific services or adding an annual dollar limit maximum where one did not exist on March 23, 2010).
- Change insurance carriers or purchase a product from a new insurance carrier.

Plan changes such as premium increases and changes in third-party administrators will not cause a plan to lose its grandfathered status.

The interim final rule includes special provisions for insured collectively bargained plans.

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Welcome to Our Newsletter!

I hope that you find these articles of interest. If you have a topic for future discussion, please let me know. Please call anytime we can answer questions or be of help with your business or personal insurance needs.

2011 Health Plan Cost Trend Projected to Outpace Inflation Again

According to the 2011 Segal Health Plan Cost Trend Survey, prescription drug cost and medical cost trends are yet again expected to denote a considerable increase over core inflation. "Trend" is a forecast of per capita claims cost that takes factors such as price, utilization, new treatments, government-mandated benefits, and inflation into account. Segal's survey used insurance carriers, pharmacy benefit managers, third party administrators, and managed care organizations to project a year to year change in the per capita cost of health plans - cost trend.

This is the 14th annual Health Plan Cost Trend Survey by The Segal Company, an independent firm of compensation, benefit, and human resource consultants. According to the Segal survey data, all types of 2011 medial plans will experience cost trends eight times greater than the CPI (consumer price index) for urban consumers, which was 1.1% during a 12-month period ending in August of 2010.

2008 was the bottom of several years of declining trends, with 2009 marking the return of an upward cost trend rate direction. One new component of the health plan cost trend is compliance with The Affordable Care Act. The Segal survey found that over 75% of the participants said that health care reform would increase the overall health plan cost trend by over 1%.

More Key Findings of the Segal Health Plan Cost Trend Survey

- Cost trend rates for HDHP's (high-deductible plans) and indemnity plans, when compared to 2010 data, are forecasted to grow slower in 2011.
- The biggest element of the overall plan cost trend is price inflation for supplies and services, with in-patient stays in a hospital being of greatest note.
- Compared to 2010, the trend rates for point of service plans and preferred-provider organizations in 2011 will be somewhat higher.
- Over the last three years, trend projections for prescription drugs have consistently been below 10%.

Cost Control

The Segal survey also addressed how plan sponsors plan to mitigate the increase with cost-management steps and strategies:

- Use of designs that drive lower net prescription drug costs by generating greater generic drug usage, waste elimination, and taking advantage of step therapy programs.
- Reasonable cost payment increases by spotlighting aggressive network hospital dialogue.
- Reduce emergency room visits; reduce excessive use of MRI and CT scans; and better use of low-intensity health care providers, such as a nurse practitioner or primary care provider, by putting smarter design rules into practice.
- Move away from contracts that are fee-for-service by investment in controlled wellness and preventive services and on-site clinics.
- Create meaningful incentives and needed support services, to assist participants in engaging in healthy behaviors and improve overall health status, and determine key cost drivers by mining medical data.

According to Segal, comparing the actual increases to past projections on health plan cost is indicative of pharmacy benefit managers and insurers tending to make conservative projections, as forecasts have previously tended to be higher than what was actually experienced. However, past projections also show that forecasters are growing more accurate in health plan cost projection.

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If the collective bargaining agreement was ratified before March 23, 2010, a fully insured plan will be considered grandfathered until the date on which the last agreement relating to the coverage in effect on that date is terminated. Self-insured collectively bargained plans are subject to the same rules as grandfathered plans that are not under a collective bargaining agreement.

As noted above, while grandfathered plans are not subject to some of the Act's provisions, they are subject to others, such as the prohibition on lifetime limits on the dollar value of benefits and the prohibition on coverage rescissions, except in cases of fraud or an intentional misrepresentation of a material fact by an enrollee.

A grandfathered plan also is required to disclose to plan participants that, as a grandfathered plan, it may not include certain elements of the consumer protections provided for under the Act.

While grandfathered status can offer significant advantages, especially in regard to avoidance of some of the Act's benefits mandates, employers will need to assess how these balance against the need or desire to modify plan provisions or change carriers in response to rising plan costs and rates.

Wellness Programs Can Reduce Health Risks, Study Finds

Based on the findings of "The Impact of The Prevention Plan on Employee Health Risk Reduction" study, within just a year, measurable health risk reduction is achievable through health promotion and wellness programs that are based on preventive medicine.

The study was published in the Population Health Management journal. It examined changes in fifteen health risk measures within a group of 2,606 employees from various American employer groups utilizing the U.S. Preventive Medicine wellness program. In 2008, the group completed a baseline health risk appraisal, biometric screening, and blood testing. The group was then reassessed in 2009.

The U.S. Preventive Medicine wellness program, also commonly known as The Prevention Plan, is comprised of multiple intervention steps designed to spur employee awareness of their own personal health risks. Based on the findings from a detailed initial assessment, members are given a personalized prevention plan, access to innumerable online tools, and continuing coaching and support from a health advocate. The program has a strong engagement, motivation, and participation rate, especially when supported by employer incentives, regular communication, and a culture of health.

Health risks are also commonly identified as being the subsurface driver of increasing health care costs.

Study Highlights

The study of The Prevention Plan participants found that:

- Forty-two percent of the 2,606 plan participants had a decrease in how many high health risks they faced after one year, with eighty-seven percent of the low risk plan participants maintaining an existing health status and sixty-four percent of the high risk plan participants actually lowering their risk status.
- The greatest declines from the high risk health factors were: cholesterol at twenty-three percent, alcohol consumption at twenty-four percent, stress at twenty-five percent, blood sugar (fasting) at thirty-one percent, and blood pressure at forty-three percent.

Many experts say that a large part of the severe health care cost crisis America is facing today is caused from the increased burden of chronic illness. Data from The U.S. Department of Health and Human Services is in line with this thought. The government agency estimates that preventable chronic conditions, such as cancer, heart disease, diabetes, stroke, and chronic obstructive pulmonary disease account, accounts for seventy-five percent of health care costs.

Health risks are also commonly identified as being the subsurface driver of increasing health care costs. Health risks play a part in health care cost because as increasing numbers of Americans are having their length of life and quality of life eroded by succumbing to avoidable lifestyle risks, they're also increasingly utilizing medical services, which in turn places an economic burden on all of society.

Health risks and chronic illnesses also have a direct impact or burden on employers. Employees with poor health are likely to be less productive workers and have more work absences on their record, a combination that usually places a serious profitability drain on businesses.

One thing is clear to expert and novice alike; the trend of health care cost is simply unsustainable. According to a survey done by Kaiser Family Foundation in 2009, the average premium for family health insurance is 131% higher than it was in 1999. This study might be the compelling scientific evidence that many need to realize that wellness, when structured atop prevention, can work.

A Look at Healthcare Reform's Impact on HSAs and FSAs

If your company currently sponsors a flexible spending (FSA) or health savings account (HSA) to allow employees to pay out-of-pocket medical expenses with pre-tax dollars, be prepared for upcoming changes. New health care reform legislation could make these "cafeteria plan" benefits less appealing to employees.

Under the new law, maximum annual FSA contributions are reduced, and there are new regulations affecting how the funds can be used. The intent of the new rules and penalties is to generate revenue which can be used to fund aspects of the health care reform package.

FSAs and HSAs (assuming the employee is covered under a qualified high deductible health plan) allow an employee to contribute tax-free funds that can be used to pay for deductibles, drug co-pays, treatments that are not covered by health insurance, and other qualified medical expenses.

Beginning on January 1, 2013, the annual limit for FSAs will be set at $2,500. Previously, the IRS had stipulated that employers could establish their own FSA contribution limit, and according to the Center on Budget and Policy Priorities, these limits generally fell into the $2,000 to $5,000 range. In 2009, Mercer's National Survey of Employer-Sponsored Health Plans stated that the average yearly employee contribution was $1,424.

Annual limits for HSAs, however, were not affected by the new legislation.

Be aware that some restrictions will become effective more quickly. For example, as of January 1, 2011, FSA and HSA participants will no longer be able to spend the funds on over-the-counter medications unless a physician has specifically prescribed them. Also starting next year, non-qualified withdrawals from HSAs will be subject to a 20% penalty instead of the 10% penalty which is currently applied.

Consumer-Directed Plan Growth Continued in 2010

Results of a recent survey show that 12.4% of all U.S. employees with insurance are covered by consumer-directed health plans (CDHP). Although at a slower rate than was seen in 2009, CDHP's have continued to steadily grow thus far in 2010.

The UBA Health Plan survey, by United Benefit Advisors, obtained health plan data from 11,413 employers and 17,113 plans during the October 1, 2009 through June 4, 2010 survey. The survey solely focused on retiree and active health plans and directly related benefits.

The UBA survey is rather unique in that the survey provides not only data relevant to and from larger companies, but a proportionate amount of mid-size to small businesses. The UBA data was compiled with the purpose of supplying relevant, comparative, and factual health plan benchmarks to aid employers of all geographic areas, sizes, industries, etc.. in making critical benefit decisions for their businesses.

The survey found that CDHP's grew at a 18.1% clip in 2010, roughly half of trend reported in 2009. One reason for the slower growth rate was early year employer uncertainty if consumer-directed plans would be restricted by U.S. health care reform. When the healthcare reform legislation was enacted, it ended up not directly addressing health reimbursement arrangements (HRA) or health savings accounts (HSA) use, aside from increasing non-qualified HSA distribution penalties (after December 31, 2010) from 10% to 20% of withdrawn money.

UBA Health Plan Survey Key and Highlighted Findings

- Preferred-provider plans (PPO) provided health coverage to 65.7% of all 2010 insured U.S. employees. Health maintenance organizations (HMO) provided coverage to 15.4% of employees. While, the rest were covered under CDHPs.
- The average 2010 cost increase for all plan types was 8%, with that of CDHPs being 7.3%.
- The largest geographical concentration of CDHPs was in the Northeast U.S. region at 26.7%. The second largest geographical concentration was in the Southeast U.S. region at 22.9%.
- Eighty one percent of all CDHP plans in the Northeast U.S. region contained 100% co-insurance.
- For a single employee, the average employee contribution to an HRA was $1,310 in 2009 vs. $1,481 in 2010. For a family, the average employee contribution was $2,502 in 2009 vs. $2,857 in 2010.
- The average employee contributed $113.00 towards single coverage and $443.00 for family coverage across all plan types.

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