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## Legislative Update

**The following information, provided by the Society for Human Resource Management (SHRM) HR Week, is being sent as a courtesy to keep you informed on the status of the Health Care initiatives taking place in our government.**

### **REFORM LAW WILL REQUIRE NEW PLANS TO COVER PREVENTIVE CARE AND LIMIT OUT-OF-POCKET EXPENSES**

Starting in 2011, the new health care reform law will require health care plans to cover most preventive medical care visits and procedures fully. Under the new requirements, plan participants will not be responsible for co-pays or shared costs for proven preventive services that are rated A or B by the U.S. Preventive Task Force (USPTF). These preventive services include annual check-ups, health child visits, breast cancer screenings for women, and immunizations.

The requirements for covering preventive services take effect for new health insurance plans that begin providing coverage on or after January 1, 2011. A health plan would be permitted to cover or deny any additional services that are not recommended by the USPTF. The reform law requires the Secretary of Health and Human Services (HHS) to develop regulations to define and enforce the provisions governing preventive health care services.

The law requires that health plans offer coverage to individuals who participate and receive treatment from clinical trials. Health care plans starting in 2011 cannot require preauthorization for emergency room visits or for visits to ob-gyn specialists.

Employers that offer wellness programs to workers must pay for the full cost of the programs and cannot impose cost-sharing requirements or co-pays on the program participants. Under the new law, the federal government will offer grants to small employers (those with fewer than 50 employees) that establish wellness programs.

The Department of Health and Human Services will provide employers with assistance and resources to help businesses evaluate their wellness programs. Within two years of the law's enactment, officials with the HHS will be required to conduct a national worksite health policies survey to assess the quality and effectiveness of employer-based health care and wellness programs.

The new law will allow employers to provide rewards to employees for participating in wellness programs. These rewards can be discounts for health insurance premiums and waivers of co-pays or cost-sharing amounts. Rewards can total up to 30 percent of the cost for participating in a wellness program.



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Employers must offer alternative standards for earning rewards to individuals who might not reasonably be able to reach the reward requirements or who might be advised by doctors not to meet the reward requirements. The reward limit can be increased to 50 percent of the cost of coverage for the wellness program if employers meet certain requirements and the higher reward standards are deemed appropriate.

In addition, the health reform law will reduce out-of-pocket spending limits for those with household incomes up to 400 percent of the federal poverty level. The new out-of-pocket limits will take effect in 2011 and will be:

- Household incomes 100 percent – 200 percent of poverty level: one-third of the health savings account (HSA) limit or \$1,983 for individuals and \$3,967 for families.
- Household incomes 200 percent – 300 percent of poverty level: one-half of the HSA limit or \$2,795 for individuals and \$5,950 for families.
- Household incomes 300 percent – 400 percent of poverty level: two-thirds of the HSA limit or \$3,987 for individuals and \$7,973 for families.

The reform law will reduce the out-of-pocket spending limits by setting up a tiered system of health care plans – which will be offered through health care exchanges and to individuals and the small group market (those with 100 or fewer employees). These plans will be categorized as bronze, silver, gold and platinum plans. The benefits paid and out-of-pocket expenses for the plans will take effect in 2014 as follows:

- Bronze plans will cover 60 percent of the costs for health care services and treatment and will limit out-of-pocket expenses to the annual deposit level for an HSA (\$5,950 for individuals and \$11,900 for families).
- Silver plans will cover 70 percent of health service costs with the HSA out-of-pocket limit.
- Gold plans will cover 80 percent of health service costs with the HSA out-of-pocket limit.
- Platinum plans will cover 90 percent of health service costs with the HSA out-of-pocket limit.

According to the new law, the plan sponsor of a group health plan cannot base eligibility rules for health care coverage on salaries or wages and create health care plans that discriminate “in the favor of higher wage employees.” The new discrimination rules will take effect in 2011. The provision exempts self-insured health care plans.

The law will require health plans to implement an effective process for appealing claim payments and coverage refusals. The new process must include, at a minimum:

- An internal appeals procedure.
- Notices to plan participants, including notifications in the appropriate language for workers who do not speak English. The notices must include information on available internal and external



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appeals processes and information on how to contact offices of health insurance consumer assistance or an ombudsman who can assist participants with the appeals process.

- A process that allows an enrollee to review his or her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.
- An external review process that includes consumer protections under the Uniform External Review Model Act developed by the National Association of Insurance Commissioners.

As always, we'll keep you posted of significant developments as they occur.

***If you have any questions, please contact your HARDEN Employee Benefits Account Manager.***