GENERAL BOARD OF PENSION AND HEALTH BENEFITS
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# How Health Care Reform Will Change HealthFlex Coverage

## Introduction

The Patient Protection and Affordable Care Act (PPACA, i.e., the "federal health care reform law") requires the General Board of Pension and Health Benefits (General Board) to make several changes to HealthFlex (the "Plan") effective January 1, 2011. Some of those changes will directly impact coverage and benefits under HealthFlex. Those changes, and others in the PPACA, are explained below.

## Extended Dependent Coverage

Because HealthFlex covers dependent children, beginning January 1, 2011 the Plan will make that coverage available for children of participants until those children reach age 26 (also called "young adults"). This coverage will be available regardless of a child's student status, tax-dependent status, marital status or whether the older child resides with the participant. Spouses and children of the participant's young adult will not be covered.

Participants whose children are not currently covered in HealthFlex but who would be eligible for this coverage in January 2011 may enroll their children during the HealthFlex Annual Election period in November 2010 for coverage beginning January 1, 2011. Participants should contact their plan sponsor's benefits office as soon as possible to obtain a *HealthFlex Enrollment/Change Form.* This form must be received before the November 18, 2010 Annual Election deadline.

Earlier this year, HealthFlex implemented a bridge policy for 2010 to prevent young adults currently covered in the Plan from losing coverage in 2010 due to their age or a loss of student status. This policy prevented unnecessary interruption in coverage for older children covered under HealthFlex in 2010 (those who were covered on or after March 23, 2010) who might have lost coverage upon graduation or when they turned 19 between March 23, 2010 and January 1, 2011. Children who lost coverage due to age, loss of student status or other factors *before* March 23, 2010 may be re-enrolled in HealthFlex during the Annual Election period in November 2010.

### Young Adult Coverage Is Tax-Free

Due to a coordinating change in the tax code made by the PPACA, this expanded health coverage for young adults will be a tax-free benefit when paid, in whole or in part, by an employer—even if the covered young adult is no longer claimed as a dependent on the participant's income tax return.

## Pre-Existing Condition Exclusions Prohibited for Children

Also effective January 1, 2011, health plans can no longer exclude from coverage the pre-existing conditions of children younger than age 19. HealthFlex will no longer apply any pre-existing condition exclusions on coverage for children younger than age 19. Children currently enrolled in HealthFlex, and children enrolled in the future, will not be subject to pre-existing condition exclusions on or after January 1, 2011.

Furthermore, after January 1, 2014, HealthFlex will no longer impose pre-existing condition exclusions on anyone enrolled in the Plan—including adults of any age.

## Lifetime Limits Prohibited and Annual Limits Restricted

Effective January 1, 2011, HealthFlex will eliminate lifetime limits on essential health benefits. In addition, HealthFlex will modify its annual limits applicable to essential health benefits as required under the PPACA. The PPACA identified broad categories of care considered *essential health benefits*, including hospitalization, emergency care, ambulatory (outpatient) care, mental health and substance abuse treatment, pediatric services, prescription drugs, and preventive and wellness services. Until the regulatory agencies further define essential health benefits in future guidance, HealthFlex will apply a reasonable good-faith standard to comply with this rule. Certain non-monetary limitations will be permitted and shall remain applicable to some HealthFlex coverage, such as limits on the number of days or visits for certain treatments.

The restriction on annual limits does not apply to health flexible spending accounts (FSAs). The restriction also does not apply to the HealthFlex health reimbursement accounts (HRAs, also called health reimbursement arrangements) that are part of the HealthFlex consumer-driven health plan (CDHP), because the HRA is integrated with other coverage as part of a group health plan. Retiree-only HRAs also are not subject to the restriction on annual limits.

## Over-the-Counter Drugs No Longer FSA-Eligible

Beginning January 1, 2011, the health FSA in HealthFlex (also called the medical reimbursement account or MRA) will no longer reimburse participants for over-the-counter (OTC) drug expenses due to the PPACA. An exception will remain so that amounts paid for OTC drugs *with a prescription* will still qualify for FSA reimbursement. The restriction does not apply to other medical items, equipment, supplies or diagnostic devices obtained over the counter without a prescription, such as bandages, crutches or blood sugar test kits. However, the IRS has not yet indicated whether "quasi-medicines," such as antibiotic creams or similar items that have drug-like characteristics, are subject to the prohibition.

The new rule applies to OTC drugs *purchased* on or after January 1, 2011. Even if a claim would otherwise have been eligible for reimbursement from a 2010 plan-year health FSA under a grace period (through March 15, 2011), *the expense will not be eligible for reimbursement if purchased on or after January 1, 2011 without a prescription*. However, expenses incurred for items purchased *before* January 1, 2011 remain reimbursable without a prescription. Eligible claims must be submitted for reimbursement before the MRA run-out period ends (April 30, 2011).

## Certain Preventive Care Services Covered at First Dollar

Co-payments, co-insurance and deductibles under HealthFlex will no longer apply to certain preventive care services from a network or participating provider, including, but not limited to, one well exam annually for children older than age 2, one well exam annually for adults age 16 and older, and eligible immunizations and diagnostic tests.

Under the PPACA, plans must cover (and not apply co-payments or co-insurance to) the following preventive services that have strong scientific evidence of their health benefits at "first dollar" when they are delivered by a network provider:

- **Evidence-based preventive services:** Preventive services given a rating of "A" or "B" by the U.S. Preventive Services Task Force (USPSTF) will be covered, such as breast and colon cancer screenings; screening for vitamin deficiencies during pregnancy; screenings for diabetes, high cholesterol and high blood pressure; and tobacco cessation counseling. Notably, the PPACA requires that breast cancer screening and mammograms be covered according to the 2002 USPTF recommendation, which encourages more frequent screenings than the 2009 recommendation.
- **Routine vaccines:** Plans must cover a set of standard vaccinations recommended by the Centers for Disease Control and Prevention (CDC), from routine childhood immunizations to periodic tetanus shots for adults.

- **Preventive care for children:** Plans must cover preventive care for children as recommended under the Bright Futures guidelines, including regular pediatrician visits, vision and hearing screenings, developmental assessments, immunizations and obesity counseling.
- **Preventive care for women:** Plans must cover preventive care provided to women under both the USPSTF recommendations and new guidelines being developed by the Department of Health and Human Services (HHS).

The complete list of preventive care recommendations and guidelines can be found at **www.HealthCare.gov/center/regulations/prevention.html**.

## Certain Cost-Sharing Allowed for Preventive Care Services

Cost-sharing will still be permitted for coverage of the following:

- **Out-of-network services:** A plan may exclude preventive services—or may impose cost-sharing requirements on them—if services are delivered outside of its network (i.e., using an "out-of-network" physician, hospital or other medical facility).
- **Non-recommended preventive services:** A plan may exclude or impose cost-sharing requirements on preventive services that are not covered by the USPSTF recommendations.
- **Separate billing:** A plan may impose cost-sharing requirements if an office visit involving a preventive service or item is billed separately from the preventive service or if the primary purpose of the office visit was not the preventive service or item.
- **Related treatments:** A plan may impose cost-sharing requirements on a treatment not required by the USPSTF recommendations, even if it results from a covered preventive service.

Plans may limit coverage using reasonable medical management techniques for frequency, method, treatment or setting for a preventive service.

## Rescissions Prohibited

A "rescission" is a retroactive termination of coverage by a plan. Under the PPACA, plans are no longer permitted to rescind health coverage unless an individual intentionally misrepresents facts or commits fraud. Plans must provide at least 30 days' advance notice of a rescission, with time to appeal. However, prospective terminations of coverage are still permitted (such as for loss of eligibility), as are retroactive terminations that are attributable to a covered individual's failure to pay required premiums or contributions on a timely basis. HealthFlex does not typically rescind participants' coverage.

## Additional Patient Protections

Participants have the right to designate any network primary care physician who is available to accept them as a patient as their primary care physician, and to designate any network pediatrician as a child's primary care physician. Female participants have a right to obtain services from any network obstetrician/gynecologist (OB/GYN) without a referral. HealthFlex has not typically imposed these sorts of referral requirements.

The Plan cannot require preauthorization for emergency services (as defined in the Emergency Medical Treatment and Labor Act), limit such services to network providers, or apply any requirement on out-of-network emergency services that is more restrictive than the requirements applicable to in-network emergency services, including cost-sharing requirements. The Plan must also make a reasonable reimbursement for out-of-network emergency care before the provider is allowed to bill a participant for the balance.

## Early Retiree Reinsurance Program (ERRP)

The federal government has established a temporary reinsurance program to help plans, such as HealthFlex, that provide early retiree health benefits for participants between the ages of 55 and 64 (pre-Medicare retirees). Plans can request reimbursement from the ERRP to cover up to 80% of claims between $15,000 and $90,000 related to coverage of early retirees. The ERRP has only $5 billion in funding; when this funding is exhausted, the program will end.

On August 31, 2010, HealthFlex received approval from HHS for its ERRP application. ERRP funds—when issued to HealthFlex by HHS—must be used in certain prescribed ways to help sustain coverage and mitigate costs for early retirees and their plan sponsors. HealthFlex will comply in a manner yet to be determined.

## Health Coverage on *Form W-2*

Beginning with the 2011 tax year, employers will be required to disclose the value of employee health care coverage on annual *Form W-2s*. This means that participants will see the value (i.e., the employer's cost) of this coverage reported on the *Form W-2* issued in January 2012. Importantly, the coverage *remains tax-free*, meaning it is merely reported for information purposes but is generally not considered taxable income.

## Future Changes

Health plans such as HealthFlex will have to provide a uniform summary of benefits designed by HHS to all participants by March 23, 2012. From that date forward, HealthFlex will have to notify participants of material modifications to benefits at least 60 days in advance. In 2013, contributions to health FSAs (the MRA) will be limited to $2,500 per year, indexed to inflation for subsequent years. More changes occur after January 1, 2014, when the most significant provisions of the PPACA take effect. The General Board will continue to provide updated information about these changes as they approach.

## For More Information

For more information about each of the provisions described above and the latest details about how health care reform may impact HealthFlex and the Church, please visit the General Board website's **Health Care Reform** page. Regulatory notices are available on the General Board website under "**Health & Welfare**." You can find additional information about the federal health care reform laws at **www.healthcare.gov**. If you have further questions, please send them to **healthcarereform@gbophb.org**.