



***Where Pennsylvania
Businesses Go To Grow***

Health Care Legislation Part 1 ~ 2010-2012

September 2010






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4 C's of Health Care Legislation

 Confusion

 Change

-  Grandfather Clause
-  2010-2012 Reforms ~ All Plans
-  2010-2012 Reforms ~ Non-Grandfathered Plans
-  Tax Implications - All Employers
-  Tax Implications - Small Business

 Compliance

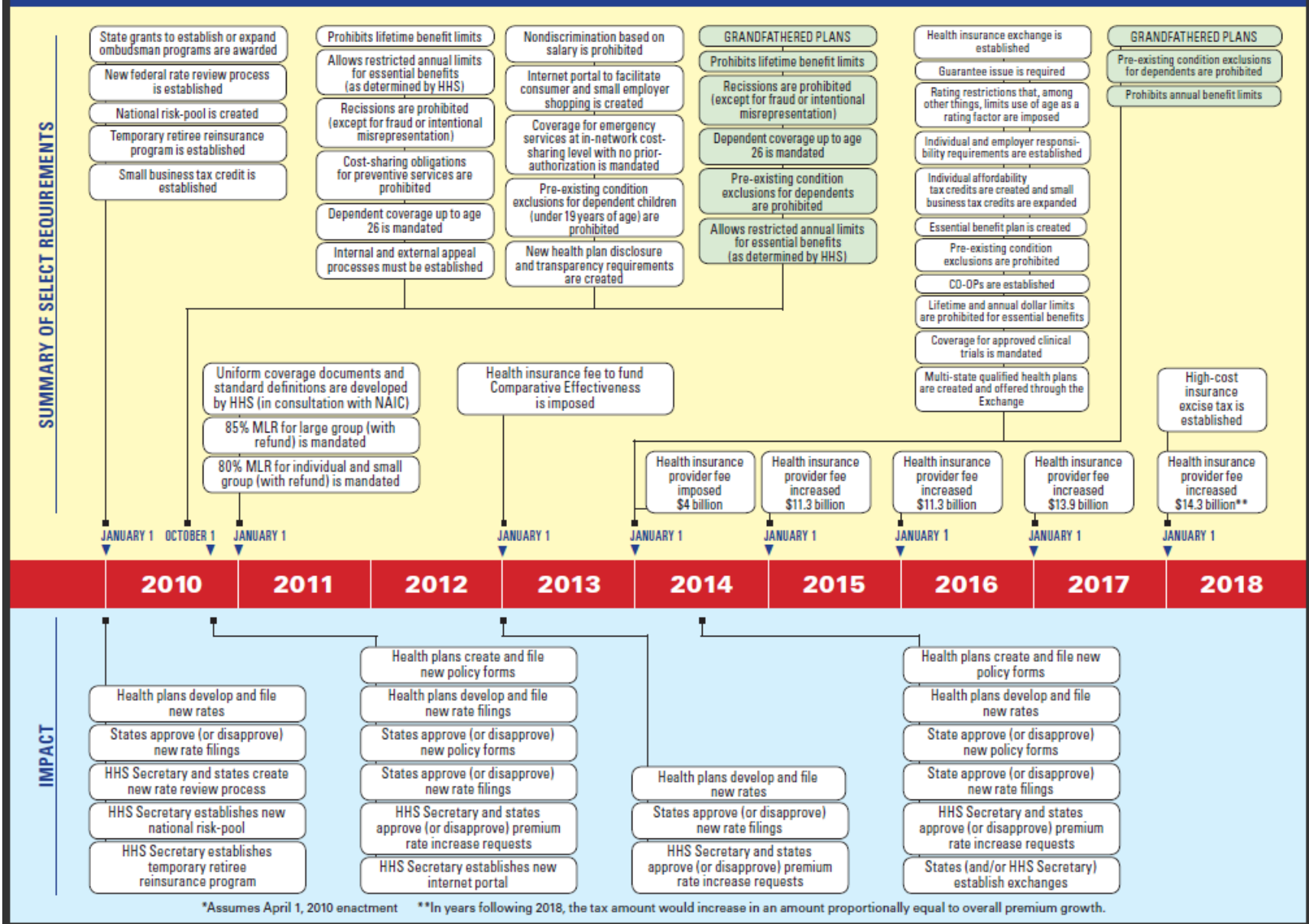
 Cost

The 4 C's of Health Care Legislation

CONFUSION



Health Care Reform Bill Timeline (as revised by the House Reconciliation Bill)*



Source: www.wiba.org/pdf/legislative/timeline.pdf

The 4 C's of Health Care Legislation

CHANGE

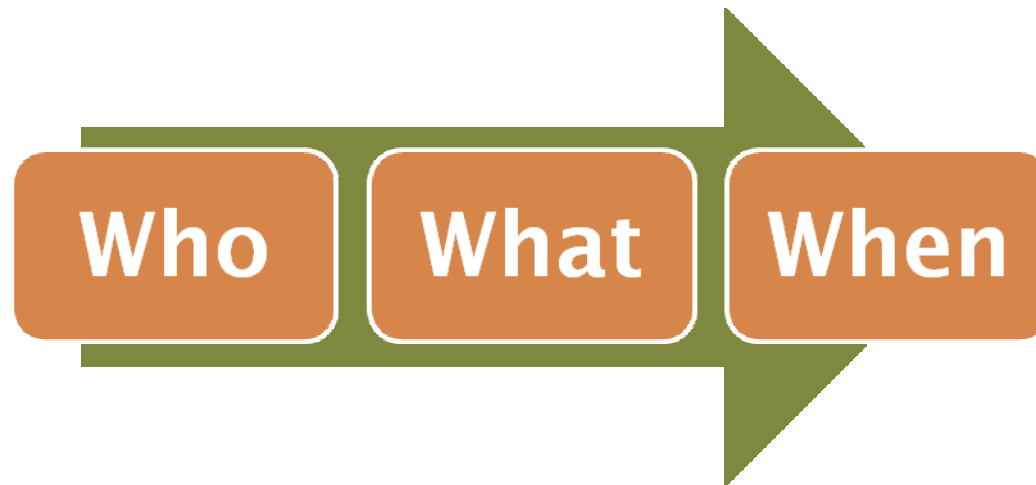


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Change



The “Grandfather Clause”

“If you like your health insurance, you can keep it”

– President Obama

The Grandfather Clause

- Certain reforms in the Patient Protection and Affordable Care Act (PPACA) AKA “Health Care Reform Act” are not applicable to “grandfathered” plans.
- Grandfathered plans are determined by the plan design, insurance carrier, and employer contribution that was in effect on ***March 23, 2010*** – the date of the signing of the Health Care Reform Act.
- The Department of Labor (DOL) has issued limitations on the changes a plan sponsor can make to a group health plan without losing grandfathered status. Loss of grandfathered status results in a group health plan being required to implement ALL of the appropriate health care reforms, immediately.

The Grandfather Clause

To maintain grandfathered status a group health plan CANNOT:

Significantly Cut or Reduce Benefits	For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.
Raise Co-Insurance Charges	For example, if a plan requires a 20% participant coinsurance, plans cannot increase this percentage.
Significantly Raise Co-Payment Charges	<p>Can increase co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15%.</p> <p>For example, assuming medical inflation is 4% and your copay for 2010 is \$30:</p> <p>4% plus 15% equals 19% in 2010, then the co-pay cannot increase more than 19% or to a maximum of \$35 in 2011. Beginning in 2012, only medical inflation is added so assuming medical inflation is again 4%, then the 2012 percentage allowed is 23% (19% + 4%) above the 2010 co-pay for a maximum copay of \$37</p>
Significantly Raise Deductibles	Same percentage formula (medical inflation + 15%) as Co-Payment Charges applies.
Significantly Lower Employer Contributions	Plans cannot decrease the percent of premiums the employer pays, by coverage tier, by more than 5%.
Add or Tighten an Annual Limit on What the Insurer Pays	Plans cannot tighten any annual limits that are already in place. Plans can add annual limits, but, the annual limit must be at least as high as the lifetime limit.
Change Insurance Companies	Does not apply to self-insured employers that switch plan administrators, or to collective bargaining agreements.

The Grandfather Clause

- The DOL fully expects that by 2014 and the introduction of the Federal Insurance Exchanges that:
 - Large Plan Sponsors (>100 Employees) – At most, **66%** of the plans will still have the grandfathered status.
 - Small Plan Sponsors (<100 Employees) – At most, **51%** of the plans will still have the grandfathered status.
- Independent SHRM Survey results released on 8/20/2010, state that **90%** of Plan Sponsors reported that they expect to lose the grandfathered status by 2014.

2010-2012 Health Reforms

**The following 2010-2012 Health Reforms
are applicable to ALL employer-
sponsored group health plans.**

Dependent Coverage

Who	Group health plans and individual plans
What	Provides coverage for dependent children up to age 26. <ul style="list-style-type: none">• Allows the dependent to be married• Not required to be a tax dependent• Can live away from parent
When	The first <u>plan year</u> on or after September 23, 2010 Many carriers provided early implementation for June 1, 2010.

Lifetime and Annual Limits

Who	Group health plans and individual plans
What	<p>Prohibits plans from placing lifetime limits on the dollar value of coverage (it appears that limits on days of treatment, number of visits, etc. are still permitted).</p> <p>Prior to 2014, plans may impose annual limits on coverage as determined by the Secretary of HHS.</p> <p>Beginning 2014, annual limits on the dollar value of coverage are prohibited.</p>
When	The first plan year on or after September 23, 2010

Pre-Existing Conditions

Who	Group health plans and individual plans
What	Prohibits pre-existing condition exclusions for children.
When	The first plan year on or after September 23, 2010. Total enactment (including adults) is effective January 1, 2014.

2010-2012 Health Reforms

The following 2010-2012 Health Reforms are applicable to Non-grandfathered employer-sponsored group health plans only.

Preventive Services

Who	Group health plans and individual plans
What	Requires minimum coverage, without employee cost-sharing for: <ul style="list-style-type: none">• services rated A or B by the U.S. Preventive Services Task Force• recommended immunizations• preventive care for infants, children, and adolescents, and• additional care and screenings for women
When	Beginning 6 months after enactment – The first plan year on or after September 23, 2010

Emergency Services

Who	Group health plans and individual plans
What	Mandates coverage of emergency services at the in-network benefit level regardless of the provider utilized. Prior authorization is not required.
When	The first plan year on or after September 23, 2010

Primary Care Physician (PCP)

Who	Group health plans and individual plans
What	For plans that require PCP selection, permits participants to designate any In-network physician (includes pediatrics) as the PCP.
When	The first plan year on or after September 23, 2010

OB/Gyn Referrals

Who	Group health plans and individual plans
What	Prohibits plans from requiring a referral or pre-authorization for a participant to seek care at any In-network OB/Gyn.
When	The first plan year on or after September 23, 2010

Claims Appeal Processes

Who	Group health plans and individual plans
What	Plans are required to have an <u>internal and external</u> appeal process for appeals of coverage determinations and claims. ERISA plans are already required to have an internal claims appeal process. This new requirement requires all plans to have both an internal and external processes with standards that satisfy the NAIC Uniform External Review Model Act.
When	Beginning 6 months after enactment - The first plan year on or after September 23, 2010

Nondiscrimination Rules

Who	Fully-Insured Group Health Plans (already applies to self-insured plans)
What	<p>Nondiscrimination rules under Internal Revenue Code Section 105(h)(2) that currently apply to self-insured plans are extended to fully-insured group health plans.</p> <p>Prevents discrimination in favor of highly compensated employees in terms of eligibility to participate and the level of benefits under the plan.</p>
When	The first plan year on or after September 23, 2010

Tax Implications

The following 2011-2012 Reforms are applicable to ALL employers, where applicable.

Over the Counter (OTC) Drugs

Who	Plans that qualify as a Health Reimbursement Account (HRA), Flexible Spending Account (FSA), Health Savings Account (HSA), or Archer Medical Savings Account (MSA)
What	The costs for most OTC drugs can not be reimbursed through an HRA or FSA nor can they be reimbursed on a tax-free basis through an HSA or MSA without a prescription. Certain OTC supplies are still eligible for reimbursement.
When	January 1, 2011

Distributions from HSA

Who	Plans that qualify as a Health Savings Account (HSA)
What	<p>The taxation on distributions that are not used for qualified medical expenses will be increasing to 20% of the disbursed amount.</p> <p>(Currently taxed at 10% for HSAs).</p>
When	January 1, 2011

Federal Premium Tax

Who	Group health plans
What	<p>A new federal premium tax will be used to fund a comparative effectiveness research program. The fee is \$2 per average number of insured lives.</p> <p>The fee will reduce to \$1 in policy years ending during fiscal year 2013.</p>
When	Effective for plan years beginning on or after October 1, 2012

Small Businesses

The following 2010-2012 Reforms are applicable to SMALL employers (<100 full-time equivalent employees) only.

Small Business Tax Credit

Who	Employers with no more than 25 full-time equivalent employees and average annual full-time equivalent wages of less than \$50,000 (\$25,000 for employers with 10 or few employees) that provide health insurance for employees
What	<p>Tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium <u>if</u> the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium.</p> <p>Tax exempt small businesses meeting these requirements are eligible for tax credits up to 25% of the employer's contribution toward the employee's health insurance premium.</p>
When	January 1, 2010

Small Business Wellness

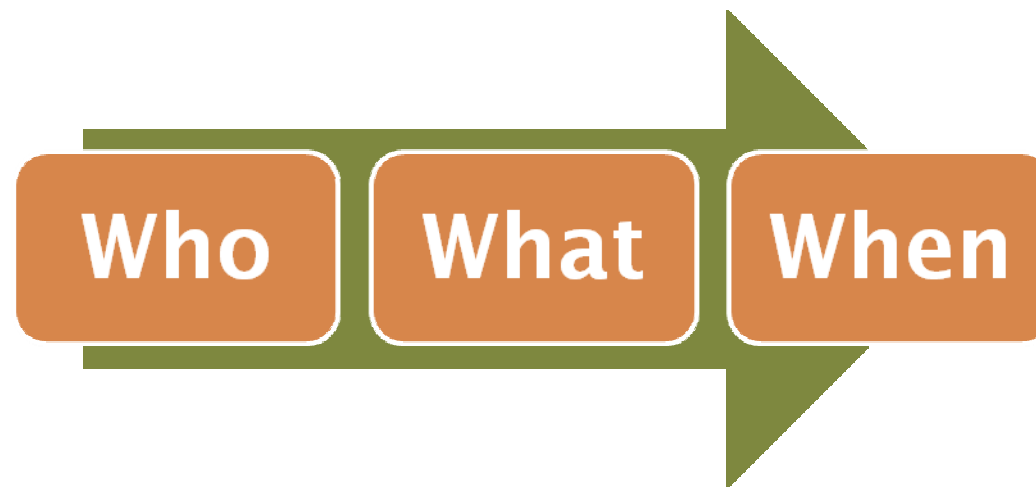
Who	Employers with less than 100 employees who work 25 hours or greater per week (and did not provide a wellness program prior to March 23, 2010).
What	Federal grants to be available for up to five years to small employers that establish comprehensive workplace wellness programs
When	January 1, 2011

The 4 C's of Health Care Legislation

COMPLIANCE



Compliance



W-2 Reporting

Who	All employers
What	<p>Disclose the value of the employer-sponsored health insurance coverage on the W-2.</p> <p>Exclude all contributions to HSAs, Archer MSA's and salary reduction contributions to FSAs.</p>
When	Benefits payable during taxable years beginning after December 31, 2010 (2011 W-2's)

Uniform Notice of Coverage

Who	Group health plans
What	<p>Plan administrators must provide a standardized summary of coverage to all employees prior to enrollment and annually. The content of the notice will be set by HHS. In addition, if material changes are made, notices must be provided to participants 60 days <u>prior</u> to the change.</p> <p>These requirements apply to all plans – even those that are ERISA exempt (such as church and government plans). Guidance is expected on ERISA plans and incorporating this notice into summary plan documents.</p>
When	The first plan year on or after March 23, 2012

Long-Term Care

Who	All working adults
What	<p>A national, voluntary insurance program will be established for purchasing Community Living Assistance Services and Support (CLASS program).</p> <p>The program will be provided through payroll deductions and all working adults will be automatically enrolled in the program unless they choose to opt-out.</p> <p>Once an adult has contributed for five years, the program will provide individuals, with functional limitations, a cash benefit of not less than an average of \$50 per day. The cash benefit is to be used to purchase non-medical services and support necessary to maintain community residence.</p>
When	January 1, 2011

The 4 C's of Health Care Legislation

COST



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Early Retiree Reinsurance Program

Who	Employment-based plans providing health benefits (including prescription drug) to early retirees (not eligible for Medicare)
What	<p>This early retiree reinsurance program will be launched by the federal government to reimburse employer plans for providing health insurance coverage to early retirees over age 55 who are <u>not</u> eligible for Medicare.</p> <p>This program reimburses employers or insurers for 80% of claims between \$15,000 and \$90,000 (indexed for inflation).</p> <p>Payments from the reinsurance program must be used to lower the costs for enrollees in the employer plan (lower premiums, deductibles, etc.).</p>
When	Beginning within 90 days of enactment (June 23, 2010) until January 1, 2014



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Part 2 in our series ~ October 2010 2012 – 2014 Health Care Legislation

Special thanks to Banyan Consulting, LLC

www.banyan-llc.com