



Health Care Reform Legislation: What employers need to consider for 2010 - 2012

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BANYAN
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Table of Contents

2010 - 2012 Changes

Provision	Page
Introduction	3
Adoption Assistance	6
Auto-Enrollment	7
Claims Appeal Processes	8
Dependent Coverage	9
Distributions from HSA or Archer MSA	10
Emergency Services	11
Federal Premium Tax	12
Indoor Tanning Services	13
Lifetime and Annual Limits	14
Long Term Care	15
Medical Loss Ratio and Rebate	16
Medicare Part D	17
Medicare Part D Subsidy	18

Provision	Page
Nondiscrimination Rules	19
Ob-Gyn Requirement	20
Over-the-counter Drugs	21
Pre-existing Conditions	22
Preventive Services	23
Primary Care Physician Requirement	24
Rescission of Coverage	25
Simple Cafeteria Plans	26
Tax Credits - Small Business	27
Temporary Reinsurance program	28
Temporary High-Risk Pool	29
Uniform Notice of Coverage	30
W-2 Reporting	31
Wellness Programs - Small Business	32



Introduction

You have seen all the summaries and reports on the health care reform bill and amendments – now what? While all components of this law are important, this presentation is designed to guide our clients with the things you need to focus on now.

The following provides information on the requirements for 2010 through 2012. Due to the complexity of this law, there are many areas that are still unclear. The law delegates responsibility to the Secretaries of Health and Human Services, Treasury, and Labor for the interpretation of many of the provisions and we await these details. We will continue to update you as additional information becomes available.

Please note that the timeline dates noted in this presentation assume the next plan year following the date shown unless otherwise noted.



Introduction

One of the key issues that remains unclear is Grandfathered Plans. We know that grandfathered plans are those that were in existence on the enactment date of March 23, 2010 and that grandfathered plans are not subject to all of the provisions of the law.

The uncertainty is how to maintain grandfathered status – some sources indicate that the only changes you can make to your plan are adding new employees or dependents or plan modifications required through a collective bargaining agreement (CBA). Does this mean that you cannot change insurance carriers or make any plan design changes if they are not already stated in a CBA? The only thing that is clear is that further detailed guidance is required on this issue.



Introduction

As soon as this guidance is provided we will update you. In the meantime, the following outlines what we know today about the provisions for grandfathered plans:

Required	Not Required
Coverage for adult children to age 26 as long as they do not have access to any other employer sponsored health plan (until 2014)	Patient protections for emergency services, primary care physician, and ob-gyn services
Elimination of waiting periods greater than 90 days	Preventive care changes
Elimination of pre-existing condition exclusions for children and adults	Nondiscrimination rules for fully-insured plans and discrimination based on health status
Elimination of lifetime limits	Claims appeal processes
Annual limits only allowed on benefits determined by the Secretary of HHS	Mandated cost sharing limits and requirements to offer at least the essential health benefits package
	Certain reporting requirements



Adoption Assistance

Who	Employers with adoption assistance programs
What	<p>The maximum exclusion is increased to \$13,170 (a \$1,000 increase). The new dollar limit and income limitations are adjusted for inflation in tax years after 2010.</p> <p>The EGTRRA sunset of provisions is also delayed for one year. Under the sunset, after 2011, there is a \$6,000 credit for special-needs children only.</p>
When	January 1, 2010



Auto-Enrollment

Who	Employers with 200 or more employees
What	Requires the employer to auto-enroll all new employees into any available employer-sponsored health insurance plan. Employees may opt out if they have another source of coverage.
When	Assumed to be 2014 - not specified in Bill - noted here due to the uncertainty of effective date



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



Dependent Coverage

Who	Group health plans and individual plans
What	Provides coverage for dependent children up to age 26. Allows the dependent to be married and still be considered a dependent (not required to be a tax dependent).
When	Beginning 6 months after enactment – The first plan year on or after September 23, 2010



Distributions from HSA or Archer MSA

Who	Plans that qualify as a Health Savings Account (HSA), or Archer Medical Savings Account (MSA)
What	The taxation on distributions that are not used for qualified medical expenses will be increasing to 20% of the disbursed amount. (Currently taxed at 10% for HSAs and 15% for MSAs).
When	January 1, 2011



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	Beginning 6 months after enactment - The first plan year on or after September 23, 2010



Federal Premium Tax

Who	Group health plans
What	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. The fee will reduce to \$1 in policy years ending during fiscal year 2013.
When	Effective for plan years beginning on or after October 1, 2012



Indoor Tanning Services

Who	All consumers
What	A new 10% tax on amounts paid for indoor tanning services. This tax will be collected from the person tanning when payment for the tanning services is made. Something went terribly wrong for the tanning industry during this healthcare debate - obviously the health incentive is to get outside and walk in the sun!
When	Services performed on or after July 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	Beginning 6 months after enactment – The first plan year on or after September 23, 2010



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



Medical Loss Ratio and Rebate

Who	Health Insurance Issuer of group health plans
What	<p>The Issuer must provide an annual rebate to each enrollee if the amount expended for the reimbursement for clinical services and activities to improve health care quality is less than 85% (large group market - over 100) or 80% (small group market - 100 or less) of the total premium.</p> <p>An Issuer of group health plans must report this information to the Secretary each plan year.</p> <p>This requirement should have no effect on self-funded group health plans and it is not yet clear how the rebates will be calculated or distributed.</p>
When	Reports to the Secretary for plan year 2010, requirement to provide rebates effective January 1, 2011



Medicare Part D

Who	Medicare Part D Beneficiaries
What	<p>Beneficiaries that hit the doughnut hole in 2010 will receive a \$250 rebate.</p> <p>In 2011, beneficiaries who hit the doughnut hole are eligible for a 50% discount on brand name drugs.</p> <p>The beneficiary coinsurance rate will phase down gradually from 100% to 25% by 2020.</p>
When	January 1, 2010



Medicare Part D Subsidy

Who	Employers who receive the government retiree drug subsidy
What	<p>Elimination of the tax deduction for employers receiving the subsidy payments.</p> <p>Although the tax change is not effective until 2013, this provision could have an immediate impact on employer's accounting statements.</p>
When	Immediate accounting impact but the provision applies to taxable years beginning after December 31, 2012.



Nondiscrimination Rules

Who	Fully-Insured Group Health Plans (already applies to self-insured plans)
What	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. The rules prevent group health plans from discriminating in favor of highly compensated employees in terms of eligibility to participate and the level of benefits under the plan.
When	Beginning 6 months after enactment - The first plan year on or after September 23, 2010



Ob-Gyn Requirement

Who	Group health plans and individual plans that covers obstetrical and gynecological care
What	Allows the female enrollee to have direct access to such care without referral or authorization.
When	Beginning 6 months after enactment – The first plan year on or after September 23, 2010



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 OTC drugs (other than insulin or doctor prescribed medication) can not be reimbursed through an HRA or FSA nor can they be reimbursed on a tax-free basis through an HSA or MSA.
When	January 1, 2011



Pre-Existing Conditions

Who	Group health plans and individual plans
What	Prohibits pre-existing condition exclusions for children.
When	Beginning 6 months after enactment - The first plan year on or after September 23, 2010. Total enactment (including adults) is effective January 1, 2014.



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



Primary Care Physician (PCP) Requirement

Who	Group health plans and individual plans that require the enrollee to designate a PCP
What	Allows the enrollee to designate any participating in-network doctor as their primary care physician.
When	Beginning 6 months after enactment – The first plan year on or after September 23, 2010



Rescission of Coverage

Who	Group health plans and individual plans
What	Plans are prohibited from rescinding coverage with respect to a participant once covered, except in the event of fraud or intentional misrepresentation.
When	Beginning 6 months after enactment - The first plan year on or after September 23, 2010



Simple Cafeteria Plans

Who	Employers that employed on average 100 or fewer employees in the preceding two years
What	The employer is permitted to establish a “simple cafeteria plan”. By complying with the contribution, eligibility, and participation requirements the plan would satisfy any applicable nondiscrimination requirements under Section 125.
When	January 1, 2011



Tax Credits – Small Business

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



Temporary 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



Temporary High-Risk Pool

Who	U.S. citizens and legal immigrants who have a pre-existing medical condition and have been uninsured for at least 6 months
What	<p>This temporary national pool will be created to provide health coverage to individuals with pre-existing conditions and who have been uninsured for at least 6 months. Premiums will be subsidized.</p> <p>Employers are prohibited from putting individuals into the high-risk pool with associated fines.</p>
When	Beginning within 90 days of enactment (June 23, 2010) until January 1, 2014



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	Beginning 24 months after enactment - The first plan year on or after March 23, 2012



W-2 Reporting

Who	All employers
What	Disclose the value of the employer-sponsored health insurance coverage on the W-2. If an employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all health coverage, but exclude all contributions to HSAs, Archer MSA's and salary reduction contributions to FSAs.
When	Benefits payable during taxable years beginning after December 31, 2010 (2011 W-2's)



Wellness Programs – Small Business

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



1215 Manor Drive, Suite 200
Mechanicsburg, PA 17055
Phone 717.795.8666

20 Stanwix Street, Suite 401
Pittsburgh, PA 15222
Phone 412.325.1699

www.banyan-llc.com



BANYAN
CONSULTING LLC.