



Current Benefit Issues

Health Care Reform

Where Do We Go From Here?

Sponsored In Part By:



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Today's Goals

- Help you understand
 - What these changes mean, when they are effective and what you may need to do to prepare
 - How to qualify for the tax credits and premium reimbursements available now
 - How your group health plan is impacted

Health Care Reform 2010

- Affordable Care Act (ACA)
- Patient Protection and Affordability Care Act of 2010 (PPACA)
- Signed into law on March 23, 2010 by President Obama
 - P.L. 111-148
 - H.R. 3590
- Health Care and Education Reconciliation Act of 2010 (HCERA)
 - Signed into law on March 30, 2010 by President Obama
 - H.R. 4872

Health Care Reform 2010

- Regulatory Challenges
 - Implementation takes place over the next 8 years with multiple election cycles
 - Legislation spans 2010-2018
 - Lawmakers already working on various legislative fixes and technical corrections to bills
 - Complex and challenging to implement
 - 2400 pages plus 153 page reconciliation bill plus managers' amendments
 - HHS, DOL, Dept of Treasury and IRS implementation guidance
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Health Care Reform 2010

Provisions Effective March 23, 2010

Small Business Tax Credit (Phase 1)

- 2010 – 2013
 - Credit is 35% of employer contribution
 - 25% if employer is tax-exempt
 - Credit increases to 50% in 2014
 - 35% if employer is tax-exempt
- Claim credit on annual income tax return
 - New Form 8941 (Draft – Final to be released later this year)
- Must have profit or carry forward 20 years

Small Business Tax Credit (Phase 1)

- Contribution requirements 2010
 - Transition Relief requirement - Employer must pay a minimum 50% of premium
- Contribution requirements beginning 2011
 - Employer must pay a minimum uniform percentage of premium of 50% of single, couple and family

Small Business Tax Credit (Phase 1)

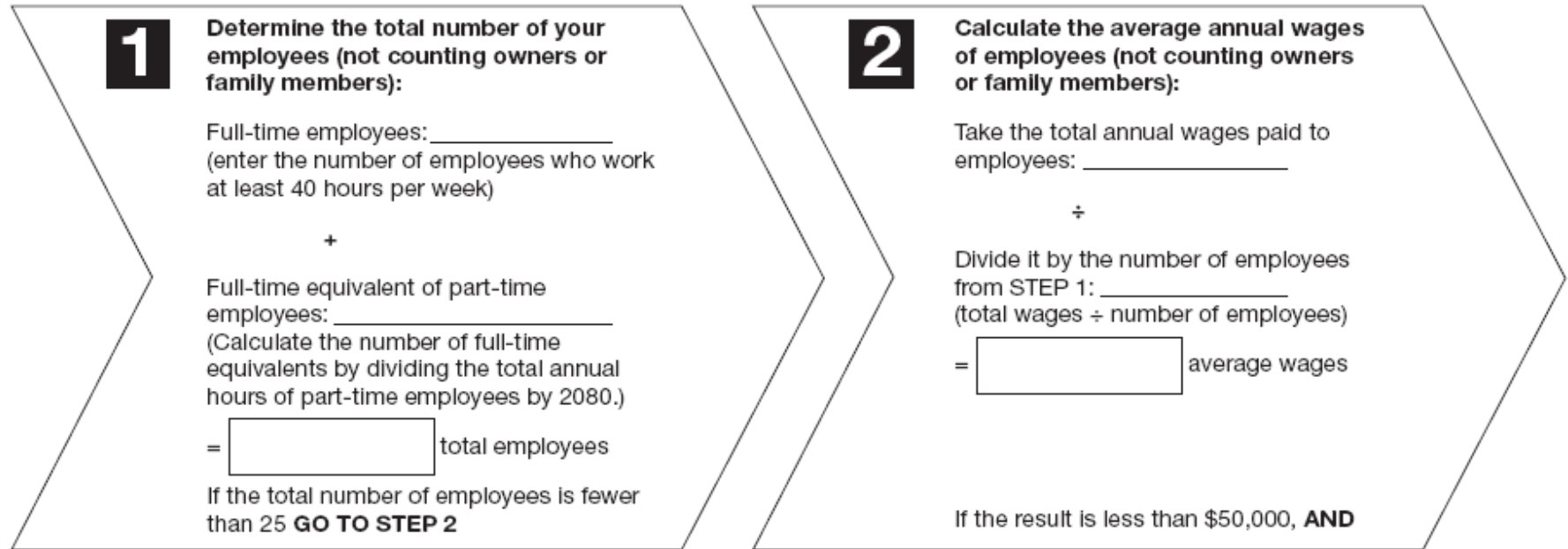
- Credit is the lesser of the portion of premium paid by the employer up to the average premium for the small group market in each state
 - Michigan average premium for 2010 is \$5,098 for employees only coverage and \$12,364 for family coverage

Small Business Tax Credit (Phase 1)

- Full credit available for employers with 10 or fewer employees AND average annual wage of less than \$25,000
 - Owners' & family members income excluded - no credit either
- Credit phases out
 - Some credit available to employers with fewer than 25 employees and average annual wages of less than \$50,000
 - Number of full time employees – divide credit by fraction
 - # FTEs over 10 (N) and 15 (D)
 - Annual wages – multiply credit by fraction
 - \$ over \$25,000 (N) and \$25,000 (D)

3 SIMPLE STEPS

If you are a small employer (business or tax-exempt) that provides health insurance coverage to your employees, determine if you may qualify for the **Small Business Health Care Tax Credit** by following these three simple steps:



3 You pay at least half of the insurance premiums for your employees at the single (employee-only) coverage rate, then

» you may be able to claim the Small Business Health Care Tax Credit.
Find out more information at **IRS.gov**

Small Business Tax Credit (Phase 1)

Example 1:

Auto Repair Shop with 10 Employees Gets \$24,500 Credit for 2010

Main Street Mechanic:

- ***Employees: 10***
- ***Wages: \$250,000 total, or \$25,000 per worker***
- ***Employee Health Care Costs: \$70,000***

2010 Tax Credit: \$24,500 (35% credit)

2014 Tax Credit: \$35,000 (50% credit)

Example 2:

Restaurant with 40 Part-Time Employees Gets \$28,000 Credit for 2010

Downtown Diner:

- ***Employees: 40 half-time employees (the equivalent of 20 full-time workers)***
- ***Wages: \$500,000 total, or \$25,000 per full-time equivalent worker***
- ***Employee Health Care Costs: \$240,000***

2010 Tax Credit: \$28,000 (35% credit with phase-out)

2014 Tax Credit: \$40,000 (50% credit with phase-out)

Example 3:

Foster Care Non-Profit with 9 Employees Gets \$18,000 Credit for 2010

First Street Family Services.org:

- ***Employees: 9***
- ***Wages: \$198,000 total, or \$22,000 per worker***
- ***Employee Health Care Costs: \$72,000***

2010 Tax Credit: \$18,000 (25% credit)

2014 Tax Credit: \$25,200 (35% credit)

Early Retiree Reinsurance Program

Interim Final Regulations issued May 5, 2010

- Temporary program provides reimbursement of 80% of the cost of benefits provided to retirees age 55 through 64
- To be eligible for the program, the employer plan must:
 - Include programs to generate cost savings for participant with chronic and high cost conditions
 - Provide documentation of the actual cost of medical claims
 - Both self-funded and fully insured plans are eligible to participate

Early Retiree Reinsurance Program

Important Update Released July 26, 2010

- Applications will be processed in the order in which they are received
- Payments are made based on when claims are submitted, not when the applications for the program were submitted
- All approved applicants are eligible to receive reimbursement for costs incurred on or after June 1st, regardless of the date on which the employer was accepted into the program
- Once an employer is accepted into the program, they can submit claims for their retirees and these claims will be processed in the order in which they are received

Early Retiree Reinsurance Program

Important Update Released September 24, 2010

- Notice to participant requirements released

Important Update Released September 28, 2010

- Reimbursement is only for claims that would be deemed eligible under Medicare

Retiree Reinsurance

- To be eligible for the program, the employer plan must:
 - Submit an application for reimbursement to HHS
 - Use recouped amounts to lower cost of plan (e.g., reduce premium costs, copayments, deductibles, coinsurance or other out-of-pocket costs)
- Amounts recouped will be audited annually by HHS

Retiree Reinsurance

- Program began 90 days from enactment and ends on the earlier of exhaustion of \$5 billion allocation or 12/31/2014
 - As of 10/4/2010 nearly 3,000 applications approved
- Breakdown:
 - Employer plan remains responsible for first \$15,000 of benefits
 - Reimbursement of 80% of benefits in excess of \$15,000 up to \$90,000
 - Employer plan responsible for claims in excess of \$90,000
- Details located at: www.errp.gov

Medicare Part D Subsidy

- Employer tax deductions reduce to the extent drug expenses are reimbursed under the Medicare Part D retiree drug subsidy program
- Effective 1/1/2013
- Full accounting impact of the loss of this federal tax deduction must be recognized on current liability and income financial statements
- Action Steps:
 - Coordinate with finance and auditors to determine financial impact
 - Public announcement of impact on financial statements required

Grandfathered Plans

- **Interim Final Regulations issued June 14, 2010 (published in Federal Register June 17, 2010)**
- Grandfathered status lost with:
 - Issuance of new policy, certificate or contract of insurance
 - Elimination of benefits for a particular condition
 - Increase in percentage coinsurance requirements
 - Increase in copays by more than the greater of \$5 or 15% (adjusted for medical inflation - CPI)
 - Increase deductibles or OOP Max more than 15% (adjusted for medical inflation)
 - Decrease in employer contribution rates by more than 5%
 - Decrease or add a new annual limit on the dollar value of benefits

All Group Health Plans

- Grandfathered plans are subject to the following provisions:
 - Extension of dependent coverage to adult children to age 26 unless eligible for other employer-sponsored coverage
 - Lifetime limits
 - Annual limits
 - Rescissions
 - Pre-existing condition exclusions for children to age 19
 - Uniform explanations of coverage and standardized definitions
 - Waiting periods

Grandfathered Plans Retain

- Right to retain copay for preventive services
 - Need not comply with expanded preventive benefits
 - Extension of dependent coverage to adult children to age 26 unless eligible for other employer-sponsored coverage
 - Not required to perform non-discrimination testing for fully insured plans – avoid 105(h)
 - Delayed establishment of an external review process for benefit claim appeals
 - Pre-authorization requirements for OB/GYN
 - Pre-authorization or out-of-network increased cost-sharing for emergency services
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Grandfathered Plans

- Collective Bargaining Agreements
 - Are not subject to the rules until the date on which the last of the collective bargaining agreements relating to the coverage terminates
- Self-funded collectively bargained plans in effect on March 23, 2010 must comply at the same time as other grandfathered plans
- Fully-insured collectively bargained plans may make changes and still retain grandfather status until the end of the last collectively bargained agreement in effect on March 23, 2010
 - At that time, collectively bargained plan either retains or immediately loses grandfather status, depending on changes made

Grandfathered Plans

- Disclosure requirements
 - Modify plan materials to include statement of grandfathered status
 - Open enrollment materials
 - Summary plan descriptions
 - Summary of material modifications
 - DOL model language issued 6/21/2010
- Record maintenance requirements
 - Retain records that document the benefit terms in effect 3/23/2010
 - Records must be provided upon request to any participant, beneficiary, subscriber, or state or Federal agency official
 - Memorialize in STONE

Grandfathered Plan Notice Language

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] **may not include certain consumer protections** of the Affordable Care Act that apply to other plans, for example, **the requirement for the provision of preventive health services without any cost sharing**. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Grandfathered Plan Notice Language

Questions regarding which **protections apply and which protections** do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a **table summarizing which protections** do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

HIPAA Excepted Benefits

- Stand alone dental & vision plans are not subject to the insurance market reform provisions
 - Wed or Bundled plans
- If plan amends independent elections does it eliminate grandfathered status? And then, must eligibility be extended?



Health Care Reform 2010

Provisions Effective First Plan
Renewal or Implementation
Following September 23, 2010

Dependent Coverage

Interim Final Regulations issued May 10, 2010

- Coverage of children extended until the child reaches age 26
 - Student status, marital status, residency, financial support, dependent status for tax purposes, or other criteria do not apply
 - Grandfathered plans may exclude dependents to age 26 who are eligible for coverage elsewhere until 2014

Dependent Coverage

Interim Final Regulations issued May 10, 2010

- Requires 30-day special enrollment opportunity
 - No later than 1st day of plan year
 - Must provide written notice to adult children
 - DOL model language issued June 28, 2010
- Eliminates need for Michelle's Law requirements

Dependent Coverage

Interim Final Regulations issued May 10, 2010

- No additional premium can be charged unless a change in family status under the contract takes place
 - Single coverage becomes two-person coverage
 - Two-person coverage becomes family coverage
 - Employee plus family continuation becomes two person coverage
 - Two person plus family continuation becomes family coverage
- Some plans may begin rating by the number of dependents covered in each family

Dependent Coverage

IRS Notice 2010-38 issued April 27, 2010

- Health coverage or reimbursement of medical expenses for a child who has not attained age 27 by the end of the taxable year will not be taxable to the employee
 - Tax exclusion applies even if the child is not a tax eligible dependent
- IRC Section 105(b) amended to permit an employer to exclude from gross income the value of employer provided health coverage to any child of a taxpayer who has not reached age 27 as of the end of the tax year

Pre-Existing Conditions

Interim Final Regulations issued June 28, 2010

- A plan may not impose a pre-existing condition exclusion on coverage for a child under age 19 to limit or deny coverage
 - 2014 applies to all participants

Preventive Care

Interim Final Regulations issued July 14, 2010

- First dollar coverage (no cost sharing for network services)
- No annual or lifetime limitations
- Preventive services include:
 - Evidence-based services with a rating of A or B from US Preventive Services Task Force
 - Preventive care and screenings in the supported guidelines established by Health Resources and Services Administration
 - Immunizations recommended by the Center for Disease Control and Prevention

Preventive Care

- Greatly expands the range of covered preventive services
- Reasonable medical management allowed to determine frequency, method, treatment or setting to receive covered services
- Designed to encourage individuals to access preventive care and health screenings appropriate to age and health status
- When new services are added to the recommendations, plans have at least a year to adopt the new recommendations
- Physician coding will determine if cost-sharing applies
- A complete list of recommendations & guidelines is available at:
<http://www.Healthcare.gov/center/regulations/prevention.html>

Annual & Lifetime Limits

Interim Final Regulations issues June 28, 2010

- A plan may not impose a lifetime limit on the dollar value of essential health benefits
 - Requires 30-day special enrollment opportunity
 - No later than 1st day of the plan year
 - Model notice language issued on 6/29/2010
 - Annual limits under health plans for essential health benefits are restricted
 - Annual aggregate of \$750,000 allowed first year
 - 2014 no annual limits are permitted
 - Non-essential annual limits are permitted
 - Appropriate stop-loss coverage becomes more critical
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Essential Benefits Defined

- Must include the *at least* following categories of coverage
 - Ambulatory patient services
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Mental health and substance use disorder services, including behavioral health treatment
 - Prescription drugs
 - Rehabilitative and habilitative services and devices
 - Laboratory services
 - Preventive and wellness services and chronic disease management
 - Pediatric services, including oral and vision care
 - HHS & DOL to further define essential benefits

Insured Plans & Non-Discrimination Rules

- IRC Section 105(h)(2) Nondiscrimination requirements apply to fully insured health plans
 - Previously applicable to self-insured plans only
 - Must not discriminate in favor of highly compensated (top 25% wage earners) as to eligibility to participate and eligibility of benefits
- A plan satisfies the eligibility requirements if the plan benefits
 - 70% or more of all employees, or
 - A minimum of 56% or more of all employees are eligible to benefit under the plan (80% x 70%)

Insured Plans & Non-Discrimination Rules

- A plan meets the eligibility requirements if it covers a classification of employees that does not discriminate in favor of highly compensated individuals
- Benefits Test
 - All benefits provided to highly compensated individuals must be provided to all employees

Insured Plans & Non-Discrimination Rules

- Failure of nondiscrimination testing will result in penalties to employers of \$100 per day excise tax per participant (not taxation of benefits to highly compensated)
 - Could be a significant change for executive only policies (e.g.; Exec-U-Care)
- Does not apply to grandfathered plans
 - Expect significant grandfathering issues to arise as to discriminatory insured health plans
 - Special caution in preserving status may be warranted

No Rescission

Interim Final Regulations issued June 28, 2010

- Rescission is a cancellation or discontinuance of coverage that has a retroactive effect
- Health insurance issuers may not rescind coverage except in cases of fraud or intentional misrepresentation
- Coverage may not be cancelled without prior notice to the enrollee except for:
 - Nonpayment of premium
 - Plan termination
 - Movement outside a plan service area
- 30-day advance notice required

No Rescission

- Impact to group health plans
 - Full time employees must work 30 hours per week to be eligible for healthcare
 - Employee transitions to part time
 - Plan administrator mistakenly continues coverage and contributions
 - When the error is found the plan cannot retroactively terminate coverage, coverage may only be terminated prospectively
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New Appeals Process

Interim Final Regulations issued July 23, 2010

External Reviews Update issued August 23, 2010

- Group health plans and insurers must implement an effective process for appeals of coverage determinations and claims, including an internal claims appeal process and employee notification
- Failure to comply is \$100 per day excise tax

New Appeals Process

- Plan appeal procedure must:
 - Allow claimants to continue coverage during appeals process
 - Treat a rescission as an “Adverse Benefit Determination”
 - Reduce response time for urgent care claims to 72 hours
 - Notification of new evidence considered in an appeal
 - Avoid conflicts of interest

New Appeals Process

- Plan appeal procedure must:
 - Additional information in denial notices
 - Provide denial notices in non-English languages
- External appeal procedure must:
 - Permit timely requests
 - Conduct an initial review
 - Contract with independent review organizations
 - Comply with IROs determination
 - Provide for expedited review in severe situations

New Appeals Process

- Plan appeal procedure must:
 - Allow claimants to continue coverage during appeals process
 - Establish external review process that complies with Uniform External Review Model Act (for self-insured plans)
 - Provide adverse benefit determinations
 - Notice of urgent care determinations
 - Full and fair review
 - Avoid conflicts of interest
 - Deemed exhaustion of internal claims and appeals processes

Patient Protections

Interim Final Regulations issued June 28, 2010

- Plans must allow enrollees to:
 - Select any participating primary care provider available, including a pediatrician for children
 - Receive obstetrical/gynecological specialist services without a referral from another primary care provider (female participants)
 - Plan may still require adherence for referrals, preauthorization, covered treatment plans and coordination with PCP of treatment decisions
 - Model notice language issued on 6/29/2010
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Patient Protections

Interim Final Regulations issued June 28, 2010

- Plans must allow enrollees to:
 - Receive emergency services provided at a hospital emergency department
 - Regardless of the hospital's participation in the plan preferred provider network AND
 - May not impose greater coverage restrictions on non-participating providers
 - May not impose greater cost sharing requirements on non-participating providers

Patient Protections

Interim Final Regulations issued June 28, 2010

- Plans must allow enrollees to:
 - Receive emergency services provided at a hospital emergency department
 - Without prior authorization requirements
 - Out-of-network cost-sharing requirements (i.e., deductible, coinsurance) may be imposed only if it applies generally to out-of-network benefits
 - Participant may be responsible to pay charges in excess of the amount the out-of-network provider charges over the amount the plan is required to pay

Other Notes

- Wellness Plans
 - May not require information on lawful firearm or ammunition ownership, storage, or use
- Indoor Tanning Services
 - 10% tax effective July 1, 2010
- Reasonable Break Time for Nursing Mothers
 - Employers must provide reasonable break time and privacy (other than a bathroom) for an employee to express breast milk for her nursing child for one year after the child's birth
 - Employers with less than 50 employees may be exempt if this requirement would impose an undue hardship

Insurance Access for Individuals With Pre-Existing Conditions

- A temporary insurance program for high risk individuals with pre-existing conditions has been established for those who have been uninsured for six months or who have a pre-existing condition
 - Funding for this program is capped at \$5 billion and it terminates on January 1, 2014
- This pool is designed to provide health insurance coverage for eligible individuals for the period from the day the program is established until January 1, 2014

Insurance Access for Individuals With Pre-Existing Conditions

- To be eligible for the high risk pool a person must:
 - Be an American citizen or a U.S. national or is lawfully present in the U.S.
 - Not been covered under creditable coverage during the six-month period prior to the date of application for coverage through the high risk pool; and
 - Have a pre-existing condition, as determined under guidance issued by the HHS Secretary

Insurance Access for Individuals With Pre-Existing Conditions

- Sanctions will apply
 - If HHS Secretary discovers an individual was encouraged by the issuer or employer-provided health plan to disenroll from health coverage prior to enrolling in the national high risk pool program
 - Reimbursement to the program for medical expenses incurred by the high risk pool program on that individuals behalf

Insurance Access for Individuals With Pre-Existing Conditions

- The criteria for determining whether an individual was urged to disenroll from the prior coverage must include at least the following circumstances:
 - For prior coverage obtained through an employer, the Secretary would look at whether money or other financial considerations for disenrolling from the coverage was provided; and
 - For prior coverage obtained directly from an issuer or under an employment-based health plan
 - the Secretary would look at whether the issuer or plan provided money or other financial considerations for disenrolling from the coverage or
 - for individuals whose premium for the prior coverage exceeded the premium required by the national high risk pool program (as adjusted based on the age factors applied to the prior coverage)

Expansion of Adoption Assistance

- Maximum tax credit and income exclusion for employer provided adoption assistance increased by \$1,000
 - From \$12,170 to \$13,170
 - Will increase with inflation annually

BCBSM's Approach

- Implementing January 1, 2011 for most groups
 - Dependent coverage to age 26
 - Extending through end of calendar year
 - Immunization and preventive care with no cost-sharing
 - Removal lifetime & annual dollar limits
 - Remove pre-existing condition exclusions up to age 19
 - Prohibit rescissions
 - Emergency services at network cost sharing & no prior authorization



Health Care Reform 2010

Provisions Effective

January 1, 2011

Small Employer Wellness Grant Program

- Available to provide participants with comprehensive workplace wellness programs
 - Less than 100 employees who work 25 hours or more per week
 - Not available for existing wellness plans
- To qualify, the wellness plan must include:
 - Health awareness initiatives
 - Health education, preventive screenings, health risk assessments
 - Efforts to maximize employee involvement and participation

Small Employer Wellness Grant Program

- To qualify, the wellness plan must include:
 - Initiatives to change unhealthy behaviors and lifestyle choices
 - Counseling, seminars, self-help materials
 - Workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity and improved mental health
- Employers must submit application to HHS for approval
 - Include proposal for implementing comprehensive wellness program
- \$200 million in funding for fiscal years 2011-2015

W-2 Reporting

- Taxable years beginning 2011
 - Employers must report the aggregate cost of benefits provided for each employee on the employee's Form W-2
 - Amounts continue to be excluded from gross income
 - Aggregate cost is determined under COBRA like rules for self-funded plans

W-2 Reporting

- Benefits Values
 - If an employee receives health insurance coverage under multiple plans
 - The employer must disclose the aggregate value of all health coverage
 - Medical and prescription
 - MiniMed plans
 - Self-Funded Reimbursements
 - Employer HRA Funding

W-2 Reporting

- Benefits Values
 - If an employee receives health insurance coverage under multiple plans
 - The employer must disclose the aggregate value of all health coverage
 - Employer provided Medicare Supplemental Coverage
 - Employee Assistance Plans
 - Exclude all contributions to HSAs and Archer MSAs and salary reduction contributions to FSAs
 - Exclude stand-alone dental and vision plans
 - Applies to benefits provided during taxable years after December 31, 2010

W-2 Reporting

- The value is reported based on coverage provided to similarly situated employees
 - For Example:
 - Employee Only
 - Employee + 1 Dependent
 - Employee + 2 Dependents
 - Family
 - 4 categories of similarly situated employees

W-2 Reporting

- Be prepared to comply early in 2011!
 - Former employees may request a W-2 at any time during the calendar year
 - Former employers have 30 days to respond

Flexible Spending Arrangements

- Over the Counter Drugs excluded from FSAs, HSAs, HRAs, & Archer MSAs unless prescribed by a physician
 - Medical products (such as bandages, braces, etc.) can still be reimbursed on a tax-free basis
 - Updates to qualified medical expenses to conform to definition used for itemized deductions
 - Debit cards no longer work for OTC drug purchases
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Simple Cafeteria Plan

- Simple cafeteria plan
 - Fewer than 100 employees during preceding two years on business days
 - Provide tax-free benefits to employees
 - Exempts employers who make contributions for employees under a “simple Cafeteria Plan” from concentration test nondiscrimination requirements
 - Plan must still satisfy minimum eligibility, participation, and contribution requirements
 - SIMPLEs cannot cover a sole proprietor, S Corp. 2% or greater shareholder or partnerships, or LLC treated as a partnership

Other 2011 Provisions

- The tax penalty on HSAs increases from 10% to 20% of distribution for non-eligible expenses
- Minimum Loss Ratios (MLR)
 - Requirement that insurance carriers spend at least 80% of premium dollar on medical expenses
 - Large groups 85%
 - Taxes?
 - Commissions?



Health Care Reform 2010

Provisions Effective
January 1, 2012

Form 1099-Misc Expanded Reporting

- The corporate exception is ending and, with few exceptions, all corporations will need to be reported on Form 1099-Misc for payments made after December 31, 2011
- New procedures will be required for reportable corporations, property, and gross proceeds based on current legislative action
- Payments for property (goods) will need to be reported on the 1099-MISC if at or above the familiar \$600 annual payment threshold
- “PAYGO”

Uniform Standards for Health Plan Summary of Benefits and Coverage

- Advance Notice of Benefit Changes
 - Group health plan participants must be notified 60 days **before** any material changes in plan terms
 - Material changes include changes to covered services, as well as deductibles and copayments
 - The penalty for a willful failure to comply with this provision can be as high as \$1,000 per day per failure

Uniform Standards for Health Plan Summary of Benefits and Coverage

- All group plans and group and individual health insurers (including self-inured plans) must provide a summary of benefits and a coverage explanation that meets specified criteria to all enrollees when
 - they apply for coverage
 - when they enroll and reenroll in coverage
 - when the policy is delivered
 - if any material modification is made to the terms of their coverage
- \$1,000 fine per enrollee for willful failure to provide the information

Uniform Standards for Health Plan Summary of Benefits and Coverage

- The summary and explanation
 - Can be provided electronically or in written form
 - Must be no more than 4 pages in length with print no smaller than 12 point font
 - Must include:
 - Uniform definitions of standard insurance terms as well as a description of the coverage, including dollar amount for benefits
 - Exceptions, reductions and limitations on coverage
 - Cost-sharing provisions
- Model notice to be provided

Uniform Standards for Health Plan Summary of Benefits and Coverage

- The summary and explanation
 - Must include:
 - Renewability and continuation of coverage provisions
 - Examples of common benefit scenarios
 - Statement whether the plan provides minimum essential benefits
 - Statement that the outline is in summary
 - Contact information where the consumer can get more information and a web link to the individual policy or group certificate of coverage

Class Act

- NEW employee-funded long-term care benefit
 - Community Living Assistance Services and Supports Act – Class Act
 - Employer involvement is voluntary
 - 5 year investment period
 - Benefits available for assisted living after years of payroll deducted premium in unable to perform daily activities
 - Employers participating must automatically enroll employees unless they opt-out
- Originally scheduled for a 1/1/2011 effective date
 - Most recent releases from HHS indicate no later than 10/01/2012



Health Care Reform 2010

Provisions Effective
January 1, 2013

Benefit Plan Requirements

- Section 125 Limits – Flexible Spending Account Limits
 - Contributions are limited to \$2,500 per year
 - Couples may make separate elections
 - Indexed by CPI annually beginning 2014

Benefit Plan Requirements

- Employer Exchange Notice
 - All employers must provide notice to their employees informing them of the existence of the state based exchanges
 - Should include
 - Conditions that make an employee eligible for premium credits
 - What happens when exchange is selected over group health plan
 - Waiting for further guidance

Tax Changes

- Premium Tax
 - Federal premium tax on health plans funding comparative effectiveness research program begins
 - Imposes an annual fee on private insurance plans equal to \$2 for each individual covered (includes fully insured and self-insured plans)
- Tax Change
 - Threshold for deducting unreimbursed medical expenses from federal taxes increases from 7.5% to 10%

Tax Changes

- Employee Portion of Medicare Hospital Insurance Tax
 - For individuals who earn \$200,000+ (\$250,000+ for joint filers) the Medicare tax rate will increase by .9% (1.45% - 2.35%) – for employee share only
 - Additional tax is imposed on combined wages of employee and spouse in the case of a joint return
 - Withhold the increased amount from all workers with wages exceeding \$200,000 regardless of marital status claimed on Form W-4
 - Standard employer penalties for failure to withhold the tax apply
 - Applies to self-employment income exceeding threshold

Tax Changes

- Medicare Tax Rate
 - 3.8% tax on investment income for individuals, estates, and trusts
 - Imposed on modified AGI exceeding \$250,000 (joint filers), \$125,000 (individual filers)
 - Distributions from qualified retirement plans are not treated as investment income



Health Care Reform 2010

Provisions Effective
January 1, 2014

Automatic Enrollment

- Employers with more than 200 full time employees that offers enrollment in one or more health benefit plans must automatically enroll new full time employees in one of the offered plans
- Adequate notice must be provided
- Option to waive coverage mandatory

Automatic Enrollment

- Supersedes state laws that would otherwise prevent automatic enrollment
- Includes “evergreen” approach to existing elections during annual enrollment period for current participants
- Secretary of Labor to issue regulations
 - Effective date is March 23, 2010, but subject to issuance of regulations which could delay this provision to as late as 2014

Small Business Tax Credit (Phase 2)

- Tax credit equal to 50% of health insurance costs
 - To qualify for the full credit the business must have:
 - 10 or fewer full-time equivalent employees
 - Average annual wages of less than \$25,000
 - Employer must pay 50% or more of the premium
 - Must purchase coverage through the state based exchange
 - Companies with between 11 and 25 workers and an average wage of less than \$50,000 are eligible for partial credits
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Wellness Incentives

- Plans may condition wellness rewards upon satisfaction of a standard that is related to a health status factor
 - Rewards may not exceed 30% of cost of employee-only coverage
 - If spouse/dependents participate the reward cannot exceed 30% of cost of couple/family coverage
 - Reward may include
 - Rebate of premium
 - Contributions
 - Waiver of cost-sharing (deductibles, copays, etc.)
 - Potential for increase to 50% of the cost of coverage

Mandates for All Plans

- Coverage of essential benefits for individual and small group plans
- No annual dollar limits on essential health care benefits
- Guaranteed issue
 - Insurers will no longer be able to set rates or exclude coverage based on pre-existing conditions, and can vary premiums only by geographic location, age, and tobacco use
 - Insurance carriers may no longer deny coverage based on health factors
- Guaranteed renewals
- No pre-existing condition exclusions for all enrollees

Mandates for All Plans

- Cost sharing may not exceed current out of pocket maximums for HDHPs
 - \$5,950 for Individuals
 - \$11,900 for Families
- Waiting period for coverage cannot exceed 90 days

Health Insurance Exchanges

- Exchanges in each State for individuals and small employers
 - Facilitates enrollment and administers tax credits
- Provides choice of coverage through multi-State plan
- Introduces premium tax credits for those with incomes above Medicaid eligibility and below 400% of poverty level
- Employee free choice vouchers required for workers who qualify to take their employer contribution and join an exchange plan

Health Insurance Exchanges

- Requires most individuals to obtain acceptable health insurance coverage or pay a Free Rider Penalty
 - If any employees' cost of coverage exceeds 9.5% of household income AND at least one employee purchases coverage through the exchange
 - Employers with 50 or more employees who do not offer coverage to their employees to pay \$2,000 annually for each full time employee over the first 30
 - Employers who offer coverage but whose employees receive tax credit to pay \$3,000 for each worker receiving a tax credit up to an aggregate cap of \$2,000 per full time employee

Health Insurance Exchanges

- Exchanges provide limits on cost-sharing
 - Actuarially equivalent percentage of coverage of the full actuarial value of the benefits provided under the plan
 - Bronze – 60%
 - Silver – 70%
 - Gold – 80%
 - Platinum – 90%



Health Care Reform 2010

Provisions Effective
January 1, 2015 & Beyond

2015 & Beyond

- 2015
 - Individual mandates increase to \$325 (from \$95) or 2% of household income over filing threshold
 - Employer reporting of health insurance coverage
 - Every person who provides minimum essential coverage to an individual during a calendar year shall make a return as prescribed by the Secretary
- 2016
 - Individual mandates increase to \$695 or 2.5% of household income over filing threshold

2015 & Beyond

- 2017
 - Large employers permitted to purchase coverage through state exchanges
- 2018
 - Tax on high cost (Cadillac) plans
 - 40% excise tax on employer-sponsored health benefits in excess of \$10,200 for individuals and \$27,500 for families
 - Employers will be required to provide information to the IRS and insurers for the amounts subject to excise tax

Our Role

- We will continue to monitor developments as regulations are released
- Provide updates and communication guidance
- Provide technical support
- Continue to seek and secure cost containment opportunities



Q & A

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