THE RESCHINI GROUP®

Health Care Reform Act

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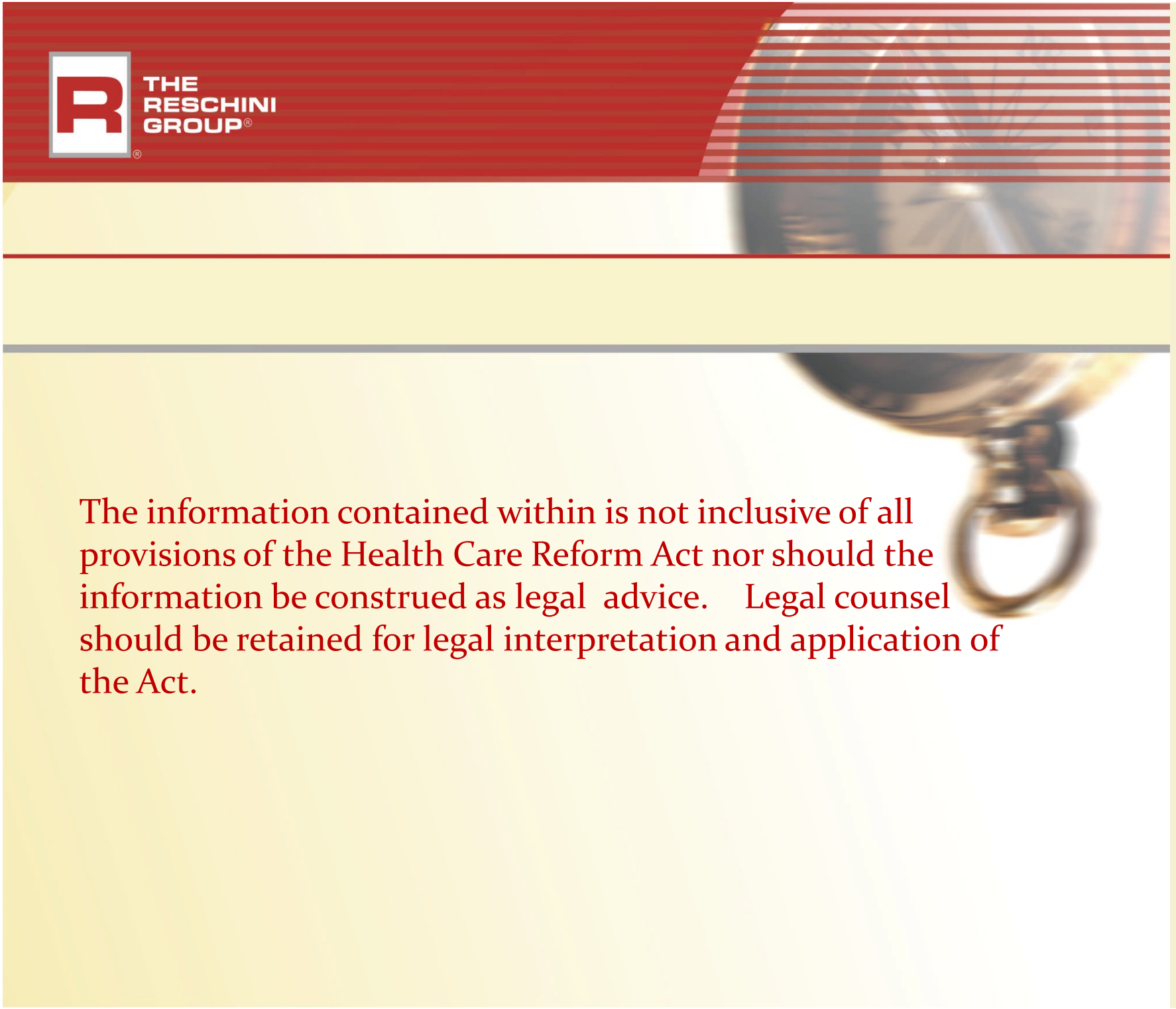

The information contained within is not inclusive of all provisions of the Health Care Reform Act nor should the information be construed as legal advice. Legal counsel should be retained for legal interpretation and application of the Act.

The Health Care Reform Act

President Obama signed into law the Patient Protection and Affordable Care Act (PPACA) with Congress passing the Health Care and Education Tax Credit Reconciliation Act of 2010 less than a week later. The Health Care and Education Tax Credit Reconciliation Act amends various PPACA provisions. Since then there have been interim final rules and clarifications from the respective agencies to further define the Act.

Key Concept of the Act – The Grandfather Provision

On June 14, 2010, interim final regulations were issued to further define the *Grandfathering* regulations. *Grandfathered group health plans* are those plans in which individuals are enrolled in a group health plan on the date of enactment March 23, 2010. Such status provides a group health plan exemptions or delays in the implementation of certain requirements under the Act.

Grandfathered Status under a Collectively Bargained Plan

> "Health insurance coverage" maintained pursuant to one or more collective bargained for agreements ratified prior to March 23, 2010, is *grandfathered* until the last agreement relating to the health coverage terminates.

The interim regulations appear to clarify that this exemption applied only to fully-insured health plans and not to self-insured plans.

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Plan Changes that will create a loss of the *Grandfathered* status:

- Elimination of coverage for particular conditions

  Example – Decision to no longer provide services for chiropractic care

- Increase in plan deductibles or out-of-pocket requirements greater than 15% plus Medical Inflation (measured from March 23, 2010 to date of change

  Example – Plan has no plan deductible and implements a $500/$1000 deductible

- Increase in copayments (of any type not just inclusive of physician visits) of the greater of $5.00 or 15% plus Medical Inflation

  Example – Plan increases copayment for Diagnostic Testing from $10.00 to $20.00

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Plan Changes that will create a loss of the *Grandfathered* status:

- Increase in a percentage-based cost sharing

  Example – Co-Insurance of 90%/10% or 80%/20% etc.

- Decrease in the level of the employer's contribution for plan coverage

  Example – 5% or more decrease in employer's contribution

- Changes to any annual benefit limits

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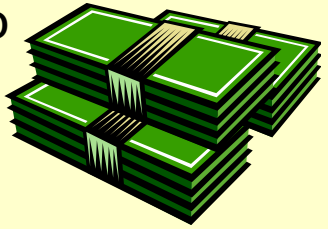
Grandfathered versus *Non-grandfathered* Status

- Is there a right answer?
- Can we save money if we preserve our *Grandfathered* status?
- Do we lose money if we make changes to our plan and lose our status?

If a group remains *Grandfathered,* there is no provision under the Act that allows the group to combat health care cost inflation.



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The Loss of *Grandfathered* Status

Effective *Plan Year following September 23, 2010*, plans must implement:

- Age 26 Provision with addition of adult child who has their own employer sponsored plan

- Coverage of preventive services w/o cost sharing

  Examples are: 1.) screening of high blood pressure, cholesterol, diabetes, colorectal cancer, counseling for tobacco use, alcohol abuse and obesity; 2.) Routine immunizations for children, adolescents, and adults that are currently recommended by the Centers of Disease and Control; 3.) Evidence-informed preventive care and screenings for infants, children, and adolescents as recommended by the Health Resources and Services Administration; 4.) Evidence-based preventive care and screenings for women provided by HRSA and to be developed by August 2011.

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The Loss of *Grandfathered* Status

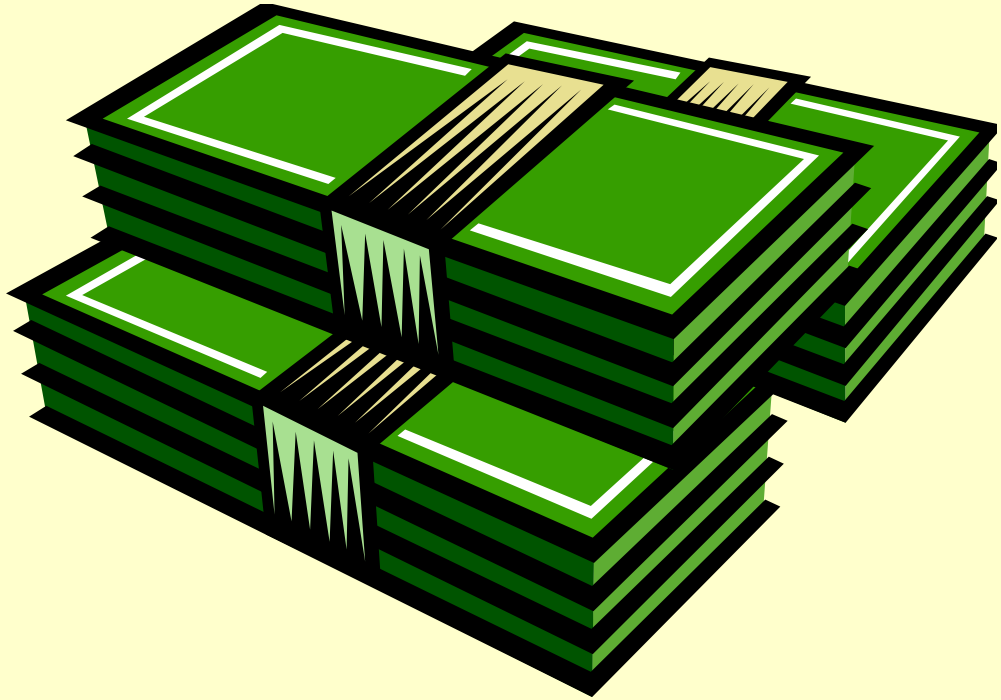
Effective *Plan Year following September 23, 2010*, plans must implement:

- Non-discrimination rules that apply to insured plans
- Internal and External claims appeal process
- Choice of physician – Pediatric and OB/GYN
- Prohibition of higher cost sharing for ER services
- Patient protection requirements for choice of providers

Effective *Plan year following January 1, 2014,* plans must implement*:*

- Clinical trial coverage
- Wellness incentives
- Nondiscrimination rules on providers practicing within the scope of their license

What is the cost impact to the Employer by losing *grandfather* status?



1.5 – 2% Increase in cost

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Transition and Anti-Abuse Rules:

Changes to a contract or plan made prior to March 23, 2010, although effective after March 23, 2010, does not cause a change in *grandfathering* status

Changes made after March 23, 2010, but prior to the issuing of the interim final regulation, does not cause a loss in *grandfathering* status if the changes are revoked or modified on or before the first plan year beginning on or after September 24, 2010. The interim regulations state that plan changes made after March 23, 2010, but before the issuing of the interim regulations will not create a change in status of the plan, if such change represents a good faith effort to comply and such changes "only modestly exceed" the interim final regulations

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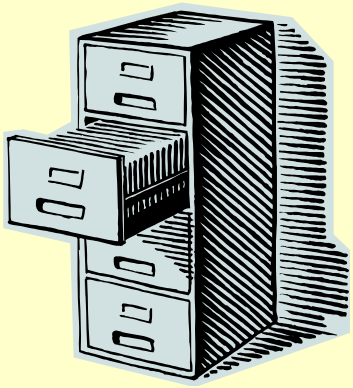
Communication Requirements for *Grandfathered* Plans:

Notification to plan participants that the benefits being provided are believed to be a *grandfathered* health plan as set forth under the Section 1251 of the Act. Contact information must be provided within the notice for any questions or complaints. Model language for the notice is provided within the interim final regulation.



Recordkeeping Requirements for *Grandfathered* Plans:

All plans that maintain a *grandfathered* status must maintain records documenting coverage in effect as of March 23, 2010 that verifies the plan's status.

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Timeline of effective dates for Act provisions:

Effective following March 23, 2010

Automatic Enrollment – Employers with over 200 employees who offer enrollment in one or more health plans are required to automatically enroll employees.

Nursing Mother's Provision

Effective 90 days following enactment March 23, 2010:

Temporary Retiree Reinsurance Program – the Act provides $5 Billion in financial assistance to help maintain coverage for early retirees age 55 years and older who are not eligible for Medicare. The program is to reimburse qualifying health plans for 80% of annual health care cost between $15,000-$90,000 (this may be indexed) for early retirees. The program ends at the exhaustion of the $5 Billion fund or by Year 2014. Early retirees are defined as plan participants aged 55 years and older and not eligible for Medicare. (90 days following enactment date)

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Timeline of effective dates for Act provisions:

Plan's first renewal following September 23, 2010:

The Patient's Bill of Rights -- applicable to all plans

Restrictions on lifetime and annual limits on the dollar value of benefits for Essential Health Benefits – phase out of annual dollar limits of essential health benefits over the next 3 years

Restrictions on pre-existing conditions for children under the age of 19. This provision will extend to all members of all ages beginning in 2014

Prohibition on retroactive cancellation of coverage (Rescission) a plan can not terminate the coverage of an enrollee unless the enrollee has been fraudulent or performed an intentional misrepresentation of material fact. Coverage can not be terminated without a 30 day prior notification

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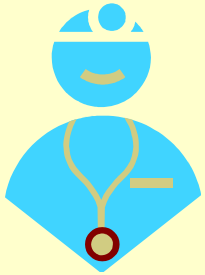
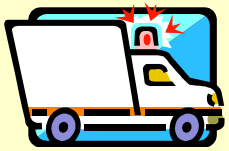
The Patient's Bill of Rights -- the following are applicable to plans that are *non-grandfathered*



Choice of doctors -- OB/GYN and Pediatric



Emergency

Prohibition on higher cost sharing for Emergency Department Services

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Effective Year	Health Care Reform Act Requirements	Applies to Grandfathered Plans	Applies to Non-Grandfathered Plans
Effective Plan Years beginning On or after 09-23-2010	Adult child coverage to age 26 years	Yes *	Yes
	Lifetime limits for essential benefits phase out	Yes	Yes
	Rescission	Yes	Yes
	Pre-existing condition exclusions under the age of 19 years	Yes	Yes
	Automatic enrollment for employers with more than 200 employees (regulation not issued as of yet)	Yes	Yes
	Coverage of preventive services w/o cost sharing	No	Yes
	Non-discrimination rules apply to insured plans	No	Yes
	Internal and External claims appeal process	No	Yes
	Choice of physician – Pediatric and OB/GYN	No	Yes
	Prohibition of higher cost sharing for ER services	No	Yes
	Patient protection requirements for choice of providers	No	Yes
2012	Uniform 4-page description of coverage	Yes	Yes
Effective Plan Years beginning On or after 01-01-2014	Waiting periods not to exceed 90 days	Yes	Yes
	Annual limits prohibited for essential benefits	Yes	Yes
	Pre-existing condition exclusions for all participants	Yes	Yes
	Clinical trial coverage	No	Yes
	Wellness incentives	No	Yes
	Nondiscrimination rules on providers practicing within the scope of their license	No	Yes

* Must provide for only those dependents who **do not** have their own employer sponsored health care coverage.

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Dependent Coverage Until Age 26

Dependents up to the age of 26 years are eligible for coverage under parent's plan regardless of student or marital status. Coverage must be offered up to age 26 years, the dependent does not have to reside with parents, can be married or unmarried, does not have to have student status and does not have to be a dependent on the parent's tax return.

However, if dependent is eligible for another group employer plan, coverage does not have to be offered for *Grandfathered plans* until 2014. Effective 2014, the exemption is not in effect. Such coverage can not be charged any differently than for similarly situated individuals enrolled under the plan. Notice of Right to Enroll required. (Plan year following September 23, 2010 and January 2104.)

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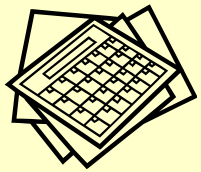
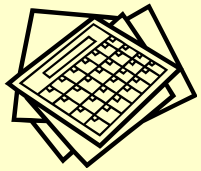


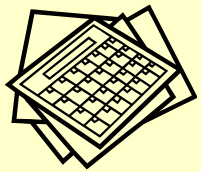
Beginning January 1, 2011:

- W-2 Reporting of the aggregate cost of coverage -- ***Just recently delayed for reporting purposes by the IRS until 2013)***
- No reimbursement of over-the-counter medicine purchases – distributions from Health Saving Accounts, Archer MSA, and Health Flexible Spending Accounts will be excludable for reimbursement unless the medicine is prescribed or is insulin
- Increased taxation penalties on HSA withdrawals for non-medical expenses



Beginning March 23, 2012:

Uniform Explanation of Coverage – Four page uniform summary of benefits for all plans. Must be done within 24 months from enactment.



Beginning January 1, 2013:

Cap on Health Flexible Spending Account Contributions – annual salary reduction contributions will be limited to $2,500 (amount may be adjusted for inflation after 2012)

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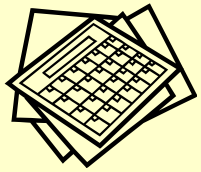
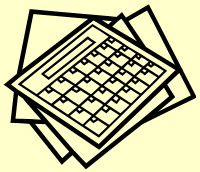


Beginning on or after January 1, 2014:

- 90-day Waiting Periods for coverage to begin
- Pre-existing Conditions Exclusions for all participants
- Annual Coverage Limits Prohibitions
- Certification of Healthcare Coverage
- State-based *Exchanges*
- *Free Rider Penalty*
- *Free Choice Voucher*



Beginning on or after January 1, 2018:

Cadillac Tax – 40% excise tax on employers for the value of health insurance benefit exceeding a certain threshold. Thresholds are $10,200 individual coverage and $27,500 family coverage (indexed to inflation)

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Plans Exempt from Act – the following plans and benefits are exempt from compliance under the Act:

- Dental-only and Vision-only plans
- Most flexible spending plans
- Separate policies for critical illness and injury
- Medigap policies
- Accidental death and dismemberment policies
- Retiree Only Plans

Retiree Only Plans

- ERISA Plans – if the retiree plan is segregated from the active plan and a 5500 form is completed for the plan then they would be exempt from the requirements under The Health Care Reform

- Non-ERISA plans – School plans must adhere to the state continuation requirement of Act 110/43; therefore retiree plans that fall under such would not be exempt

- All other type plans – must review plans to determine if such are exempt

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As of January 2014, employers with 50 or more full time equivalent employees (defined as working 30 or more hours per week) are to provide *minimum essential health benefits* to all full-time employees and dependents.

Essential health benefits (to be further defined by HHS) but will include the following categories:

- Pediatric services,
- Prevention and wellness services and Chronic disease management,
- Mental health/substance abuse disorder benefit and behavioral health,
- Prescription drug,
- Ambulatory services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Rehabilitative and habilitative services and devices and
- Laboratory services.

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However, if employers fails to offer *minimum essential coverage* to all full-time employees and at least one employee receives coverage through a state-based exchange, employers will be assessed a penalty of the lesser of $2,000 per full-time employee (Act does allow the employer to subtract 30 full-time employees from the penalty calculation.) or $3,000 per employee who goes to the State Exchange for coverage.

Example – Best Company has 70 full-time employees as defined under the Act. The company provides benefits to 50 of the employees. There are 15 employees who do not have coverage that go to the **State Exchange** to purchase coverage. The company would realize an annual penalty of $45,000.

Penalty equals the lesser of

70 employees – 30 employees X $2,000 each = $80,000

15 employees X $3,000 each = $45,000

The Act does not require an Employer to cover any employee it does not cover currently nor does it require an Employer to provide a plan to its employees.

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Employers must cover at least 60% of the cost of the *minimum essential coverage* with the total employee cost of the health coverage not to exceed 9.5% of an employee's household income.

If the employee's cost exceeds the 9.5% of the household income, and at least one employee purchases coverage through an exchange, the employer will be assessed a **Free Penalty Rider**, which is an assessment equal to the lesser of $3,000 per employee who obtains coverage through an exchange or $2,000 per full-time employee.

If the employee's cost exceeds 8.0% of the household income but does not exceed 9.5% of the household income and the household income is less than 400% of the Federal Poverty Level, employers must offer a **Free Choice Voucher.** Such voucher would be used to purchase insurance through an exchange. The cost of the voucher is equivalent to the amount that the employer would have paid for the most generous option in the employer's plan. The employer pays the amount directly to the exchange.

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Regulatory Agencies

Since the enactment, guidance through interim regulations have been issued and will continue to be issued by the following agencies:

- Department of Labor
- Internal Revenue Service
- Health and Human Service.

The Reschini Group would like to thank you for you attending this webinar and if you have any questions on Health Care Reform please forward them to HealthCareReform@reschini.com.