



**KISTLER TIFFANY
BENEFITS**

HEALTH CARE REFORM

Patient Protection and Affordable Care Act (PPACA) and
Health Care and Education Reconciliation Act of 2010

On March 23, 2010, President Obama signed historic health care reform legislation into law when he signed the Patient Protection and Affordable Care Act (PPACA). Then on March 20, 2010, the President signed the Health Care and Education Reconciliation Act of 2010. These two laws together will affect health insurance and higher education funding for all Americans, with a particularly strong impact on employers who sponsor group health plans. The requirements of the law will take effect over the next few years as follows:

2010	
High Risk Pool	Any individual who has been uninsured for at least 6 months and has a pre-existing condition will be able to receive coverage through a high risk pool until 2014, when the exchanges will be in place.
Reinsurance for Early Retirees	Health and Human Services (HHS) will establish a reinsurance program for employers who sponsor retiree medical coverage for retirees not eligible for Medicare. The program provides for reimbursement of claims at 80% of eligible expenses incurred between \$15,000 and \$90,000. The reinsurance program has a fixed \$5 billion budget and ends 1/1/14.
Grandfathering of Plans	<p>Individual and group health plans in effect as of 3/23/10 and plans in effect under a collective bargaining agreement that was ratified before 3/23/10.</p> <ul style="list-style-type: none"> • Family members of employees and new employees may enroll in the grandfathered plan in the future as long as the plan allowed family coverage as of 3/23/10. • Grandfathered plans must disclose to participants every time it distributes materials that the plan is grandfathered and is not subject to some requirements of the Affordable Care Act, including contact information for enrollees to have their questions and complaints addressed. <p>Changes that will result in a LOSS of grandfathered status:</p> <ol style="list-style-type: none"> 1. Cannot significantly cut or reduce benefits. 2. Cannot raise the percentage of co-insurance charges required under the plan. 3. Cannot significantly raise co-payment charges- grandfathered health plans may not raise no-payment charges more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. 4. Cannot significantly lower employer contributions- grandfathered plans cannot decrease the percentage of the premium paid by the employer by more than 5 percentage points. 5. Cannot add or tighten an annual limit on what the insurer pays- grandfathered plans cannot tighten any annual dollar limit in place as of 3/23/10, and plans with no annual limit cannot put one in place unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit. This is viewed as more protective of high-cost

	<p>enrollees.</p> <p>6. Cannot change insurance companies- this does not apply when employers that provide their own insurance to their workers switch plan administrators or to collective bargaining agreements.</p> <p>7. A plan will also lose grandfathered status if it forces participants to switch to another grandfathered plan that has less benefits or costs more or if it is bought by or merges with another plan in an effort to avoid complying with the law.</p> <p>Grandfathered plans must still adhere to the following requirements (explained in more detail below):</p> <ol style="list-style-type: none"> 1. Uniform summary of benefits 2. No lifetime caps and restrictions on annual coverage limits 3. Limits on rescissions of coverage 4. Adult child coverage 5. No pre-existing conditions exclusions for children under age 19 6. Maximum waiting period for benefits of 90 days (effective 2014) 7. No pre-existing conditions exclusions for anyone (effective 2014)
Protection for Nursing Mothers	Employers covered by the Fair Labor Standards Act (FLSA) must provide “reasonable” breaks to mothers to express milk for their infants who are up to one year old; a private space other than a restroom must also be provided. This amendment does not apply to employers with fewer than 50 employees if its requirements would “impose an undue hardship by causing the employer significant difficulty or expense.” The time does not have to be paid under FLSA. Many states have similar laws and the requirements of both the federal and state laws must be complied with as applicable to provide the greatest protection to employees.
Retaliation Provisions	Employers may not discriminate or retaliate against any individual who makes a complaint about noncompliance with the Reform laws, receives any subsidy, or participates in the Exchanges.
Medicare Prescription Drug Coverage Gap	The gap in Medicare prescription drug coverage, the “donut hole,” will be phased out by 2020. In 2010, a one-time \$250 rebate will be paid to each enrollee who enters the donut hole. In 2011, a 50% discount on brand name drugs will be provided with funding by pharmaceutical manufacturers. Starting in 2011 the donut hole will be phased down until it reaches a 25% coinsurance in 2020.
Small Employer Tax Credits	Small employers with 10 or fewer Full Time Equivalent (FTE) employees earning less than \$25,000 may be eligible for a tax credit of 35% of health insurance costs. Companies with 11 to 25 FTE workers earning up to \$50,000 may be eligible for partial credits. After exchanges are in place, the credit will increase to 50% for the first two years the company buys insurance through the exchange.
1st Day of Plan Year After September 23, 2010	
Limits on Coverage	Lifetime caps on coverage are prohibited. Annual caps are also prohibited; however, between now and 2014 plans may place limits on nonessential benefits only.

1st Day of Plan Year After September 23, 2010	
No Rescission of Coverage	Plans may not cancel the policies of people who fall ill. Policies can only be cancelled if the participant engaged in fraud or intentional misrepresentation of material fact.
Pre-Existing Conditions	Children under the age of 19 with pre-existing conditions can not be denied coverage.
Adult Child Coverage Requirements	Dependent children must be offered coverage under their parents' plans until they turn 26 whether married or unmarried. Adult child coverage is exempt from federal taxes through the end of the tax year in which the child turns 26.
Preventative Care <i>*not applicable if grandfathered</i>	Coverage for preventative care must be covered without cost sharing, including immunizations, preventative care and screenings for infants and adolescents, and preventative care for women. Prior authorization and referrals for OB/GYN services are prohibited.
Emergency Services <i>*not applicable if grandfathered</i>	Participants may use emergency services without prior authorization and at in-network rates, even if the emergency facility or provider is out-of-network.
Primary Care Providers <i>*not applicable if grandfathered</i>	Plans that require participants to establish a primary care provider must allow any available participating provider to be used as a primary care provider, including pediatricians.
Appeals Process Expanded <i>*not applicable if grandfathered</i>	Plans must establish an effective external appeals process that meets or exceeds state law or the NAIC model. Notice of these processes and the availability of any assistance must be provided to enrollees in a culturally and linguistically appropriate manner, meaning that notices may need to be provided in multiple languages. Enrollees must be allowed to review their files, present evidence and testimony, and receive continued coverage pending the outcome of the appeals process.
Non-Discrimination Rules Expanded <i>*not applicable if grandfathered</i>	Insured and uninsured plans may not discriminate in favor of highly compensated employees (those earning in the top 25% at their employer).
Long-Term Care (CLASS Act)	A new public long-term care program will require all employers to enroll employees unless the employee elects to opt out.
Auto Enrollment	Employers with 200 or more employees must automatically enroll employees in their group health plan and allow employees the opportunity to opt out if they can demonstrate they have other coverage.

2011	
Medical FSA's, HSA'S, and HRA'S	Over-the-counter drugs no longer reimbursable by medical FSA's, HSA'S, or HRA'S unless a health care provider provides a written prescription.
Penalties for Non-Qualified Distributions from HSA's and Archer MSA's	The tax imposed on non-qualified distributions increases from 10% to 20%.

W-2 Reporting	The cost of employer-sponsored coverage must be reported each year on the employee's W-2; excludes FSA's, HRA's, and Archer medical savings accounts.
Uniform Summary of Benefits	HHS will develop standards by March 23, 2011 for providing summaries of benefits and coverage explanations. Uniform summaries of benefits must be provided to plan participants by March 23, 2012. Notice of material modifications to plan benefits thereafter must be provided at least 60 days before they become effective.

2012	
Per-Head Fee	Insured and self-insured plans will be charged a \$2 fee for each covered life under the plan for each plan year ending after September 30, 2012 (\$1 for plan years ending during fiscal year 2013). In 2014, the per-head charge will increase by the percentage increase in health care spending and does not apply to plan years ending after September 30, 2019. The fees collected will fund a "Patient-Centered Outcomes Research Trust Fund."

2013	
Medical FSA's Limits	There will be an annual limit on the maximum election for medical FSA's of \$2500 per year. Cost of living increases may occur annually thereafter.
Employee Notice	By March 1, 2013, employers must provide notice to employees regarding the availability of the insurance exchange, the availability of premium credits and cost-share reductions if the plan's share of the costs of benefits is less than 60%, and that if the employee purchases coverage through an exchange and the employer is providing minimum essential coverage the employee will lose the benefit of the employer subsidy under the plan. New employees must receive this notice at their time of hire beginning March 1, 2013.
Taxation of Retiree Drug Subsidies (Medicare Part D)	Employers will be taxed on subsidies they receive for maintaining retiree drug coverage for Medicare-eligible employees. Employers will be required to report any subsidies they receive for providing creditable prescription drug plans for their retirees as gross income.
Taxes for High-Income Families	Families with annual gross income higher than \$250,000 will have additional 3.8% tax on all investment income and contribute higher amounts to Medicare through payroll taxes.

2014	
Guaranteed Coverage	Coverage must be available to everyone with no pre-existing conditions exclusions or rescissions of coverage.

2014	
<p>Essential Benefits</p> <p><i>*not applicable if grandfathered</i></p>	<p>HHS will establish essential benefits and types of coverage required of all plans. Essential benefits must include at least: 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, preventative and wellness services and chronic disease management, and pediatric services including oral and vision care. Plans must also provide coverage for clinical trial participation.</p>
<p>Medicaid Expansion</p>	<p>Medicaid will be expanded to cover more low-income individuals with incomes up to 133% of the federal poverty level.</p>
<p>Exchanges and Subsidies</p>	<ul style="list-style-type: none"> • States will be required to have Health Care Exchanges where individuals and small businesses will be able to pool together to buy insurance. • Small employers (100 employees or less) will have the ability to purchase insurance at lower rates through these exchanges. • Large employers (more than 100 employees) will be able to participate in Exchanges in 2017 if states choose to allow. • Premiums capped at a percentage of income from 3% to 9.5%. • Each state must offer at least two multistate plans.
<p>Individual Coverage Requirements and Penalties</p>	<ul style="list-style-type: none"> • Individuals are required to purchase insurance by 2014 or pay a penalty, which is the greater of \$95 or 1% of gross annual income for the first year and subsequently increases to \$695 or 2.5% of income. • Waivers will be available for those who cannot find a policy that costs less than 8% of their income, for families who fall below the income-tax filing thresholds, members of Indian tribes, religious objectors, individuals not lawfully present in the U.S. and incarcerated individuals. • Individuals who cannot find a plan that costs less than 8% of their income, regardless of age, will also be eligible to purchase catastrophic policy that otherwise would be limited to individuals under age 30. • Individuals would be able to receive a sliding scale of tax credits if they have income between 100% and 400% of the federal poverty level. If employer coverage is available that meets the minimum standards, the employee is not eligible for this tax credit/subsidy unless their income is less than 400% of the federal poverty level, the employer plan is unaffordable (costs more than 9% of their income), or does not cover at least 60% of their benefits. This is in addition to the “free choice vouchers.”

2014	
Employer-Sponsored Coverage	<p><u>ALL EMPLOYERS</u>- Group health plans will be prohibited from setting rates or denying coverage based on pre-existing conditions, from placing excessive waiting periods on eligibility for benefits for new hires (90-day maximum), and from placing annual and lifetime dollar limits on benefits. Insurers will only be able to vary premiums based on geographic location, age, and tobacco use.</p> <ul style="list-style-type: none"> • Group health plans will be required to cover specific services and at least 60% of employee health costs overall.. • Employees who pay more than 9.5% of their income on premiums or whose group health plan covers less than 60% of the cost of their benefits will be eligible to purchase coverage through the state-run exchange. • Employers that offer coverage must also provide a “free choice voucher” to any employees with incomes between 133% and 400% of the federal poverty level (currently about \$29,327 to \$88,000 for a family of four) if that employee’s share of the premium is between 8% and 9.8% of his or her income and the employee enrolls in an exchange. The amount of the voucher is the amount the employer would have paid for the employee under the employer’s group health plan. Employers providing free choice vouchers are exempt from the penalties for employees receiving premium credits for coverage purchased through the exchange. Free choice vouchers are not taxable income. <p><u>SMALL AND MID-SIZE EMPLOYERS</u>- A grant program will be established to encourage small and mid-sized employers to develop workplace wellness programs. Specific requirements for wellness programs will be established similar to the current requirements under HIPAA. Definitions for what employers are considered small and mid-sized will be established for this.</p> <p><u>EMPLOYERS WITH 50+ EMPLOYEES</u>- “Play or Pay” = Beginning in 2014, tax penalties will be assessed for companies with 50+ FTE employees that do not provide health insurance up to \$2,000 per employee, with the first 30 employees being exempt.</p> <ul style="list-style-type: none"> • Any employer 50+ employees that does not offer coverage but has at least 1 full time employee receiving the premium assistance to purchase coverage through the exchange will be required to pay the lesser of \$3,000 for each employee receiving that credit or \$750 for each of their full time employees.

2018	
Tax on Cadillac Health Plans	Employers will be taxed on high-end “Cadillac” health plans (those with total premiums of \$10,200 or more for singles and \$27,500 for families) each year. The excess premium will be subject to a 40% tax. HSA’s, HRA’s and FSA’s are included for purposes of calculating this tax. Free-standing dental and vision benefits are not taxable benefits for purposes of determining this tax.

Additional Fundraising Measures

- Eliminates the Medicare Part D tax deduction.
- Creates a 10% tax on indoor tanning.
- \$2 billion fee annually on pharmaceutical and medical device manufacturers.
- \$6 billion fee annually on health insurance companies with \$50 million in profits, prorated based on profits.

Student Loan Administration

The Health Care and Education Reconciliation Act of 2010 also includes changes to the college student loan system by cutting commercial banks out of the process. Additional funds will be funneled into the Pell Grant program, student loan repayments will be capped at 10% of discretionary income, and loan balances will be forgiven after 20 years of timely payments.

In response to the Patient Protection and Affordable Care Act and the Health Care and Education Tax Credit Reconciliation Act, collectively known as Health Care Reform, Kistler Tiffany Benefits has formed a Health Care Reform committee to monitor legislation and provide guidance to our valued clients. Our team is creating user-friendly tools and resources, as well as establishing best practices for our clients in regards to the application of this legislation. For more information regarding our services, access the KTB Health Care Reform Center at www.ktbenefits.com.