

Preparing for Health Care Reform in 2011 Under Recent Guidance



Tuesday, September 14, 2010

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Agenda



- Anti-Discrimination
- Coverage of Dependents
- Grandfathered Plans
- Cafeteria Plans
- Procedural Provisions
- Insurance Market Reforms

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Anti-Discrimination



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Whistleblower Protection



- Employee “reasonably believes” conduct is a violation of PPACA
- Conduct likely to dissuade a reasonable worker from whistleblowing
- Must file a complaint with OSHA (180 days)
- After OSHA, employee may sue
- Rights may not be waived by agreement

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Nursing Mothers



- Must provide for nursing mothers:
 - A break to express milk
 - Location that is shielded from view
 - 1 year after birth
- Breaks do not have to be paid
- Exception for “undue hardship”
 - Only if less than 50 employees

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Nursing Mothers



- Presumed to be effective March 23
- Does not trump state laws
- Questions
 - No penalty provision
 - No exception for collective bargaining agreements
 - Maintenance of location when no employees are nursing

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Coverage of Dependents



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Health Plan Tax Exclusions



- IRS Notice 2010-38
- Effective Immediately
- Internal Revenue Code §105(b) amended
 - Individuals >27 before end of 2010 considered children
 - “Child” includes natural, adopted, step & foster
- Children do not need to be “dependents” for tax purposes to qualify under tax exclusion
- Makes insurance coverage of “adult” children tax exempt

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Health Plan Tax Exclusions



- How does the plan define child / dependent?
 - Reference to § 105(b)
 - No amendment needed
 - Reference to § 152
 - Amendment required
- Any amendment may be made retroactive to March 30, 2010

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Coverage of Children



- Distinct from individual mandate
- Plans that cover dependent children must cover them through age 26
- No grandfathering—all plans must comply
 - Grandfathered plans may exclude children under age 26 if eligible for their own employer-sponsored coverage.
 - Exception ends January 1, 2014

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Coverage of Children



- Generally effective first plan year beginning after September 23, 2010
- Employers may elect to extend coverage before the deadline
 - Many insurers (incl. BCBSDE), agreed to limited effective date of June 1, 2010
 - Children who would lose coverage due to age after May 30, 2010

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Coverage of Children



- Permitted Exclusions
 - Plans may redefine “child” to exclude step-children
 - Children of children are not covered
 - Limited scope plans provided under a separate insurance policy
 - Participants must elect coverage and
 - Pay additional premium for coverage

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Coverage of Children



- Plans May Not:
 - Charge more for coverage of adult dependent children than for similarly situated dependents
 - Offer different benefit packages
 - Exclude children on the basis of:
 - Student status
 - Financial dependency
 - Residency
 - Marital Status

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Coverage of Children



- Enrolling:
 - Plans must offer a 30-day special enrollment opportunity and provide written notice regarding enrollment rights
 - Children covered under COBRA must be given the opportunity to enroll in a non-COBRA plan
 - Even children never enrolled in plan must have the opportunity to enroll

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Small Employer Tax Credit



- Requirements
 - 25 FTEs
 - Average compensation under \$50,000
 - Pay 50% of premium
- Phase-out begins at 10 employees or average compensation of \$25,000

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Small Employer Tax Credit



- **IRS Notice 2010-44**
- Effective for the 2010 to 2013 tax years
- Employers can claim the credit for up to 6 years
- Eligible employers have:
 - Less than 25 full-time equivalent employees “FTEs”
 - With annual average wages less than \$50,000
 - The employer must pay at least 50% of premium for employee health care

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Small Employer Tax Credit



- Employees taken into account for the purpose of calculating FTEs—
 - All employees who perform services
 - Not:
 - Sole proprietors
 - Partners
 - S-Corp shareholders owning > 2% of stock
 - Owners of > 5% of other businesses
 - Family members

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Small Employer Tax Credit



- Employees taken into account (con't):
 - Not:
 - Dependents under Revenue Code § 152
 - Seasonal workers who work more than 120 days during year
 - Employees of control group, affiliated service group, etc.

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Small Employer Tax Credit



- Hours of Service –
 - Each hour paid for work
 - Each hour paid for no work
 - vacation, holiday, illness, incapacity, layoff, jury duty, military duty or leave of absence
 - no more than 160 hours required to be counted for an employee on account of any single continuous period of absence

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Small Employer Tax Credit



- Hours of Service Calculated in 3 Ways
 - actual hours of work
 - days-worked equivalency –
 - 8 hours of service for each day
 - weeks-worked equivalency
 - 40 hours of service for each week

Method used is the employer's choice

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Small Employer Tax Credit



- Determining FTEs
the total hours of service, (but not more than 2,080 hours for any employee)
2,080
- Round down to whole number

Small Employer Tax Credit



- Example Calculating FTEs:
Employer pays
 - 5 employees wages for 2,080 hours each
 - 3 employees wages for 1,040 hours each
 - 1 employee wages for 2,300 hours.
- a. 10,400 hours of service for the 5 employees (5 x 2,080)
- b. 3,120 hours of service for the 3 employees (3 x 1,040)
- c. 2,080 hours of service for the 1 employee (lesser of 2,300 and 2,080).
- d. The sum of a, b and c equals 15,600 hours of service.
FTEs equal 7 (15,600/2,080 = 7.5, rounded down).

Small Employer Tax Credit



- Average Annual Wages =
total wages paid by the employer during the employer's
taxable year to employees taken into account
FTEs

Small Employer Tax Credit



- Premium Payments
 - Premiums paid through salary reduction in cafeteria plan are NOT paid by employer
 - For 2010, all premiums paid by employer – even before March 23, 2010 – are included.
 - If employer seeks reimbursement for multiple plans, he must meet the requirement for each plan individually.

Small Employer Tax Credit



- Premiums Subject to Reimbursement:
 - Medical care under a contract offered by an insurer;
 - Limited scope dental or vision coverage;
 - Long-term care, nursing home care, or home health care;
 - Coverage for a specified disease or illness;
 - Other similar supplemental coverage.

Small Employer Tax Credit



- Maximum credit is 35% of employer expense
 - The credit is capped at 35% of the average premium for the small group market in the relevant State, i.e. no Cadillac plans allowed.
- Phases out beginning at 10 employees with average annual wages of \$25,000

Small Employer Tax Credit



- The Phase-Out
 - For employers with more than 10 FTEs:
 - Multiply credit amount by a fraction equal to $\text{FTEs} > 10 / 15$
 - For example, if you have 12 FTEs: $2/15$
 - For employers with average annual wages exceeding \$25,000:
 - Multiply credit amount by fraction equal to $\text{wages} > \$25,000 / \$25,000$
 - For example, if average annual wages are \$30,000: $\$10,000/\$25,000$

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Small Employer Tax Credit



- A qualifying employer's federal tax credit is NOT reduced by any state tax credit or premium subsidy.
- Any premium subsidy or state tax credit is included as part of the employer's premium contribution.
- But, the employer cannot receive a tax credit that exceeds his net premium payment.

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Small Employer Tax Credit



- Example: R is an employer in a state with a 50% premium subsidy. E is R's employee enrolled in employer-provided insurance program with a monthly premium of \$100.
- Premium split: \$50 by state, \$20 by R, \$30 by E.
- R's premium contribution is 70%, so he qualifies for the tax credit of 35% x \$70 (\$24.50). But, R may not recover more than his net premium payment, so his credit is limited to \$20.

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Small Employer Tax Credit Transition Relief for 2010



- Designed to allow employers to satisfy the uniformity requirement in 2010.
- In 2010, an employer that pays 50% of the cost of single (employee only) coverage for each employee will satisfy the requirement, even if he does not pay the same percentage for employees with family (or other) coverage.

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Small Employer Tax Credit: 2014 and Beyond



- Effective beginning 2014 tax year
- Same eligibility requirements and phase out
- Maximum credit increases to 50%
- Credit limited to Healthcare Exchange
- No IRS guidance yet

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Form 8941 Credit for Small Employer Health Insurance Premiums		OMB No. 1545-0046
Department of the Treasury Internal Revenue Service		2010
Name(s) shown on return		Attachment Separator No. 63
Identifying number		
1	Enter the number of individuals you employed during the tax year who are considered employees for purposes of this credit (see instructions)	
2	Enter the number of full-time equivalent employees you had for the tax year (see instructions). If you entered 25 or more, skip lines 3 through 11 and enter -0- on line 12	
3	Average annual wages you paid for the tax year (see instructions). If you entered \$50,000 or more, skip lines 4 through 11 and enter -0- on line 12	
4	Premiums you paid during the tax year for employees included on line 1 for health insurance coverage under a qualifying arrangement (see instructions)	
5	Premiums you would have entered on line 4 if the total premium for each employee equaled the average premium for the small group market in which you offered health insurance coverage (see instructions)	
6	Enter the smaller of line 4 or line 5	
7	Multiply line 6 by the applicable percentage: • Tax-exempt small employers, multiply line 6 by 25% (25) • All other small employers, multiply line 6 by 50% (50)	
8	If line 2 is 10 or less, enter the amount from line 7. Otherwise, see instructions	
9	If line 3 is \$25,000 or less, enter the amount from line 8. Otherwise, see instructions	
10	Enter the total amount of any state premium subsidies paid and any state tax credits available to you for premiums included on line 4 (see instructions)	
11	Subtract line 10 from line 9. If zero or less, enter -0-	
12	Enter the smaller of line 9 or line 11	
13	If line 12 is zero, skip lines 13 and 14 and go to line 15. Otherwise, enter the number of employees included on line 1 for whom you paid premiums during the tax year for health insurance coverage under a qualifying arrangement (see instructions)	
14	Enter the number of full-time equivalent employees you would have entered on line 2 if you only included employees included on line 13	
15	Credit for small employer health insurance premiums from partnerships, S corporations, cooperatives, estates, and trusts (see instructions)	
16	Add lines 12 and 15. Partnerships and S corporations, stop here and report this amount on Schedule K; all others, go to line 17	
17	Credit for small employer health insurance premiums included on line 16 from passive activities (see instructions)	
18	Subtract line 17 from line 16	
19	Credit for small employer health insurance premiums allowed for 2010 from a passive activity (see instructions)	
20	Carryback of the credit for small employer health insurance premiums from 2011	
21	Add lines 18 through 20. Cooperatives, estates, and trusts, go to line 22. Tax-exempt small employers, skip lines 22 and 23 and go to line 24. All others, stop here and report this amount on Form 3800, line 29h	
22	Amount allocated to patrons of the cooperative or beneficiaries of the estate or trust (see instructions)	
23	Cooperatives, estates, and trusts, subtract line 22 from line 21. Stop here and report this amount on Form 3800, line 29h	
24	Enter the amount you paid in 2010 for taxes considered payroll taxes for purposes of this credit (see instructions)	
25	Tax-exempt small employers, enter the smaller of line 21 or line 24 here and on Form 990-T, line 44.	

For Paperwork Reduction Act Notice, see separate instructions. Cat. No. 9757S Form **8941** (2013)

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Grandfathered Plans



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Grandfathered Plans



- Insured or self-insured group health plan offered that was in existence on March 23, 2010
- New family members
- New participants
- Added to assure individuals that they can keep the coverage they had on date of enactment

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Grandfathered Plans



- Loss of Grandfathered Plan Status.
 - A group health plan will lose grandfathered status if any of the following events occur:

Grandfathered Plans



- ***Elimination of Benefits.*** All, or substantially all, benefits to diagnose or treat a particular condition are eliminated.
- ***Increase in Percentage Cost-Sharing Requirements.*** Percentage cost-sharing requirements (e.g., coinsurance) are increased to any extent after March 23, 2010.

Grandfathered Plans



- ***Increase in Copayment Fixed Amount Cost-Sharing Requirements.*** Fixed-amount copayments are increased more than the greater of medical inflation (from March 23, 2010) plus 15 percentage points, or \$5 (as increased by medical inflation).

Grandfathered Plans



- ***Increase in Non-Copayment Fixed Amount Cost-Sharing Requirements.*** Fixed-amount cost sharing requirements other than copayments (e.g., deductibles) are increased more than medical inflation (from March 23, 2010) plus 15 percentage points.

Grandfathered Plans



- **Decrease in Employer Contribution Rates.** Employer contributions toward the cost of any tier of coverage for any class of similarly situated individuals are decreased by more than 5 percentage points below the contribution rate (the percentage of employer contributions towards the total cost of coverage) for the coverage period that includes March 23, 2010.

Grandfathered Plans



- **Changes in Annual Limits.** Annual limits are changed, as follows:
 - No overall annual or lifetime limit as of 3/23/10-- limits cannot be added.
 - Lifetime dollar limit as of 3/23/10, but no annual dollar limit --cannot adopt an annual dollar limit lower than the lifetime limit on 3/23/10
 - Overall annual dollar limit as of 3/23/10 --cannot decrease the annual limit

Grandfathered Plans



- **Issuance of New Insurance Policy.** A new insurance policy is issued after 3/23/10.
- **Transfers of Employees.** Employees are transferred into plan from another plan in which they were covered on 3/23/10, where
 - (i) the plan from which they transferred would lose grandfathered plan status if it were amended to be the same as the plan into which they transferred, and
 - (ii) there is no bona fide employment-based reason to transfer the employees.

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Grandfathered Plans



- **Mergers, Acquisitions, and Other Business Restructurings.** There is a merger, acquisition, or similar business restructuring the principal purpose of which is to cover new individuals under a grandfathered health plan.

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Grandfathered Plans



- **Other Changes – No Loss of Status**
 - Premiums
 - Comply with Federal or State legal requirements
 - Voluntarily comply with the Health Care Reform
 - Third party administrators
 - Changes to Structure?

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Grandfathered Plans



- **Collectively Bargained Plans**
 - Must be insured
 - Grandfathered until expiration of CBA
 - Changes before expiration of CBA
 - Open contract to make Health Care Reform Changes
 - Can continue grandfathered status after CBA

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Grandfathered Plans



- **Disclosure Requirements**
 - Materials provided to participants and beneficiaries must state that plan believes it is grandfathered
 - Model Language available

Grandfathered Plans



- **Maintenance of Records**
 - Maintain records to document terms as of 3/23/10

Grandfathered Plans



- **Transition Relief**
 - Changes after 3/23/10 – action before enactment
 - Good Faith changes before Regulations issued
 - Revoke Noncompliant changes before 1st day of plan following 9/23/10

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Grandfathered Plans



- **Exempted from:**
 - Preventative care benefits, w/o cost sharing
 - Compliance with the non-discrimination requirements of Section 105(h) (insured plans)
 - External review in benefit claims and appeals process
 - Emergency and OB/GYN services be provided without the need for prior authorization or a referral

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Grandfathered Plans



- **Exempted from (con't):**
 - Auto- enrollment for eligible employees
 - Submit to HHS and plan participants whether the benefits under the plan
 - Improve health outcomes,
 - Implement activities to prevent hospital readmission,
 - Implement activities to improve patient safety and reduce medical errors, and
 - Implement wellness and health promotion activities

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Grandfathered Plans



- **Exempted from (con't):**
 - Self-insured plans not required to comply with “cost sharing” restrictions
 - Insured plans not required to disclose claim payment policies and practices, financial information, enrollment and denials, claim denials and rating practices

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Grandfathered Plans



- **Grandfathered plans will be subject to:**
 - Restriction on imposing waiting period for coverage to not more than 90 days (effective 1/1/2014)
 - Restrictions on imposing annual and lifetime limits on essential health benefits (effective for first plan year after 9/23/2010)
 - Limitation on circumstances under which employer sponsored group health plan can terminate or cancel coverage (effective for first plan year after 9/23/2010)

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Grandfathered Plans



- **Grandfathered plans will be subject to (con't):**
 - For plan years beginning after 9/23/2010, plan must allow continued coverage of adult children up to age 26 unless they are eligible for coverage under another employer sponsored plan
 - Beginning in 2014, plan must allow continued coverage of adult children up to age 26 regardless of whether or not they are eligible for other non-parent employer sponsored coverage.

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Grandfathered Plans



- **Grandfathered plans will be subject to (con't):**
 - Effective for the first plan year beginning after 9/23/2010, employer sponsored plans are prohibited from excluding anyone under age 19 due to pre-existing condition.
 - Effective after 1/1/2014, prohibition extends to all other individuals, regardless of age

Grandfathered Plans



- **Procedural Requirements Under the Act**
 - Give at least 60 days advance notice of benefit changes
 - Report cost of coverage on Form W-2
 - Notify employees about health care exchanges and if employer pays less than 60% of cost of benefits, a summary of the benefits available to employee if purchasing benefits through the exchange

Cafeteria Plans



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Cafeteria Plans/FSAs



- Meds Reimbursed only if Prescribed
 - The medicine or drug requires a prescription
 - is available without a prescription (an over-the-counter medicine or drug) and the individual obtains a prescription, or
 - Is insulin

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Cafeteria Plans/FSAs



- Prescription
 - a written or electronic order
 - a medicine or drug
 - meets the legal requirements of a prescription
 - issued by an individual who is legally authorized to issue a prescription
 - State law applies

Cafeteria Plans/FSAs



- 2010 run-out payments - ok
- Grace Period payments - no
- Also applies to HRAs and FSAs

Cafeteria Plans/FSAs



- “Benny Cards” affected
 - Enforcement after January 15, 2011
- OTC Meds must be substantiated
 - a customer receipt issued by a pharmacy
 - date and amount of the purchase
 - Rx number satisfies the substantiation requirements for over-the-counter medicines or drugs,
 - receipt without an Rx number and a copy of the related prescription

Cafeteria Plans/FSAs



IRS Q & A on OTC Drug Reimbursement at

<http://www.irs.gov/newsroom/article/0,,id=227308,00.html>

Cafeteria Plans/FSAs



- FSA contributions limited to \$2,500
 - Effective 1/1/2013
 - Adjusted for CPI beginning in 2014
- Limited to employee deferrals
- Does not apply to HRA or dependent care FSA (current limit is \$5,000)

Simple Cafeteria Plans



- “Small employers”
 - 100 or fewer employees
 - During either of the two preceding years
 - Until have 200 employees
- Employer contributions
 - Uniform % of comp (not less than 2%); or

Simple Cafeteria Plans



- Employer Contributions (con't.)
 - Not less than lesser of
 - 6% of comp; or
 - 2 times the salary reduction of each employee
 - Rate of contribution for HCE or Key employee cannot exceed that of any other employee

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Simple Cafeteria Plans



- Employees
 - 1,000 hours in prior plan year
 - Can exclude
 - Not 21 by plan year end
 - Less than 1 year of service anytime during plan year
 - Collectively bargained employees
 - Non-resident aliens working outside of US /non-US income
 - Successor Employers

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Simple Cafeteria Plans



- Exempt from certain nondiscrimination requirements:
 - 79
 - 105(h)
 - 125
 - 129
 - 13

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Procedural Provisions



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Uniform Health Plan Summary



- Implement within 24 months of enactment
- 60-days advance notice of any *material modifications*
- \$1,000 fine per participant
 - willful failure to notice of *material modification*

Uniform Health Plan Summary



- Not greater than 4 pages – 12pt font
- Issue annually
- In addition to usual Summary Plan Description

Uniform Health Plan Summary



- Presented in culturally and linguistically appropriate manner
- Fewer than 100 participants
 - If 25 percent of all plan participants are literate only in the same non-English language
- 100 or more participants
 - If lesser of 500 participants, or 10 percent of all plan participants, being literate only in the same non-English language

Appeals Process



- Denial includes rescission of coverage
- Urgent Care Claims – 24 hours vs 72
- Full and Fair Review
 - provide new or additional evidence relied upon or generated

Appeals Process



- Eliminate Conflicts of Interest
 - Independent and impartial reviewers
 - No employment decisions based on likelihood to deny appeals
- Deemed exhaustion of internal appeals process
- Continued coverage during process

Appeals Process



- Culturally and Linguistically” appropriate manner
 - Fewer than 100 participants
 - If 25 percent of all plan participants are literate only in the same non-English language
 - 100 or more participants
 - If lesser of 500 participants, or 10 percent of all plan participants, being literate only in the same non-English language

Appeals Process



- Model Notice of Adverse Benefit Determinations
- Model Notice of Final External Review Decision
- Model Notice of Final Internal Adverse Benefit Determination

Appeals Process



- External Review Process – Insured Plans
 - Comply with state external review requirements
 - DE, PA, MD all have state procedures
 - If no state process Federal Standards apply
- Self-Insured Plans – not subj. to State law
 - Voluntary compliance with State law
 - Federal Rules in Tech Guidance 2010-01

Appeals Process



- Federal Rules for External Review
 - Request within 4 months
 - Complete prelim review in 5 business days
 - Written notice within 1 day of decision
 - Refer to Independent Review Organization (IRO)
 - Contract with 3 and rotate
 - Decision within 45 days of request
 - If reversal, plan must pay immediately

Appeals Process



- Federal Rules for External Review
 - Expedited review
 - Jeopardize life, health or max function, or
 - Also involves
 - admission, availability of care, continued stay
 - 72 hours

Rescission



- Rescission is prohibited except in case of fraud or intentional misrepresentation of material fact
 - cancellation or discontinuance of coverage that has retroactive effect
- Not Rescission if:
 - prospective effect
 - Attributable to non-payment of premiums
- Coverage may not be terminated without 30 day prior notice

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Non-Discrimination in Favor of Highly Compensated



- Section 105(h)
- Currently applies only to self-insured plans
- No discrimination in favor of HCIs –
 - Eligibility to participate
 - Benefits provided
- Eligibility to participate
 - 70% of all
 - 70% of all are eligible and 80% participate
 - Fair cross section

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Non-Discrimination in Favor of Highly Compensated



- Exclude
 - Less than 3 years
 - Under 25
 - Union employees
 - Non-resident aliens
- Benefits provided to HCs must be provided to all

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Non-Discrimination in Favor of Highly Compensated



- Highly Compensated Individuals –
 - 5 highest paid officers
 - Greater than 10% shareholder
 - Highest paid 25 employees
- Self Insured Plan
 - Discriminatory benefits included in income of HCI
- Insured Plan after PPACA
 - Excise tax

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Reinsurance of Certain Early Retirees



- Early Retiree Reinsurance Program
 - Reimburse employers for a portion of their early retiree health program costs
- \$5 billion limit

Reinsurance of Certain Early Retirees



- Employment-Based Health Plan –
 - Group health plans that provide health benefits to early retirees (other than federal governmental plans)
- Programs or Procedures that Promote Cost Savings -- generate cost savings for chronic and high-cost conditions

Reinsurance of Certain Early Retirees



- “Chronic and high-cost conditions”
 - Conditions for which \$15,000 or more in claims are likely to be incurred during one plan participant.
- Such programs and procedures do not have to be newly created and need not address every chronic and high-cost condition.

Reinsurance of Certain Early Retirees



- Written Information Sharing Agreement between Sponsor and Plan
- Policies and Procedures to Detect Fraud
 - Details with respect to these policies and procedures must be provided to HHS upon request

Reinsurance of Certain Early Retirees



- Applications will be processed in the order received.
- Incomplete applications will be denied, and a new application (with a new application date) must be filed

Reinsurance of Certain Early Retirees



- One application is to be filed for each plan
 - Benefit options under a plan are not separate plans

Reinsurance of Certain Early Retirees



- Application must summarize how reimbursements will be used
 - Reduction of participant or sponsor costs, or any combination
 - Plans to implement programs and procedures to generate savings for plan participants with chronic and high-cost conditions.

Reinsurance of Certain Early Retirees



- Reimbursed funds may not be used as general revenue for the plan sponsor
- Application must show how the reimbursement amounts will be used to maintain the same level of contribution to the applicable plan.
- HHS to monitor the appropriate use of the reimbursements
- Reimbursement may be used for all participants, not just early retirees and their dependents.

Reinsurance of Certain Early Retirees



- **Retirees** who are age 55 or older, their spouses and dependents (regardless of age); and
- Not eligible for Medicare
- Self-funded and insured plans
 - Plans sponsored by private entities,
 - State and local governments, and
 - Nonprofit organizations, religious entities, unions

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Reinsurance of Certain Early Retirees



- Includes expenses for benefits paid for items or services
 - Including medical benefits,
 - Surgical benefits,
 - Hospital benefits,
 - Prescription drug benefits, and
 - Other benefits for the diagnosis, treatment, cure, mitigation, or prevention of physical or mental disease or condition with respect to any structure or function of the body

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Reinsurance of Certain Early Retirees



- Reimbursement for 80% of costs (less negotiated price concessions) for health benefits between
 - \$15,000 “cost threshold” and
 - \$90,000 “cost limit”for a retiree (and spouse and dependents)

Reinsurance of Certain Early Retirees



- Cumulative health benefits incurred in a given plan year and paid for a given early retiree
- Includes retiree cost-sharing (deductible, copayments, or coinsurance)

Reinsurance of Certain Early Retirees



- Not taxable income to the employer
- Reduce premium costs for the employer or multiemployer plan

Reinsurance of Certain Early Retirees



- Reduce retiree premium contributions, co-pays, deductibles, etc.
(Note: The White House has issued a Fact Sheet which states that plans must use these proceeds to lower health costs for enrollees, e.g., premium contributions, co payments, deductibles, etc.)

Miscellaneous 2011 Provisions



- Excise tax for Non-Medical distributions from HSAs increased from 10% to 20%
- W-2 Reporting required regarding value of coverage offered in 2011 and later
 - to show employees the value of their health care benefits so they can be more informed consumers
- New sector tax on health insurers (but not self-insured plans or TPAs) beginning in 2011

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Miscellaneous 2011 Provisions



- Quality of Care Reporting
- Constraints on Loss Ratios
- Unreasonable premium increases
- Adoption Assistance increased to \$13,170

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Insurance Market Reforms




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Essential Health Benefits

HHS to define *essential health benefits*



- ambulatory patient services
- hospitalization
- mental health and substance use disorder services
- prescription drugs
- laboratory services
- preventive and wellness services and chronic disease management
- maternity and newborn care
- emergency services
- behavioral health treatment
- rehabilitative and habilitative services and devices
- pediatric services, including oral and vision care

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No Limits on Benefits



- No lifetime or annual limits on value of essential benefits
- *Restrictive* annual limits on essential benefits until 2014
 - What is *restrictive*? HHS to rule
- Can limit non-essential benefits
 - Annual limits
 - Day or visit limits

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Emergency Services



- Emergency room services must be covered
 - Without prior authorization
 - Whether or not provider in network
 - Copays/coinsurance must be same for out of network as in-network

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Emergency Services



- Emergency Medical Condition
 - Placing the health of the individual in serious jeopardy
 - Serious impairment to bodily functions
 - Serious dysfunction of any bodily organ or part
- Appears to apply to grandfathered and non-grandfathered plans after September 23, 2010

Wellness Grants



- Grant program for small employers
 - Fewer than 100 employees
 - Work 25 or more hours per week
- No workplace wellness program as of March 23, 2010
- Funded with \$200 million

High Risk Pools



- Temporary Insurance Program
- Uninsured for 6 months with pre-ex condition
- Funding capped at \$5 Billion
- Expires on January 1, 2014

High Risk Pools



- Protection against “dumping”
- If encouraged by insurer or employer to dis-enroll, HHS will impose sanctions
 - Reimburse high risk pool for such employee’s claims
- Did employer or insurer
 - Provide financial incentive to dis-enroll

Preventative Services



- Full coverage (no co-pays, etc.) for certain preventive care – includes
 - Evidence based services recommended by U.S. Preventative Task Force
 - Well infant, child and adolescent care/screenings supported by the Health Resources and Services Administration
 - Immunizations recommended by CDC

Preventative Services



- Preventative Services for Women
 - As recommended by Health Resources and Services Administration
 - For breast cancer screenings, mammography and prevention – US Preventative Services Task Force – other than 2009

Preventative Services



- Preventative Services
 - immunizations
 - blood pressure, diabetes and cholesterol screening
 - cancer screening
 - adolescent depression screening
 - lead and autism testing
 - counseling, screening and vaccines for healthy pregnancies
 - counseling related to tobacco cessation, losing weight, eating better, treating depression, and reducing alcohol use

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Questions?



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