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A majority of states intend to control their own destiny if possible

Feature Story

Understanding the New Healthcare Reform Law

While it has been difficult for all of us to sort through the new healthcare reform law and coverage of the law by the media, we are using this edition of our newsletter to provide you with an overview of significant tax provisions and requirements that will impact health plans and covered members in the near future. We hope you will find this newsletter helpful and that you will feel free to contact us for more information on these or other important aspects of the new PPACA law.

The Value of Grandfathered Status

A Grandfathered Plan is a Self-Funded or insured group health plan in which individuals were enrolled on March 23, 2010, the date of enactment. Even though Grandfathered Plans must have been in force on the date of enactment, they are allowed to continue enrolling family members of existing plan participants and new employees. Grandfathered Plans must comply with the following limited PPACA requirements:

- Dependent coverage must be extended to age 26 if no other employer-based coverage is available to the dependent.
- Lifetime limits can no longer be imposed on the dollar value of health benefits for "essential" services.
- Health plans cannot discriminate against individuals under age 19

based on pre-existing medical conditions. This provision extends to all enrollees after 2014.

While these and other PPACA provisions apply to grandfathered plans, others do not. Going forward, employers will need to weigh the cost of not making recommended plan design changes against the cost of complying with added PPACA requirements if grandfathered status is lost. Contact us for help in this important area.

Big Changes for Consumer Directed Plans

With the exception of insulin to treat diabetes, the cost of over-the-counter (OTC) medicines not prescribed by a provider, currently reimbursable by a FSA, HRA, HSA or Archer MSA, will no longer be reimbursable for tax years beginning after December 31, 2010.

In addition, employee contributions to flexible spending accounts (FSAs), currently not subject to limits, will be capped at \$2,500 per year for tax years beginning after December 31, 2012. In future years, the ceiling for allowable contributions will be adjusted annually for inflation.

Penalties on nonqualified distributions from HSAs and Archer MSAs, which are now assessed at 10% of the nonqualified disbursement amount, will increase to 20% for distributions made after December 31, 2010.



Note: While the regulatory process has been completed, the details of PPACA will evolve through a generally slow and tedious Rule Making process. The information we have provided is based upon the guidance that we have received as of 7-15-10 and will be updated in future newsletters. This newsletter is not intended as a substitute for personal medical, employee benefits or legal advice.

PPACA Compliance Calendar

While healthcare reform is likely the most talked and written about legislation ever to become law, we hope you will find this calendar of significant tax provisions and requirements helpful.

Upon enactment at 3/23/10

Subsidies for small businesses – Small businesses with fewer than 25 employees and less than \$50,000 in average full-time equivalent (FTE) employee wages are eligible for tax credits against their contributions to employee healthcare coverage.

3 months after enactment (6/23/10)

High-risk insurance pools – A temporary High-Risk Health Insurance Pool is established by the Federal Government to provide insurance coverage for eligible individuals until 1/1/14. Eligible adults must have a pre-existing health condition and have been uninsured for at least the past 6 months. There is no age requirement and the new program caps an individual's out-of-pocket costs at \$5,950 per year.

Early retiree insurance – \$5 billion is directed to a temporary Reinsurance Program, established to reimburse employer-sponsored plans for 80% of costs (between \$15,000 and \$90,000) to cover early retirees 55 and older who are not yet Medicare-eligible.

Individual and small business portal – The Department of Health and Human Services is required to develop an Internet consumer tool to facilitate shopping for affordable coverage by individuals and small employers (by 7/1/10).

6 months after enactment (9/23/10)

For most health plans, these mandates will become effective on 1/1/11 or later.

Prohibition of pre-existing conditions – All health plans, insured or Self-Funded, are prohibited from discriminating against any individuals under the age of 19 based on pre-existing medical conditions. This requirement extends to all enrollees for plan years beginning after 1/1/14.

Coverage for dependent children to age 26 – Insured and Self-Funded (grandfathered) health plans that cover dependent children will have to extend that coverage to dependent children up to their 26th birthday provided they are without access to employer-provided coverage.

Prohibition of lifetime limits – Insured and Self-Funded plans can no longer impose a lifetime cap on the dollar value of health benefits for “essential” services. Lifetime limits can apply to non-essential health benefits to the extent such limits are allowed by law.

Emergency services – All non-grandfathered group health plans, including Self-Funded plans, covering emergency department services must do so without the need for prior-authorization and without regard for PPO network participation.

Appeals process – All non-grandfathered plans, including Self-Funded plans, are required to implement a process for the appeal of coverage determinations and claims.

Prohibition on rescissions – All group health plans, including Self-Funded plans, are prohibited from rescinding coverage from any beneficiary unless he or she has misrepresented material facts or committed an act of fraud against the plan.

First dollar preventive care – All non-grandfathered health plans, including Self-Funded plans, must provide first-dollar coverage for Level A or B preventive care, government-recommended immunizations and government-recommended screenings for infants, children and women.

PPACA Glossary Terms You Should Know

Essential Benefits

PPACA requires all health insurance plans sold after 2014 to include a basic package of benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services among other benefits. It also places restrictions on the maximum amount of out-of-pocket costs that patients must pay for these services.

Grandfathered Plan

A health plan that an individual was

enrolled in prior to March 23, 2010. Grandfathered plans are exempted from some changes required by PPACA. New employees may be added to group plans that are grandfathered and new family members may be added to all grandfathered plans.

Guaranteed Issue

A requirement that health insurers sell a health policy to any person who requests coverage. PPACA requires that all health insurance be sold on a guaranteed-issue basis beginning in 2014.

High Risk Pool

A state-subsidized health plan that provides coverage for individuals with pre-existing healthcare conditions who cannot purchase it in the private market. PPACA creates a temporary federal high-risk pool program, which may be administered by the states, provide coverage to individuals with pre-existing conditions who have been uninsured for at least 6 months.

Individual Mandate

Perhaps the most controversial provision

of the new healthcare reform law is the requirement that every U.S. citizen and legal resident who can purchase health insurance coverage for less than 8% of their household income do so or be subject to a tax penalty. Under PPACA, penalties will be phased in according to a schedule that begins in 2014.

Large Employer

With respect to a calendar year and plan year, the term refers to an employer who employed an average of at least 101

Discrimination based on salary prohibited

– All non-grandfathered group health plans, except Self-Funded plans, are prohibited from establishing rules regarding eligibility based on annual salary or hours worked.

Increased transparency of plan details

– All group health plans, except Self-Funded plans, must submit a report presenting the percentage of collected premiums spent on reimbursement of clinical services, wellness activities and non-claims costs.

Medical loss ratio limitations – Insurers are required to meet loss ratios of 80% in individual and small group markets and 85% in the large group market. Rebates are required for insurers not meeting these requirements. Self-Funded plans are excluded.

Choice of primary care provider – All non-grandfathered health plans, including Self-Funded plans, that require beneficiaries to designate a primary care physician, must allow the choice of any available provider.

9 months after enactment (1/1/11)

OTC medications no longer FSA eligible – Over the counter medications are no longer medical expenses, and may no longer be reimbursed from an FSA, HSA, HRA or Archer MSA unless prescribed by a provider.

Increased tax on unqualified use of HSAs – The penalty for non-qualified distributions from HSAs and Archer MSAs increases from 10% to 20%.

Reporting on W-2s – Employers that offer minimum essential coverage are required

to include the aggregate value of coverage for each employee (and any dependents) on the employee's W-2 form (excluding Section 125 FSA salary reductions).

Fees on Prescription Drug Manufacturers

– Manufacturers and importers of branded prescription drugs are required to pay an annual fee based on a ratio of their annual sales and total industry sales.

1 year after enactment (3/23/11)

Reporting by Self-Funded plans – By this date, the U.S. Department of Labor is required to issue a report on Self-Funded health plans, using information from Form 5500s submitted.

30 months after enactment (9/23/12)

Reporting on benefits and coverage – All insured and Self-Funded health plans will be required to provide enrollees and applicants with an accurate summary of benefits and coverage under the plan. Health insurers and TPAs administering Self-Funded health plans are responsible for developing these summaries.

Reporting on health and outcomes – This is the date by which the Secretary of HHS will decide on the information to be included in reports on initiatives and programs that improve health outcomes. All non-grandfathered plans will be required to issue these reports annually for plan years beginning after the release of reporting requirements.

Fees on large group plans – Beginning with plan years after 9/30/12, large group health plans, including those that are Self-Funded,

will be assessed a fee to contribute to the Patient-Centered Research Outcomes Trust Fund. Fees begin at \$1 per covered life and end after 2019.

Beginning January 1, 2013

\$2,500 cap on FSA contributions – Contributions to flexible spending accounts (FSAs) will be limited to \$2,500 and indexed to the CPI for subsequent years.

Deduction for Medicare D subsidy ends

– Subsidy payments made by the government to employers that provide retiree drug coverage are no longer tax deductible.

Increase in Medicare tax – The employee portion of Medicare tax, currently 1.45%, will increase to 2.35% for individuals earning more than \$200,000 and joint filers earning more than \$250,000.

Itemized deductions for medical expenses

– The adjusted gross income threshold for claiming an itemized deduction for medical expenses is increased from 7.5% to 15%, but held at 7.5% for those age 65 and older through 2016.

New tax on high-income earners – A new 3.8% tax on "net investment income" for earnings in excess of \$200,000 for individuals and \$250,000 for joint filers becomes effective.

Fees on large group plans – The fee for large group health plans, including those plans that are Self-Funded, which was \$1 per covered life after 9/30/12, increases to \$2 per covered life.

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employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

Lifetime Limit

Traditionally, healthcare plans have placed limits upon the total dollar value of claims the insurer will pay over the course of an individual's lifetime. Under PPACA, for plan years beginning after 9/23/10, all self-insured and other group health plans are prohibited from establishing lifetime

limits on the dollar value of essential benefits for any beneficiary. Lifetime per-beneficiary limits on non-essential health benefits will be allowed to the extent that such limits are permitted under Federal or State laws.

Medical Loss Ratio

PPACA requires that large group health plans spend 85% of premiums on clinical services and other activities for the quality of care received by enrollees. Small group and individual plans (expected

to apply to those businesses with one to 100 employees) must devote 80% of premiums to these purposes. All plans (other than self-insured plans) with plan years beginning after 9/23/10 are required to report on how premiums have been allocated.

Out-of-Pocket Limit

An annual limitation on all cost sharing for which patients are responsible under a healthcare plan. PPACA requires out-of-pocket limits of \$5,950 per individual

and \$1,900 per family, beginning in 2014. These amounts will be adjusted annually to account for the growth of health insurance premiums.

Small Employer

In connection with a group health plan, a small employer is one who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

PPACA Compliance Calendar (continued)

Fees on Medical Devices – Manufacturers and importers will be required to pay an excise tax of 2.9% on the first sale for use of medical devices.

Effective January 1, 2014

Implementation of insurance exchanges – States must establish exchanges to sell coverage to individuals and small employers and the Federal government will establish an exchange in states that are not able to do so.

Individual mandate penalties – All U.S. citizens and legal residents will be assessed penalties for any month they, or their dependents, are without minimum essential coverage.

Employer mandate penalties – The “play or pay” employer mandate becomes effective, requiring employers with more than 50 full-time employees to offer a minimum level of coverage.

Free choice vouchers – Employers are required to provide Free Choice Vouchers to qualified employees, which can be used to purchase coverage through the Exchange.

Rules related to prevention and wellness – All non-grandfathered health plans, including Self-Funded plans, must comply with prevention and wellness program provisions, specifically those provisions

relating to discounts, rebates or rewards offered for meeting health-related standards.

Maximum 90-day waiting period – All health plans, including Self-Funded health plans are prohibited from maintaining waiting periods longer than 90 days.

Automatic enrollment by large employers – Employers with more than 200 full-time employees are required to automatically renew full-time employees into one of the benefit plans offered, with an option to opt out.

Guaranteed availability, renewability – All health plans, except Self-Funded plans, are required to accept every employer and individual that applies for coverage and must provide the opportunity for the individual or plan sponsor to renew.

Fees on Insurance Carriers – Issuers of health insurance policies will be assessed a yearly non-deductible fee based on a ratio of their net premiums vs. all health insurers. This fee will not apply to Self-Funded plans or their administrators.

Reporting to employees and the IRS – Employers must report on whether minimum “essential” coverage was offered and whether specific requirements imposed by HHS were met.

29 States to Administer High Risk Insurance Pools

One of the most important aspects of Healthcare Reform has already become effective with the July 1st launch of a Federal High Risk Insurance Pool program, designed to provide coverage to Americans who have been denied coverage because of a pre-existing health condition. According to the HHS Office of Consumer Information and Information Oversight, monthly premiums will range from \$140 to \$900 based on age and state of residence. To qualify for coverage through the high-risk pool, consumers must have been uninsured for the previous six months and have been denied coverage because of cancer, AIDS, diabetes, obesity, hypertension or other pre-existing condition.

Health and Human Services expects the program to cover about 350,000 individuals between this summer and 2014 when insurers are required to accept all applicants. \$5 billion has been budgeted to fund the pool, which will provide insurance covering prescription drugs and treatment from primary-care doctors, specialists and hospitals.

Please Contact Us: This newsletter is not intended as a substitute for personal medical or employee benefits advice. Please consult your physician before making decisions which may impact your personal health. Talk to your benefits administrator before implementing strategies which may impact your organization's employee benefit objectives.



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29 States to Administer High Risk Insurance Pools

According to Health and Human Services officials, coverage under the federal pool was expected to kick in August 1 for people who applied by July 15, 2010. Several states, including California, Michigan and Maryland do not expect to begin offering coverage through their pools until September.

The 29 states that have opted to administer their own coverage, according to HHS, are as follows:

Washington	Michigan
Oregon	Ohio
California	West Virginia
Montana	Pennsylvania
Utah	North Carolina
Colorado	New York
New Mexico	Vermont
South Dakota	New Hampshire
Kansas	Maine
Oklahoma	Massachusetts
Iowa	Rhode Island
Missouri	Connecticut
Arkansas	New Jersey
Wisconsin	Maryland
Illinois	District of Columbia



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