



# The Winning Approach

Insights From The Kennion Group



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### **IMPACT ON EMPLOYER-SPONSORED PLANS**

The Patient Protection and Affordable Care Act (PPACA) will have a profound impact on employers and our health insurance system. While the employer community hoped that reform would place a priority on controlling cost trend and improving quality of care, the final legislation was skewed toward expansion of government-funded insurance coverage.

The law did not create a comprehensive or certain path toward a more rational health care system; however, the reform puts the US on a path that increases consumer expectations of having comprehensive and affordable insurance coverage. Unless there are significant changes in health care cost, this expectation is unrealistic. The federal subsidies that are intended to make insurance coverage more affordable simply mask the cost problem rather than correct it.

### **IMPACT ON EMPLOYER COST**

As a result of the new insurance reforms, employers face new pressures to control costs, expand eligibility, comply with new coverage and contribution requirements, absorb new fees and, at the same time, try to avoid paying excise taxes for having a high-cost plan. It is assumed that in the near future employers will absorb an additional 4% to 6% increase above current health care cost trends due to new sources of cost, including:

- Expanded eligibility for groups of employees who are not currently eligible and for dependent children up to age 26;
- Higher contributions for low-income employees who are currently paying more than 9.5% of income for coverage;
- Expanded benefit coverage to eliminate any copayment or coinsurance on preventive care and to eliminate lifetime and annual plan maximums;
- Industry fees on suppliers, manufacturers and health plans that add billions of dollars that are likely to be passed through to employers as part of the cost of materials and administrative expense; and,
- Per-participant fees for effectiveness research.

Unintended consequences from the combination of two provisions in the law – the “Shared Responsibility” and the “excise tax” – will have a significant impact on employer benefit costs and plan design.



## SHARED RESPONSIBILITY ON EMPLOYERS

### Employers With More than 50 Full-Time Equivalent Employees\*

Shared Responsibility requirements will apply to any public or private employer that has more than 50 full-time equivalent (FTE) employees in the preceding calendar year. To avoid excise tax penalties, such employers may offer full-time employees health care coverage that meets certain affordability and minimum value tests.

- Employers who do not offer health care coverage are subject to a penalty.
- Employers who offer a self-funded benefit plan will be penalized if the plan does not meet the affordability and minimum value tests.
- Health insurers will be penalized if their plan does not meet the affordability and minimum value tests. It is assumed that any assessed penalties will be passed along to the employers through premium increases.

To determine whether an employer meets the 50 FTE threshold, any employee working 30 or more hours a week will count as one FTE. Employees will count toward the threshold for the year in which they retire, but not thereafter.

Although the Shared Responsibility penalty calculations exclude part-time staff, employees working fewer than 30 hours a week do count in determining whether an employer is subject to Shared Responsibility. To come up with an FTE figure for part-timers, employers divide the aggregate number of hours worked by those employees in a month by 120 (30 hours per week x 4 weeks). For example, if an employer has 15 employees who each work 20 hours a week for an aggregate of 1,200 hours in a month, that group will count as 10 FTE employees (1,200 ÷ 120).

Affordable employer health coverage caps the employee contribution at 9.5% of a full-time employee's household income. Starting in 2015, the 9.5% threshold will increase annually to reflect premium growth rates nationwide. In measuring affordability, the required employee contribution for self-only coverage is the key. If this meets the 9.5% threshold, then all tiers of coverage apparently will meet the affordability test.

Under the minimum value test, an employer plan must pay at least 60% of total costs for allowed benefits. This means that a covered individual's copayment, deductible and other out-of-pocket expenses for allowed benefits can't exceed 40% of total benefit costs under the plan.

The minimum value test only requires that a plan pay at least 60% of whatever benefits are covered but doesn't specify any benefits that must be covered. However, different legal mandates may dictate that plans must cover certain benefits. For example, another part of the health care reform law requires non-grandfathered plans to provide in-network coverage of recommended preventive services without cost sharing. In addition, insured small-group plans will have to offer an "essential benefits package" beginning in 2014. Other federal laws require coverage of minimum hospital stays for newborns and mothers, certain post-mastectomy benefits, and parity in mental health and substance abuse benefits.

The federal assistance generally will be available for people with household incomes at or below 400% of the federal poverty level (FPL). Financial help will include premium-assistance tax credits to buy insurance exchange coverage and cost-sharing reductions to offset out-of-pocket expenses under certain exchange plans.



The federal assistance will be provided on a sliding scale, giving more financial help to people with lower incomes. Since household income varies by family size, employees with seemingly decent incomes may qualify for financial assistance and trigger Shared Responsibility penalties for the employer. For example, some observers currently estimate that a household income of \$99,000 for a family of four may be below 400% of the FPL in 2014.

In addition to individuals with household incomes exceeding 400% of FPL, anyone who can be claimed as another person's tax dependent or who is illegally in the US cannot receive assistance. Moreover, any employee receiving a free-choice voucher cannot qualify for income-based assistance. Finally, people eligible for Medicaid, Medicare, TRICARE or Veterans' benefits generally are ineligible for assistance.

Health insurance exchanges will inform an employer when one of its employees qualifies for premium tax credits because the employer's plan doesn't meet the minimum value test or is unaffordable. To help exchanges make that determination, employees will have to provide information about their employer-sponsored benefit plans and family income. This means that employers will need to give employees information about plan value and cost.

The notice to employers will include information about potential penalties and appeal processes. The Treasury Department will establish an appeal process for employers to use.

\*Employers with 50 or fewer employees will not be penalized.



## PENALTIES

Shared Responsibility penalties will be determined monthly, and the dollar amounts will increase annually to reflect the average national increase in health insurance premiums. Employers will not be able to deduct penalties as business expenses for federal tax purposes.

One penalty structure will apply to employers that do not offer coverage to full-time employees, and another penalty structure will apply to employers whose health coverage for full-time employees fails the affordability and minimum value tests. In either case, the employer will face Shared Responsibility penalties only if at least one full-time employee enrolled in insurance exchange coverage has received federal financial assistance to do so.

In 2014, employers whose health coverage fails the minimum value or affordability tests will face an annual penalty of up to \$3,000 for each full-time employee enrolled in insurance exchange coverage with federal financial assistance. However, an employer's total penalty liability is capped. *This limit is calculated by multiplying \$2,000 by the employer's total number of full-time employees – regardless of exchange coverage or eligibility for assistance -after subtracting 30 full-time employees.* Full-time employees who receive employer-provided, free-choice vouchers are disregarded in calculating the penalties. *Employers that don't offer coverage to full-time employees will face an annual penalty of up to \$2,000 for every full-time employee, excluding the first 30 full-time employees, in 2014.*

Shared Responsibility will bring new reporting and disclosure requirements for employers. For example, beginning March 1, 2013, employers must give new hires written information on health insurance exchanges and the potential for individuals to receive premium credits and cost-sharing subsidies for exchange coverage. The notice also must inform employees that they may lose any employer health plan contribution by buying coverage through a health insurance exchange, unless they are eligible for free-choice vouchers.

Although much is still unknown and subject to change by law, regulation or court decision, employers should begin factoring their Shared Responsibility obligations into strategic and compliance planning. Just how an employer will be affected will depend on such variables as whether its employee population is largely full or part-time or high or low income; whether health insurance exchanges become viable sources of coverage in states where employees reside; and whether health benefits remain an important attraction and retention tool. The interplay with other health care reforms, such as the obligation to auto-enroll new full-time employees in a health plan or the 40% excise tax on high-cost coverage slated to begin in 2018, also will be important for employers' strategic decisions.

Regardless of other variables, all employers should be prepared to change administrative and other processes to comply. Employers will need procedures to accommodate interactions with state health insurance exchanges, prepare new employee notices and meet government disclosure obligations.



**IMPACT ON WORKFORCE STRATEGY**

All employers are asking how health care reform will affect their plans and costs. While many employers place a high value on health plans as a way to drive productivity and retain employees, that view is not universal. Some employers are looking into the option of eliminating health care benefits and giving some type of contribution to help employees buy coverage. Among the cautions to consider:

- There is not a viable individual market that would provide access to all employees without constraints.
- The “savings” to an employer are not simply the difference between current cost and the penalty. Employees will expect some compensation adjustment to help them buy coverage in the individual market, and employers must ask if they can afford the compensation boost sufficient to pay for high-cost individual marketed insurance.
- The law is not likely to result in individual market coverage that is more affordable than employer-sponsored coverage. Employers with self-insured plans, in particular, will have a more favorable cost due to lower administrative expense, less adverse selection and plan design flexibility.



## GRANDFATHERED PLANS

PPACA exempts so-called “grandfathered plans” from certain requirements applicable to health plans in the group and individual markets. Grandfathered plans include any group health plan or individual plan that was in existence on the date of enactment. PPACA provides that family members are permitted to join the grandfathered coverage if the terms of the plan in effect on the date of enactment would allow such enrollment. New employees (and their families) may enroll in a grandfathered group health plan. Grandfathered group health plans provided by employers are deemed to meet the “minimum essential coverage” for purposes of the individual mandate to have insurance.

### **Summary of Interim Final and Proposed Rule - Status as a Grandfathered Health Plan under Healthcare Reform**

The following is a brief summary of the Interim Final and Proposed Rules relating to Grandfathered Status under the Patient Protection and Affordable Care Act (Grandfathering Regulations) issued by the Departments of Health and Human Services, Labor and Treasury on June 17, 2010 and November 15, 2010.

For plan years beginning on and after October 1, 2010, group health plans must comply with certain requirements under Title I (Subtitles A and C) of the Patient Protection and Affordable Care Act (Healthcare Reform). If your plan is a “grandfathered group health plan”, you must comply with the Healthcare Reform provisions described in the enclosed **Summary of Healthcare Reform Grandfathered Plan Provisions**. If your plan is not a grandfathered group health plan, you must comply with the Healthcare Reform provisions described in the enclosed **Summary of Healthcare Reform Non-Grandfathered Plan Provisions**.

### **What is a Grandfathered Plan?**

The Healthcare Reform statute provides that a group health plan that existed on March 23, 2010 was a grandfathered plan. The statute also provides that new employees and new family members may be added to that plan without the loss of grandfathered status. However, the Healthcare Reform statute is silent regarding whether changes to health care coverage will result in the loss of grandfathered status for the plan. The Grandfathering Regulations provide some answers to this question.

***Please note that the determination of grandfathering status is made on a benefit option by benefit option basis.*** For example, assume that on March 23, 2010, a plan had Benefit Option A, Benefit Option B and Benefit Option C. Thereafter, coverage changes are made to Benefit Option C that results in a loss of grandfathered status for Benefit Option C. No changes are made to Benefit Option A and Benefit Option B. Under the Grandfathering Regulations, Benefit Option A and Benefit Option B remain grandfathered.

### **What Plan Changes will Result in the Loss of Grandfathered Status?**

The following changes to the plan coverage that existed on March 23, 2010 will cause a group health plan to lose its grandfathered status for purposes of Healthcare Reform:

- (1) An exclusion of all or substantially all benefits to diagnose or treat a particular condition. An exclusion of benefits for any necessary element to diagnose or treat a condition is also considered an exclusion of all or substantially all benefits to diagnose or treat a particular condition.
- (2) Any increase in the percentage of coinsurance.



- (3) Any increase in deductibles or out-of-pocket maximums by more than medical inflation (the medical portion of the CPI-U index) plus 15%.
- (4) Any increase in copayments by more than the greater of medical inflation plus 15% or, if greater, \$5.00 increased by medical inflation.
- (5) Any decrease in the employer contribution percentage by more than 5%.
- (6) Adding an overall annual dollar limit on plan benefits (even if permissible under the Healthcare Reform rules) if the plan did not have an overall (comprehensive) annual or lifetime limit on March 23, 2010.
- (7) Adding a lower annual dollar limit on plan benefits than the overall (comprehensive) lifetime dollar limit or, if lower, the overall (comprehensive) annual dollar limit, that the plan had on March 23, 2010.
- (8) Entering into a new group health insurance contract (with the same or a new insurer) with an effective date of coverage before November 15, 2010.

#### **What Plan Changes will NOT result in the Loss of Grandfathered Status?**

The following *changes to the plan coverage that existed on March 23, 2010* will NOT cause a group health plan to lose its grandfathered status for purposes of Healthcare Reform:

- (1) Changes to premiums.
- (2) Changes required by law.
- (3) Changes to voluntarily comply (or voluntarily comply early) with any provision of Healthcare Reform.
- (4) Changes to add benefits or increase benefits in favor of the plan member.
- (5) Entering into a new group health insurance contract (with the same or a new insurer) with an effective coverage date on and after November 15, 2010.
- (6) For self-funded groups, changing claims administrators.

#### **What is Plan Coverage on March 23, 2010?**

A plan's grandfathered status for purposes of Healthcare Reform is determined by looking at what changes have been made to the plan's coverage as it existed on March 23, 2010. The Grandfathering Regulations further provide that if a plan adopted a written plan amendment before March 23, 2010, then that plan amendment is deemed part of the plan's coverage as of March 23, 2010 - even if the adopted plan amendment is not effective until after March 23, 2010.

#### **Transition Rules**

For any changes that a plan made after March 23, 2010 but before the issuance of the Grandfathering Regulations, you may modify any of those changes that would cause loss of grandfathered status. To keep grandfathered status, however, this modification must be made no later than the first day of the plan year beginning on and after October 1, 2010.

#### **Rules for Collectively Bargained Plans**

Collectively bargained plans that have collective bargaining agreements ratified on or before March 23, 2010 are considered a grandfathered plan and must comply with the grandfathering provisions of Healthcare Reform until the time of the collective bargaining agreement's termination or expiration. After the expiration or termination of the collective bargaining agreements, these plans must look back to plan coverage on March 23, 2010 and determine whether it must then comply with the grandfathering or non-grandfathering provisions of Healthcare Reform. These



plans make this determination based upon the changes made since March 23, 2010 in accordance with the Grandfathering Regulations. However, the fact that an underwritten or self-funded plan entered into a new underwritten health insurance contract (with the same or a new insurer) with an effective coverage date prior to November 15, 2010 is disregarded. If the plan is now non-grandfathered, the plan must comply with the non-grandfathered provisions of Healthcare Reform no later than the date the collective bargaining agreements terminate.

For collectively bargained plans that have collective bargaining agreements ratified after March 23, 2010, the determination of whether that plan is grandfathered or non-grandfathered is made the exact same way that any other group health plan determines its grandfathered status. These plans will be either grandfathered or non-grandfathered based upon the changes made to benefits and/or employer contributions in accordance with the Grandfathering Regulations. If an underwritten or self-funded plan entered into a new underwritten health insurance contract between March 23, 2010 and November 15, 2010, that fact alone will cause the plan to lose grandfathered status. If an underwritten or self-funded plan enters into a new underwritten health insurance contract on or after November 15, 2010, then that fact alone will not cause it to lose grandfathered status. If the plan made any offending changes between March 23, 2010 and June 17, 2010 pursuant to the Grandfathering Regulations, the plan can take advantage of the transition rules to amend their plan to remove the offending changes effective no later than the first day of the plan year beginning on and after October 1, 2010.

#### **Important Grandfathering Documentation Requirements**

**Grandfathered Status Model Notice:** A plan will lose grandfathering status if it does not include in its plan materials a disclaimer that lets the plan members know that the plan is grandfathered for purposes of Healthcare Reform. HHS/DOL/Treasury prepared a model disclaimer notice that plans can use for this purpose. This model notice may be found at [www.dol.gov/ebsa/grandfatherregmodelnotice.doc](http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc).

**Keep Grandfathered Documentation:** You must retain documentation to prove that the plan is a grandfathered health plan for as long as grandfathered status is claimed and thereafter for the time period required by other applicable laws, such as ERISA.

#### **Special Health Plans**

The Grandfathering Regulations provide that retiree only plans and HIPAA excepted benefit plans (dental, vision, flexible spending plans) are exempt from Title 1 (Subtitles A and C) of Healthcare Reform. These plans do not have to comply with any of the Title 1 (Subtitles A and C) requirements – regardless of whether these plans would be considered grandfathered or non-grandfathered.

#### **Grandfathered Plan Checklist**

*Grandfathered plan status for purposes of Title I, Subtitles A and C of the Patient Protection and Affordable Care Act, as amended (Healthcare Reform) is made on a benefit option by benefit option basis. The following are four easy steps to help you identify your plan status as a Grandfathered vs. Non-Grandfathered Plan.*



**Step 1 – Assess your plan coverage as of March 23, 2010.**

1. Plan Benefits to Diagnose or Treat a Condition
2. Coinsurance percentage(s)
3. Deductible amount(s) and Out-of-Pocket Maximum amount(s)
4. Copayment amount(s)
5. Employer contribution percentage(s)
6. Lifetime Dollar Maximum amount(s) and overall Annual Dollar Maximum amount(s)

**Step 2 – Are you making any of the following changes to your plan?**

If you answer “Yes” to any one of the following, your plan will not be a grandfathered plan.

1. Exclude all or substantially all benefits to diagnose or treat a particular condition (including any necessary element to diagnose or treat a condition)?
2. Increase coinsurance percentage(s)?
3. Increase deductibles or out-of-pocket maximums by more than medical inflation plus 15%?
4. Increase copayments by more than the greater of (a) medical inflation plus 15% or (b) \$5.00 adjusted annually by medical inflation?
5. Decrease employer contribution percentage(s) by more than 5%?
6. Add an overall annual dollar limit on plan benefits (even if permissible under the Healthcare Reform rules) if the plan did not have an overall (comprehensive) annual or lifetime limit on March 23, 2010?
7. Add a lower annual dollar limit on plan benefits than the overall (comprehensive) lifetime dollar limit or, if lower, the overall (comprehensive) annual dollar limit, that the plan had on March 23, 2010?

**Step 3 – What Healthcare Reform plan changes apply on the first day of the plan year beginning on and after October 1, 2010?**

If your plan is a grandfathered plan under Healthcare Reform, the enclosed **Summary of Healthcare Reform Grandfathered Plan Provisions** applies to you. If your plan is a non-grandfathered plan under Healthcare Reform, the enclosed **Summary of Healthcare Reform Non-Grandfathered Plan Provisions** applies to you.



### Summary of 2010/2012 Healthcare Reform Grandfathered Plan Provisions

If your plan is a “grandfathered group health plan” under the Patient Protection and Affordable Care Act (Healthcare Reform), your plan must maintain the following plan provisions.

#### 1. Grandfathering Notice.

All your plan materials describing plan benefits must include a grandfathering notice. You can find a copy of the federal model grandfathering notice at [www.dol.gov/ebsa/grandfatherregmodelnotice.doc](http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc).

If we prepare your benefit booklet, we will include the following grandfathering notice in the Overview of the Plan section of your benefit booklet.

*Your group believes this plan 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 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 essential benefits.*

*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 the contact information in the Administrative Information section of this benefit booklet. [For ERISA plans: 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](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For nonfederal governmental plans: You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).]*

#### 2. No Annual Dollar Limits

Generally, your plan cannot have any overall annual dollar limits on essential health benefits, for plan years beginning on or after October 1, 2011, no less than the greater of \$1.25 million or the amount of your plan’s overall lifetime limit on March 23, 2010. Other limits, such as visit limitations, on essential health benefits are still permissible.

#### 3. No Lifetime Dollar Limits

Your plan cannot have any lifetime dollar limits on essential health benefits.

#### 4. Dependent Coverage up to Age 26

If your plan provides dependent child coverage, you must cover certain dependent children up to age 26 without any eligibility restrictions other than the relationship of the child to the employee. Unless you tell us otherwise during your group’s renewal process, we will include the following eligibility provision in your benefit booklet for all plans (health, dental, vision and retiree) that we administer or insure:



### Eligible Dependents

Your eligible dependents are:

- Your spouse (of the opposite sex);
- A married or unmarried child up to age 26; and,
- An unmarried, incapacitated child who (1) is age 26 and over; (2) is not able to support himself; and (3) depends on you for support, if the incapacity occurred before age 26.

The child may be the employee's natural child; stepchild; legally adopted child; child placed for adoption; or, other child for whom the employee has permanent legal custody. *However, **the child is not eligible for coverage if he or she is eligible for any other employer-sponsored health plan coverage other than his parents' coverage.***

A grandchild is only eligible if he or she meets all of the following guidelines: (1) under 26 years of age; (2) unmarried; (3) depends on the employee for over one-half support; (4) resides in the same household full time with the employee in a parent-child relationship; and (5) is not employed on a regular full-time basis. If the parent of the grandchild is covered under the plan, the grandchild may not be covered by the employee's contract unless the grandchild has been adopted by the grandparents.

#### 5. **No Pre-existing Condition Exclusion Periods for Members under 19**

Your plan cannot apply any pre-existing conditions exclusion periods to members (both contract holders and dependents) who are under age 19.

#### 6. **No rescissions (except for fraud and intentional misrepresentation)**

You cannot retroactively cancel coverage for any reason other than non-payment of premiums/contributions, fraud and intentional misrepresentation of a material fact. If you retroactively cancel coverage for fraud or intentional misrepresentation, you must provide the affected member with a prior written 30 day notice of your intent to retroactively cancel such coverage. If we prepare your benefit booklet, we will replace the present Misrepresentation provision in your booklet with the following:

#### **Misrepresentation**

If you commit fraud or make an intentional material misrepresentation when applying for coverage, when we learn of this we may terminate your coverage back to the effective date on which your coverage began as listed in our records. We need not refund any payment for your coverage. If your group commits fraud or makes an intentional material misrepresentation in its application, it will be as though the plan never took effect, and we need not refund any payment for any member.



**Summary of 2010/2012 Healthcare Reform Non-Grandfathered Plan Provisions**

If your plan is a NOT a “grandfathered group health plan” under the Patient Protection and Affordable Care Act (Healthcare Reform), your plan must maintain the following plan provisions.

**1. No Annual Dollar Limits**

Your plan cannot have any annual dollar limits on essential health benefits for plan year beginning on or after October 1, 2011, less than \$1.25 million. Other limits, such as visit limitations, on essential health benefits are still permissible.

**2. No Lifetime Dollar Limits**

Your plan cannot have any lifetime dollar limits on essential health benefits.

**3. Dependent Coverage up to Age 26**

If your plan provides dependent child coverage, you must cover certain dependent children up to age 26 without any eligibility restrictions other than the relationship of the child to the employee. Unless you tell us otherwise during your group’s renewal process, we will include the following eligibility provision in your benefit booklet for all plans (health, dental, vision and retiree) that we administer or insure:

**Eligible Dependents**

Your eligible dependents are:

- Your spouse (of the opposite sex);
- A married or unmarried child up to age 26; and,
- An unmarried, incapacitated child who (1) is age 26 and over; (2) is not able to support himself; and (3) depends on you for support, if the incapacity occurred before age 26.

The child may be the employee’s natural child; stepchild; legally adopted child; child placed for adoption; or, other child for whom the employee has permanent legal custody.

A grandchild is only eligible if he or she meets all of the following guidelines: (1) under 26 years of age; (2) unmarried; (3) depends on the employee for over one-half support; (4) resides in the same household full time with the employee in a parent-child relationship; and (5) is not employed on a regular full-time basis. If the parent of the grandchild is covered under the plan, the grandchild may not be covered by the employee’s contract unless the grandchild has been adopted by the grandparents.

**4. No Pre-existing Condition Exclusion Periods for Members under 19**

Your plan cannot apply any pre-existing conditions exclusion periods to members (both contract holders and dependents) who are under age 19.

**5. No rescissions (except for fraud and intentional misrepresentation)**

You (the employer/group) cannot retroactively cancel coverage for any reason other than nonpayment of premiums/contributions, fraud and intentional misrepresentation of a material fact. If you retroactively cancel



coverage for fraud or intentional misrepresentation, you (the employer/group) must provide the affected member with a prior written 30 day notice of your intent to retroactively cancel such coverage. If we prepare your benefit booklet, we will replace the present Misrepresentation provision in your booklet with the following:

**Misrepresentation**

If you commit fraud or make an intentional material misrepresentation in apply for coverage, when we learn of this we may terminate your coverage back to the effective date on which your coverage began as listed in our records. We need not refund any payment for your coverage. If your group commits fraud or makes an intentional material misrepresentation in its application, it will be as though the plan never took effect, and we need not refund any payment for any member.

**6. No Cost Sharing on Required in-Network Preventive Services and Immunizations**

Your plan must provide In-Network coverage for the preventive services and immunizations described at <http://www.healthcare.gov/law/about/provisions/services/lists.html> with no cost sharing of any kind (for example, no deductibles, copayments or coinsurance). However, if immunizations and preventive services are billed separately from the member's office visit or other facility visit, then the applicable office visit or other facility copayments may apply. Applicable office visit or other facility copayments may also apply if the primary purpose for the member's visit is not for preventive services and/or immunizations.

**7. Emergency Services**

Your plan cannot require any precertification or prior authorization for emergency services in an emergency department of a hospital. Requiring notification thereafter, however, is still permissible. In addition, the copayment amount and/or coinsurance amount for emergency services in the emergency room department of an out-of-network hospital must be the same as those amounts for such services in an in-network hospital. Healthcare Reform also provides rules for calculating the permissible out-of-network allowed amount for these services. Balance billing for the charges in excess of the out-of-network allowed amount is permitted.

**8. Internal Claims and Appeals**

Your plan must comply with the internal claims and internal appeals requirements under Healthcare Reform.

**9. External Appeals**

Your plan must comply with the external appeals requirements under Healthcare Reform.

**10. Internal Revenue Code Section 105(h) – Discrimination Testing**

**If your plan is underwritten, you must now comply with Internal Revenue Code Section 105(h)** discrimination testing. Self-funded plans have always been subject to this rule. Generally, Section 105(h) provides that if the plan is discriminatory (that is, it does not meet the Section 105(h) requirements), then certain group health plan benefits provided to "highly compensated individuals" will be included in those individual's gross income. In order to meet Section 105(h), a group health plan must satisfy two tests:



- (1) The Eligibility Test: The plan cannot discriminate in favor of highly compensated individuals (HCIs) as to eligibility to participate in the plan; and
- (2) The Benefits Test: The plan cannot discriminate in favor of HCIs as to benefits under the plan.

For purposes of these two tests, an HCI is any of the following:

- (1) One of the 5 highest-paid officers;
- (2) A shareholder who owns more than 25% of all stock; or
- (3) Among the highest-paid 25% of all employees.

There are detailed rules to follow when conducting this Section 105(h) nondiscrimination testing. You should check with your legal or tax adviser regarding this required discrimination testing.



**NON-GRANDFATHERED GROUP PLAN vs GRANDFATHERED PLAN COMPARISON**

<p align="center"><b>Non-Grandfathered Group Plan Title I, Subtitles A. and C 2010-2011 Plan Year (beginning with Oct 1, 2010 plan year)</b></p>	<p align="center"><b>Grandfathered Group Plan Title I, Subtitles A and C 2010-2011 Plan Year (beginning with Oct 1, 2010 plan year)</b></p>
<p>Only the following annual dollar limits on essential health benefits are permissible (§ 2711):</p> <ul style="list-style-type: none"> <li>• Plan years beginning Oct 1, 2010 - no less than \$750,000</li> <li>• Plan years beginning Oct 1, 2011 - no less than \$ 1.25 million</li> <li>• Plan years beginning Oct 1, 2012 - no less than \$2 million</li> </ul>	<p>Only the following annual dollar limits on essential health benefits are permissible (§ 2711):</p> <ul style="list-style-type: none"> <li>• Plan years beginning Oct 1, 2010 - no less than \$750,000</li> <li>• Plan years beginning Oct 1, 2011 -no less than \$1.25 million</li> <li>• Plan years beginning Oct 1, 2012 - no less than \$2 million</li> </ul>
<p>No lifetime limits on essential benefits (§ 2711)</p>	<p>No lifetime limits on essential benefits (§ 2711).</p>
<p>No rescissions (except for fraud or intentional material misrepresentation) (§ 2712).</p>	<p>No rescissions (except for fraud or intentional material misrepresentation) (§ 2712).</p>
<p>Must offer coverage to adult children of insured up to age 26 (§2714).</p>	<p>Must offer coverage to adult children of insured up to age 26 (but, prior to 1/1/14, not applicable if adult child is eligible for employer-sponsored coverage other than parents' coverage) (§ 2714).</p>
<p>Must provide rebates if plan does not meet required medical loss ratio (§ 2718).</p>	<p>Must provide rebates if plan does not meet required medical loss ratio (§2718).</p>
<p>No preexisting condition exclusions for individuals under 19 years old (§2704).</p>	<p>No preexisting condition exclusions for individuals under 19 years old (§2704).</p>
<p>No cost sharing for immunization or preventive care (§ 2713).</p>	
<p>No discrimination in favor of highly compensated individuals (internal Revenue Code § 105(h) rules apply). (§ 2716). Already applied to self-funded groups; now applies to underwritten groups</p>	
<p>Must allow individuals to choose pediatrician for child's primary care physician (§ 2719A(c)),</p>	
<p>Must allow females to choose gynecologist or obstetrician without referral (§ 2719A(d)).</p>	
<p>Must allow emergency services without preauthorization and treat as in-network (§2719A(b)).</p>	
<p>Must provide internal appeals and external review process (§ 2719).</p>	



<b>Non-Grandfathered Group Plan Title I, Subtitles A and C By March 2012</b>	<b>Grandfathered Group Plan Title I, Subtitles A and C By March 2012</b>
Must create summary documents using HHS uniform definitions (§2715).	Must create summary documents using HHS uniform definitions (§2715).
No annual limits on essential benefits (§ 2711).	No annual limits on essential benefits (§2711).
No pre-existing condition exclusions (§ 2704).	No preexisting condition exclusions (§ 2704).
Waiting periods limited to 90 days (§ 2708).	Waiting periods limited to 90 days (§ 2708).
Must follow rating limitations (rating based on: tobacco use 1.5:1, age 3:1, rating area, and coverage for individual versus family) (§ 2701). Applies to small group health insurance coverage only, unless large group coverage is offered through an exchange.	
Guaranteed issue (§ 2702).	
Guaranteed renewability (§ 2703).	
No discrimination based on health status (§2705).	
No discrimination on health care providers acting within the scope of their license (§ 2706).	
Must cover essential benefits (§ 2707(a)). Applies to small group health coverage.	
Must follow cost sharing limits (§ 2707(b)).	



**SUMMARY OF IMPORTANT DATES FOR EMPLOYERS**

**2010**

January 1, 2010 Provides for small employer tax credit subsidies (applies to employers with no more than 25 employees with average annual wages of less than \$50,000); the maximum credit is available for employers with 10 or fewer employees with average annual wages of less than \$25,000.

June 23, 2010 (3 months after enactment)

Creates a temporary reinsurance program for employers providing retiree benefits for retirees over 55 and not eligible for Medicare (pays 80% of retiree claims between \$15,000 and \$90,000); it phases out in 2014.

September 23, 2010 (6 months after enactment)

Permits dependent coverage for children to age 26 (also catastrophic coverage up to age 30).

September 23, 2010 (6 months after enactment)

Reforms plan benefits, including eliminating lifetime benefit caps, modifies annual limits, eliminates the rescission right absent fraud or intentional misconduct, requires coverage for certain preventative services, imposes prohibitions on benefit discrimination, and eliminates pre-existing condition limitations for dependent children under age 19. Similar provisions apply for existing individual and group plans (“grandfathered plans”) that are excluded from certain changes.

**2011**

January 1, 2011 Excludes the cost of over-the-counter medications that do not have a doctor’s prescription from being reimbursed under an FSA, HRA, HSA and Archer Medical Savings Accounts.

Provides a rebate to subscribers if a plan’s medical loss ratio is not at least 85% (80% for individual and small group markets).

Increases the tax on distributions from an HSA or Archer MSA that are not used to pay qualified medical expenses to 20%.

**2012**

March 23, 2012 Group health plans and self-insured companies must provide participants a uniform summary of benefits and coverage. This summary may not be longer than four pages and must describe the benefits in a “culturally and linguistically appropriate manner”.

**2013**

January 1, 2013 Increases Medicare hospital payroll tax by .9% on individuals that earn over \$200,000 and joint filers with incomes over \$250,000 (no indexing for inflation).

Imposes a new Medicare tax of 3.8% on investment income (including interest, dividends, royalties, rents and passive income) for individuals that earn over \$200,000 and joint filers with joint incomes over \$250,000 (no indexing for inflation).



Limits the amount of contributions to an FSA at \$2,500, subject to indexing.

Eliminates the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments

March 1, 2013

Employers are required to give notice to employees regarding the Exchanges and the availability of subsidies if applicable

**2014**

January 1, 2014

Requires U.S. citizens to have coverage (imposes a tax for noncompliance of the greater of \$695 (up to \$2,085 for family) or 2.5% of household income per year, implemented on a sliding scale commencing in 2014) and exceptions apply.

Assesses employers with more than 50 employees not offering coverage and having at least 1 full-time employee receiving a premium credit a fee (\$2,000 per full-time employee excluding the first 30). Also, assesses employers with more than 50 employees that offer coverage and have at least 1 full-time employee receiving a premium credit a fee (lesser of \$3,000 per employee receiving a premium credit or \$2,000 per full-time employee).

Limits any waiting period for coverage to 90 days.

Makes additional plan reforms (guaranteed issue, rating restrictions, essential level of plan benefits, elimination of pre-existing conditions for all adults and eliminating annual caps) except that for “grandfathered plans” reforms provide for elimination of pre-existing conditions for adults and annual caps.

Requires employers that offer coverage to provide a free voucher to employees with incomes less than 400% of the federal poverty guidelines whose premium share exceeds 8% but less than 9.8% of income. The voucher amount is equal to the employer cost and employers that provide vouchers will not be penalized for employees that receive premium credits.

Individuals meeting income guidelines are eligible for premium and cost sharing subsidies.

Requires employers with more than 200 employees to automatically enroll employees into its lowest cost plan (employees can opt out).

**2018**

January 1, 2018

Imposes an excise tax on issuers of employer-sponsored health plans with premiums that exceed certain thresholds.



This is a summary only of important dates applicable to employers generally and there are other provisions applicable to employers in health care delivery and insurance- related industries. While the time line identifies specific implementation dates, we await further guidance on how these requirements will be applied. The Information in this document is for informational purposes only and is not intended to provide specific financial, investment, tax, legal or accounting advice for you, and should not be relied upon in that regard. You should not act or rely on the Information without seeking the advice of a professional.

**References:**

- Blank Rome, LLP
- Internal Revenue Services
- HR Web Advisor
- SZD – Schottenstein, Zox & Dunn Company
- Kaiser Health
- ISCEBS
- SPBA
- Mercer, LLC
- Blue Cross Blue Shield



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