HMA UPDATE 4.15.2010

Impact of Healthcare Reform
Effective: September 23, 2010

HMA is actively committed to helping our clients manage the challenging area of Healthcare Reform. The recent landmark legislation signed into law will significantly change how we all approach healthcare, and our Compliance department has prepared a brief summary of the critical elements of that far reaching law. That summary is attached here for your review. HMA will continue to follow the changes in the law, and as regulations are published we will endeavor to provide this essential information to you so that you will have the information needed to make informed decisions regarding plan design and administration changes that may be required.

If you have any questions, please don't hesitate to contact any member of your HMA account team. We will be happy to assist you.

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April 14, 2010

Health Reform Update

Executive summary of the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act

As you know, a far reaching health care reform bill was passed by Congress, signed into law by the President and amended with technical corrections within the last few weeks. HMA has been following these developments closely, and will be providing additional information to you in the coming weeks and months to help you be fully prepared to be compliant with this new law.

Many of the provisions in this new law will directly impact self funded plans and require not only plan changes, but also changes in how group health plans are administered. At the time this summary was prepared, the actual meaning of some provisions of this voluminous law are still being actively debated and regulations implementing the law will take years to complete. Knowing this, HMA still feels it is important for you to have early interpretations of this ground breaking legislation, so that as you are developing your plans to modify benefits as required. We believe this will allow you to make a reasonable effort at compliance while we all wait for regulations and clarification. Please note that this brief summary is not intended to be a complete explanation of the many details and provisions in the law, and represents HMA's good faith interpretation as informed by significant research we have done. HMA will strive to keep you updated on this new law as the full impact unfolds and regulations are published.

The spreadsheet following this letter contains brief summaries of the most relevant provisions of the new law for self-funded plans, along with the effective date of the provisions. Note that all of the information provided here applies specifically to self-funded plans already in existence when the legislation passed in March 2010 and represents HMA's best interpretation of the law based on the information available at this time. Requirements for new group health plans are not addressed in this summary.

While some of the actual provisions of the law vary in their application depending on size of employee population, current interpretation is that the reform provisions we have outlined will apply to the vast majority of the self-funded group health plans regardless of whether or not they are governed by ERISA.

Disclaimer: The information contained herein is not intended to be legal advice, and while every effort has been made to ensure that the content of this legislative summary is accurate, HMA makes no representations or warranties in relation to the information provided, and assumes no liability or responsibility for any acts or omissions based on this information. As always, we encourage you to consult with your own legal counsel prior to making any decisions regarding plan design or administration.

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Plan Changes	Supplemental Information	Effective Date	Subsequant Plan changes required?	Second Effective Date
Pre-existing condition exclusion	No pre-existing condition exclusions will be permitted for children under age 19.	Plan years beginning after September 23, 2010	No pre-existing condition exclusions will be permitted for anyone.	2014
Dependent eligibility for coverage	Must allow dependent up to age 26 to remain eligible for coverage under the plan if they are not eligible for other employer sponsored coverage, regardless of tax dependent status, or dependent's financial, marital or full time student status.	Plan years beginning after September 23, 2010	Removes the limitation that dependents up to age 26 who are eligible for other employer sponsored coverage may be dropped from plan coverage. All dependents up to age 26 must be considered eligible for coverage regardless of eligibilty for other employer sponsored coverage, tax dependent status, dependent's financial status, marital status, or full time student status.	2014
Lifetime maximums	Plan may impose lifetime limits on non-essential health benefits. Services exempt from lifetime limitations (defined as essential health benefits) are currently hospitalization, ambulatory services, emergency services, maternity, mental health, Rx drugs, and other specified services as determined by HHS. Regulations pending.	Plan years beginning after September 23, 2010	No lifetime maximums for any plan benefits will be permitted.	2014
Annual dollar maximums	Plan may impose "reasonable" annual dollar limitations on non-essential health benefits. Services that are exempt from annual dollar limitations (defined as essential health benefits) are currently hospitalization, ambulatory services, emergency services, maternity, mental health, Rx drugs, and other specified services as determined by HHS. Regulations pending.	Plan years beginning after September 23, 2010	No annual dollar limitations permitted.	2014
Termination of coverage	Plan may not cancel coverage for anyone otherwise eligible for coverage except for fraud or intentional misrepresentation of material fact.	Plan years beginning after September 23, 2010	No additional changes required per the current law.	
Preventive services coverage	Specific preventive services must be covered with no deductible, co-pay or co-insurance. Includes but is not limited to annual checkups, well child visits, breast cancer screenings for women, immunizations. Could include other services as recommended by the US Preventive Services Task Force, such as screening adults for depression, oral fluoride supplementation to preschool children, screening and behavioral counseling intervention to reduce alcohol misuse by adults. Regulations pending.	Plan years beginning after September 23, 2010	No additional changes required per the current law.	
Appeals process for claims denials	Specified internal and external appeal process must be implemented. There are expected to be few material changes for self-funded plans governed by ERISA under this new law. Regulations and additional information pending.	Plan years beginning after September 23, 2010	No additional changes required per the current law.	
Emergency services cost sharing	Reimbursement and cost sharing for both In network or out of network emergency services must be the same in the plan.	Plan years beginning after September 23, 2010	No additional changes required per the current law.	
Over the counter drugs in a health FSA or HRA	Over the counter drugs no longer be eligible for reimbursement under a health FSA or HRA, unless the patient has a prescription.	Taxable years beginning after 12/31/2010	No additional changes required per the current law.	
Pre-tax contributions to a health FSA	Annual limitation on pre-tax contributions to a health FSA capped at $2,500 (indexed) per year.	2013	No additional changes required per the current law.	
Out of Pocket maximums	Limited to HDHP levels. Regulations pending.	2014	No additional changes required per the current law.	
Clinical trial coverage	Routine costs for clinical trials for life threatening conditions must be considered an eligible expense.	2014	No additional changes required per the current law.	
Waiting period	The waiting period for coverage cannot exceed 90 days.	2014	No additional changes required per the current law.	

Administrative changes	Supplemental Information	Effective Date	Subsequant Plan changes required?	Second Effective Date
Plan disclosures of coverage and cost sharing	Requires periodic disclosures on plan finances, data on enrollment, disenrollment, cost sharing, number of claims denied, etc.	Plan years beginning after September 23, 2010		
Annual cost of employer provider health coverage must be included in the employee's W-2	This information will serve as proof of individual coverage in anticipation of the implementation of the individual coverage mandate. This information will also likely be used as the basis for the tax on "cadallic" plans in 2014. There is no expectation that the cost of employer provided health benefits will become taxable to the employee.	Taxable years beginning after 12/31/2010		
HSA penalty for withdrawal of funds	If funds are withdrawn from an HSA for reasons other than qualified medical expenses prior to age 65, the penalty increases from 10% to 20%.	2011		
Fee for Research on comparative medical effectiveness	For any plan year ending after September 30,2012, the Plan Sponsor/Employer of a self-insured plan must pay a fee equal to $2.00 multipled by the number of average covered lives. (For plan years beginning prior to September 30, 2012 but ending in fiscal year 2013, the fee is $1.00 per average covered life). Beginning for plan years ending after September 30, 2014, the fee shall be equal to the dollar amount paid for the previous plan year multipled by the percentage increase in projected per capita National Health Expenditures as promulagated by the Secretary before the beginning of that fiscal year. Fee required only for health plan participants who reside in the US. Fee purpose is to fund research on comparative medical outcomes and effectiveness.	2012-2019	Fee sunsets on plan years ending September 30, 2019.	
Employers/Plan Sponsors must provide uniform explanation of coverage to all plan participants	Form and format to be determined by HHS by March 2011.	2012 expected		
New full time employees must automatically be enrolled for Medical coverage when first eligible (subject to plan waiting period)	Applies to employers with at least 200 employees. Employer must provide adequate notice to employee and they must have the option to opt out.	Law is silent on the effective date, but expectation is 2014 effective date. Date pending regulations from the Secretary of Labor.		
New reporting obligations	Plan must report actuarial value of plan, length of waiting period, lowest cost option, etc to the Secretary. Regulations and additional information pending	2014		
Health Coverage (if offered) must be qualified and "affordable"	Plan must pay at least 60% of covered expenses to be qualified, and employee premiums cannot exceed 9.5% of household income to be affordable. If does not meet requirements, employer/plan sponsor must pay penalty of $3000 (indexed) per full time eligible employee.	2014		