



Benefit Beat

Volume 9, Issue 2

We're here to serve you!

Fall 2011

UPDATE: Healthcare Reform Act - Impact on the Church and Other Considerations

The following is an update on some of the provisions of PPACA (updates in blue).

2010

1. Prohibits individual and group health plans from placing lifetime limits on essential health benefits (EHBs) including preventive and wellness services. On August 1st, 2011, the Obama Administration announced new standards mandating coverage of contraceptives under the Preventive Services Provision of PPACA. The new standards appear to cover all contraceptives that have been approved by the FDA. A religious exemption does apply with certain eligibility requirements. However, it has faced scrutiny by the Catholic Church because many/most Catholic hospitals and Catholic Charity organizations would not be eligible for the exemption. The USCCB is supporting proposed legislation that would broaden the religious exemption so that it would better apply to such entities.
2. Requires employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer, however, employees may opt out of coverage. The effective date of enactment is 3/23/10. For all practical purposes, an employer cannot comply until regulations are issued. The start date for this provision now appears to be in 2014.

2011

1. Requirement to report medical (and assumed Rx) loss ratio- Must provide rebates to consumers for the amount of the premium spent on clinical services that is less than 85%. Does not

apply to self-funded plans.

2. Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program is financed through voluntary payroll deductions. However, all working adults will be automatically enrolled in the program unless they choose to opt-out, effective January 1, 2011. HHS recently determined the CLASS program was not viable and could not be implemented. The Obama Administration announced it was unworkable and would be dropped.
3. Requires employer W-2 reporting of the value of health benefits provided to employees. In transitional relief, it appears that since self-insured church plans are not subject to COBRA continuation coverage requirements, they do not have to comply for the 2012 Form W-2s. Insured church plans must comply unless the employer can qualify for another category of transitional relief. Furthermore, if an employer was required to file fewer than 250 W-2 forms in 2011 (the preceding year); they appear to also receive transitional relief and will not have to comply for 2012.

2012

- 1, Imposes a fee on insured and self-insured health plans to finance a patient-centered outcomes research trust fund. It appears that employers who sponsor self-funded plans must pay \$1 per participant for year 2013, \$2 for 2014 then \$2 indexed by annual medical inflation for years 2015-2019. The fees are scheduled to take effect for policy or plan years ending after

September 30th, 2012.

2. A summary of coverage and benefits must be developed and distributed to applicants and enrollees. The Department of HHS will develop standards for this summary. HHS has released an interim template to be used as the Summary of Benefit Coverage (SBC) document. CMG has confirmed that most carriers will provide assistance with this requirement but none have determined if/what fees will apply for this service. This requirement starts March 23, 2012 and states a SBC must be provided to:
 - * participants or beneficiaries upon request, no later than 7 days following the request,
 - * special enrollees within 7 days of a request for enrollment assuming a special enrollment right under HIPAA exists, and
 - * a participant or beneficiary, with respect to each benefit option for which the participant or beneficiary is eligible, no later than the first date the participant is eligible to enroll (or with any written application materials distributed before enrollment).

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Watch for more details

The 2012 Employee Benefit Buying Alliance meeting will be held January 31st and February 1st in Ft. Lauderdale, FL at the Westin Beach

Resort. Invitations will be sent shortly.



Qualified Mid-Year Status Changes

Special enrollment provisions allow individuals who previously declined health coverage to enroll for coverage. Special enrollment rights arise regardless of a plan's open enrollment period. Enrollment changes must be approved based on a qualified mid-year status change. Location administrators should collect necessary documentation from the employee prior to reporting the change as some carriers/administrators may require proof or verification for these changes.

Here are the Qualified Mid-Year Changes in Status as defined by the Internal Revenue Code:

1. Change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
2. Change in number of dependents due to birth, adoption, placement for adoption, legal guardianship or death of a dependent; NOTE: any child under age 19 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as self pay privilege continuation coverage) for the child;
3. Change in employment status of Employee, spouse or dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under Family and Medical leave Act (FMLA) or change in worksite;
4. Changes in employment status of Employee, spouse or dependent resulting in eligibility or ineligibility for coverage;

5. Change in residence outside of an HMO service area of Employee, spouse or dependent;
6. Changes which cause a dependent to become eligible or ineligible for coverage;
7. Loss of coverage due to the exhaustion of another Employer's COBRA or continuation benefits, provided you were paying for premiums on a timely basis;
8. Employee or eligible Dependent incurs a claim that would exceed a lifetime limit of all benefits (Note: this may not apply due to PPACA);
9. Termination of employee's or their Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility within 60 days of termination;
10. Employee or their Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP within 60 days of determination of subsidy eligibility;
11. Change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent;
12. The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare, or enrolls or increases coverage due to loss of Medicare eligibility;
13. If the cost of benefits increases or decreases significantly during a benefit period; and
14. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan.

TIPS

- * Become familiar with the events that can trigger a special enrollment right.
- * Be sure the requested enrollment is within **30** days of a marriage, birth, adoption, placement of a child for adoption, or any event that results in a loss of

eligibility for health coverage or within **60** days of the loss of coverage under a State CHIP or Medicaid program or a determination of eligibility for premium assistance under those programs.

* Any change in coverage must be consistent with the change in status. Please do not hesitate to contact CMG with any questions or concerns.



Welcome. Donna Johnson!

The Member Benefit Services Department continues to grow! Donna Johnson joined Catholic Mutual Group in June of 2011 as a Benefit Specialist. Donna has over 25 years of experience in the insurance/employee benefits industry and has a very strong self-funding background.

Welcome, Donna!

Visit the Catholic Mutual website for more information about the benefit programs and services available through the Employee Benefit Buying Alliance. Check us out at www.catholicmutual.org and click on Member Benefits under the Services tab.

Client Testimonial—Archdiocese of Newark

“The Catholic Mutual Group (CMG) has really been an answer to our prayers here at the Archdiocese of Newark. Prior to 2006, our first year with CMG, we seemed to be on the unending treadmill of escalating benefits costs. Each renewal year we would raise deductibles and/or reduce benefits on our fully insured plans in order to keep our renewal increase tolerable.

In the Catholic Mutual Group, we have a partner who specializes in meeting the insurance needs of diocesan and other church plans. Their mission is to serve the Church.

Since we have been with them, they have fully coordinated the transfer of our medical plan from Oxford to UnitedHealthcare and handled much of the workload that otherwise would have been done by staff.

They facilitated the transfer of

our administration and billing after our former administrator resigned the account with short notice. They negotiated the transfer of our prescription coverage and group life plans, resulting in more favorable terms for our plan. As the coalition continues to grow, we enjoyed deeper discounts on our prescription drug plan.

CMG provides full support for the Medicare Part D subsidy applications relieving staff of that responsibility. They are familiar with the Archdiocese and our programs and provide on-going consultation and support for our plans, including detailed reporting and analysis of how the plans are running and they have successfully shep-



herded several difficult large claims thru the reinsurer.

Best of all is that they provide these services by waiving or taking reduced commissions on several of our plans.

As you can see, I cannot say enough good things about the service the employees at The Catholic Mutual Group bring to our employee benefits needs. They act as true partners with us not just through words but through their deeds.

My hope is that more (Arch) dioceses' and church groups take advantage of their services, which would result in lower costs for us all.”

**Deacon John J. McKenna,
K.H.S., SPHR
Executive Director of Human
Resources
Archdiocese of Newark**

Congratulations, Matt Hartz!



Catholic Mutual Group would like to Congratulate Matt Hartz, Benefits Analyst, on successfully completing his Registered Health Underwriter (RHU) designation.

Way to go, Matt!!

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3. Health plans must notify enrollees 60 days prior to the effective date of any material changes to coverage that are not reflected in the most recent summary. [This relates to the prior bullet regarding Summary of Benefit Coverage.](#)

2014

1. Assesses employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit, a fee of \$2,000 per full-time employee, excluding the first 30 employees. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving premium assistance for State or Federal Exchange coverage because the employee's income is at or below 400% of the Federal Poverty

Level and either:

- * Employer coverage is not "affordable" (i.e., costs more than 9.5% of total household income) or
- * The plan does not provide minimum value (i.e., plan does not pay 60% of total allowable costs), will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee (minus the first 30). A question to consider is how will the employer determine the employee's household income?
- * [Proposed Employer "Safe Harbor" coverage would be considered "affordable" if the premium contribution for single coverage does not exceed 9.5% of an employee's W-2 wages.](#)
- * [Small employers must offer coverage that's "affordable" and provides "minimal value". Tax credits](#)

[will be available for employers with fewer than 25 employees. Since the Church is tax exempt, we are unsure how these tax credits will apply.](#)

2. Requires employers that offer coverage and make a contribution to provide free choice vouchers to qualified employees for the purchase of qualified health plans through State or Federal Exchanges. The voucher must be equal to the contributions that the employer would have made to its own plan. Employees qualify if their required contributions under the employer's plan would be between 8 and 9.8 percent of the employees taxable income for the year, whose household income is less than or equal to 400% FPL and who do not participate in a health plan offered by the employer. [This was repealed as part of the final budget agreement in April 2011.](#)

