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HEALTH CARE REFORM: THE EMPLOYER PERSPECTIVE

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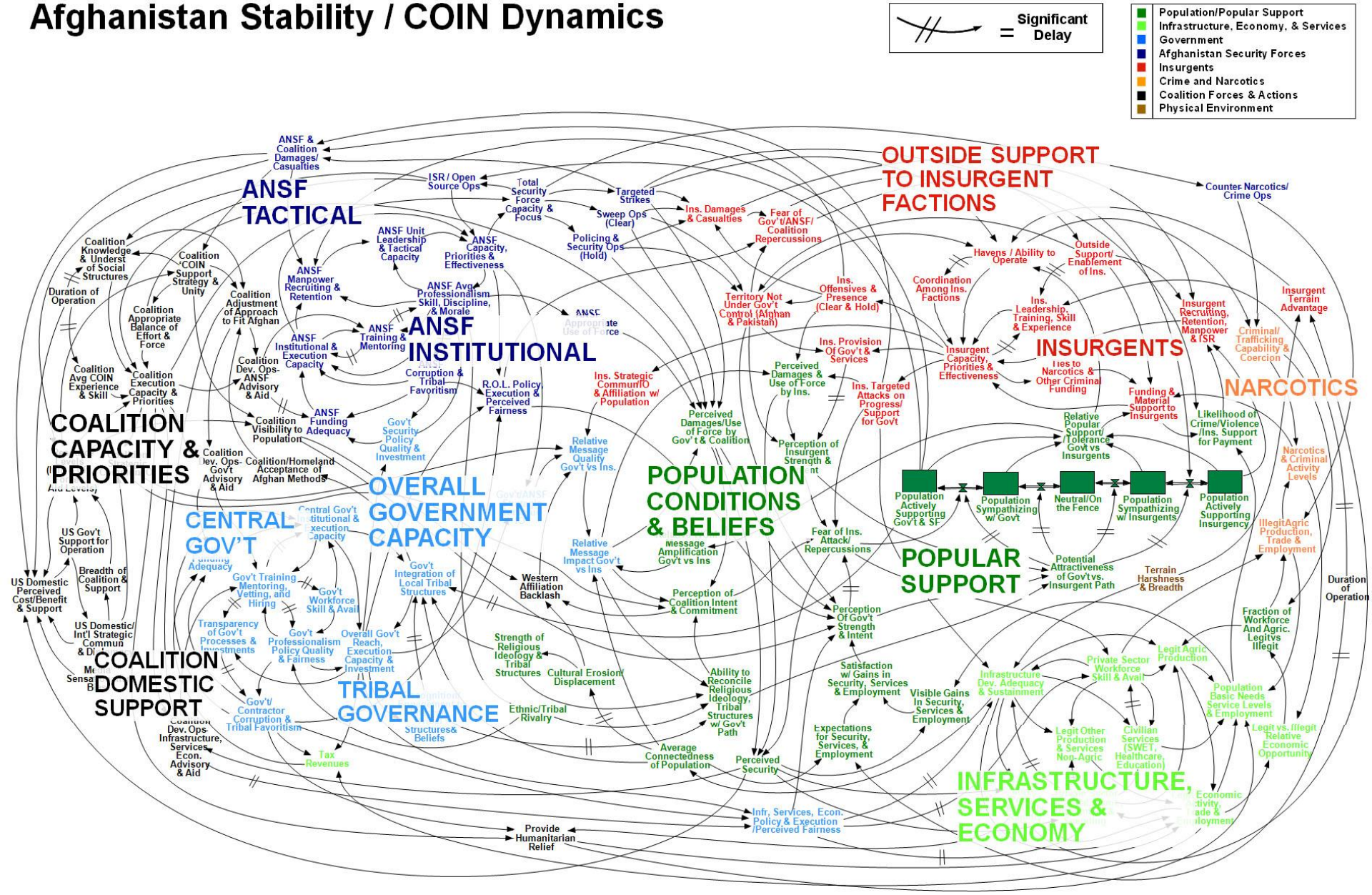
The New Environment

Two Different Bills

- H.R. 3590 – Patient Protection And Affordable Care Act, signed into law March 23, 2010

- H.R. 4872 – Health Care And Education Reconciliation Act of 2010, signed into law March 30, 2010

Afghanistan Stability / COIN Dynamics



WORKING DRAFT – V3

Individual Coverage Mandate

- Effective 2014, individuals will be required to maintain “minimum essential coverage”
- Dollar penalties will apply for failing to maintain this coverage
- Entities that provide “minimum essential coverage” must file annual reports
- More detail later

Employer Mandate

- Employers aren't required to provide coverage, but starting in 2014, medium and larger employers will be subject to a "play or pay" mandate
- Employers with at least 50 FTEs will generally be subject to an excise tax ("free rider penalty") if they do not provide sufficient coverage

Health Insurance Exchanges

- PPACA requires each state to establish a health insurance exchange by 2014
- Exchange will be to provide health coverage to individuals and employers with 100 or fewer employees
- States can choose initially to limit to smaller employers (50 or less) and to offer to larger employers beginning in 2017

Health Insurance Exchanges

- Establishes concept of “qualified health plan”
- All plans offered through the exchange must be qualified health plans, which means they pass through to employees no more than 40% of total benefit costs, and limit out of pocket expenses to HSA thresholds

Health Insurance Exchanges

- Plans for employers must limit deductibles to $2,000 ($4,000 for families)
- Individuals and families with income at or under 400% of federal poverty level are eligible for a subsidy of up to 2/3 of premium charged for “essential health benefits” package (to be defined by regulation)

Health Insurance Exchanges

- Provides for various levels of permissible coverage (bronze, silver, gold, as well as “young and invincible”)
- Employers will have the primary obligation to provide their employees with information about the exchange

The Good News

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Small Employer Tax Credit

- Starting in 2010, small employers may qualify for a tax credit
- Requirements for credit:
  - Employer must employ fewer than 25 FTEs
  - Employer must pay average annual wages of less than $50,000 per FTE
  - Employer must contribute a uniform percentage of at least 50% of premium cost of single coverage for enrolled employees

Small Employer Tax Credit

- Maximum Credit
  - Through 2013, 35% of premiums paid (25% for eligible tax-exempt employers)
  - Beginning in 2014, will increase to 50% (35% for eligible tax-exempt employers)
- Credit is phased out for employers with 10 to 25 employees and average annual wages of $25,000 to $50,000

Early Retiree Reinsurance

- HHS program will reimburse employers for a portion of costs for covering early retirees and their dependents
- An early retiree is age 55 through 64 and not actively employed by the employer maintaining the plan
- Plan must meet certain eligibility requirements

Early Retiree Reinsurance

- Plan sponsor is eligible for reimbursement of 80% of retirees' covered claims from $15,000 to $90,000
- HHS will conduct annual audits of programs receiving these benefits
- Funding is limited – expires when $5 billion runs out or at end of 2013
- HHS has issued draft applications and instructions, and expects to start accepting applications later in June

Simple Cafeteria Plans

- Effective 2011, PPACA permits small employers to establish a new type of cafeteria plan
- This plan will be exempt from the regular non-discrimination requirements of IRC Section 125
- Plans must meet specific contribution, eligibility and participation requirements

Temporary High Risk Pool

- HHS will establish a temporary high-risk health insurance pool program (ending after 2013, when exchanges are in place)
- There are various requirements for obtaining high risk pool coverage
- There are sanctions for employment-based health plans that try to dump participants onto this program

CLASS Program

- Effective 2011, HHS will establish a national employee-funded long-term care program
- Involvement is voluntary, but employers are encouraged to participate and offer automatic enrollment
- Employers are required to facilitate payroll deduction

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The Bad News

How (And How Soon)

- PPACA will impact every business that maintains a health plan
- The first significant set of changes will affect employer group health plans at the start of the first plan year after 9/23/2010 (1/1/2011 for calendar year plans)

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Immediate Impact

- Small employer tax credit
- Early retiree reinsurance program
- Elimination of pre-existing condition limitations for children (under 19)
- Temporary high risk pool for individuals
- 60-days' prior Notice of Material Modifications?

Beginning In 2011

- Lifetime, annual benefit limit restrictions
- Non-discrimination rules for insured plans
- Expansion of dependent coverage rules
- Over the counter medications not permitted from FSA, HSA, HRA
- Form W-2 reporting for health care costs

Beginning In 2011 (cont.)

- Plan appeals process changes
- New cafeteria plan for qualified small employers
- Certain small group insurance market reforms
- Government long-term care insurance program (CLASS)
- New benefit summaries (2012)

Beginning In 2013

- Health flexible spending account cap
- Changes to rules governing itemized deductions for medical expenses
- Increased Medicare tax for high-income earners

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Beginning In 2014

- Employer “Play or Pay” provisions
- Individual mandate provisions
- Market reforms, including elimination of pre-existing condition exclusions, expansion of guaranteed issue and renewability, and prohibition against discrimination based on health status

Beginning In 2014

- Annual limit and waiting period restrictions
- Additional dependent coverage expansion
- HIPAA wellness incentives
- Minimum benefit package for small group market
- Purchasing exchanges for individual and small group insurance

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Beginning In 2018

- "Cadillac Plan" excise tax

Grandfathered Plans

Grandfathered Plans

- PPACA will require changes to all existing employer group health plans
- Grandfathered plans will be exempt from some requirements, but subject to others
- Grandfathered treatment will be easy to lose – by decreased coverage or increased employee cost sharing

Grandfathered Plans

- A grandfathered plan is a health plan in existence on the date PPACA became law, March 23, 2010
- The Reconciliation Act substantially reduced the value of grandfathering
- Grandfathered plans may admit new employees and dependents

Grandfathered Plans

- Effective 2011, grandfathered plans must:
  - Eliminate pre-existing condition limits for children under age 19
  - Provide for dependent coverage up to age 26 (with certain limits)
  - Eliminate lifetime maximums and certain annual limits
  - Eliminate coverage rescissions

Grandfathered Plans

- Effective 2014, grandfathered plans must:
  - Provide for dependent coverage up to age 26
  - Eliminate waiting periods in excess of 90 days
  - Eliminate pre-existing condition limits entirely
  - Eliminate annual limits on benefits

Grandfathered Plans

- Grandfathered plans need not comply with Code Section 105(h) non-discrimination requirements (fully insured plans)
- Grandfathered plans will not have comply with the expanded appeals rights

Grandfathered Plans

- Agencies released interim regulations describing changes that will trigger loss of grandfathered status
- The following will cause a loss of grandfathered status:
  - Change of insurance company
  - Increasing participant premium cost by more than 5%
  - Increase in a fixed copayment exceeding the greater of:
    - $5.00; or
    - 15% plus adjustment for medical inflation

Grandfathered Plans

- Increase in fixed cost sharing (other than copayment), like deductible or coinsurance exceeding 15% plus medical inflation adjustment
- Addition of annual limit
- Elimination of all or substantially all benefits to diagnose or treat a particular condition

Grandfathered Plans

- The following will not cause loss:
  - Compliance with laws;
  - Improving benefits should not trigger loss; or
  - Changing TPAs

Grandfathered Plans

- Transitional Rules:
  - Changes effective after March 23, 2010 are considered to be part of plan/policy as of March 23, if:
    - Made pursuant to a legally binding agreement entered into on or before March 23;
    - Made pursuant to a filing on or before March 23 with a DOI; or
    - Made pursuant to a written amendment that was adopted before March 23.

These changes will not trigger loss of grandfathered status.

Grandfathered Status

- Changes made after March 23, but before June 14, 2010 (date regulations were issued) may be “undone” to preserve grandfathered status. Revocation of changes must occur before first day of plan year commencing after September 23, 2010.
- Must include notice advising participants that plan deems itself grandfathered.

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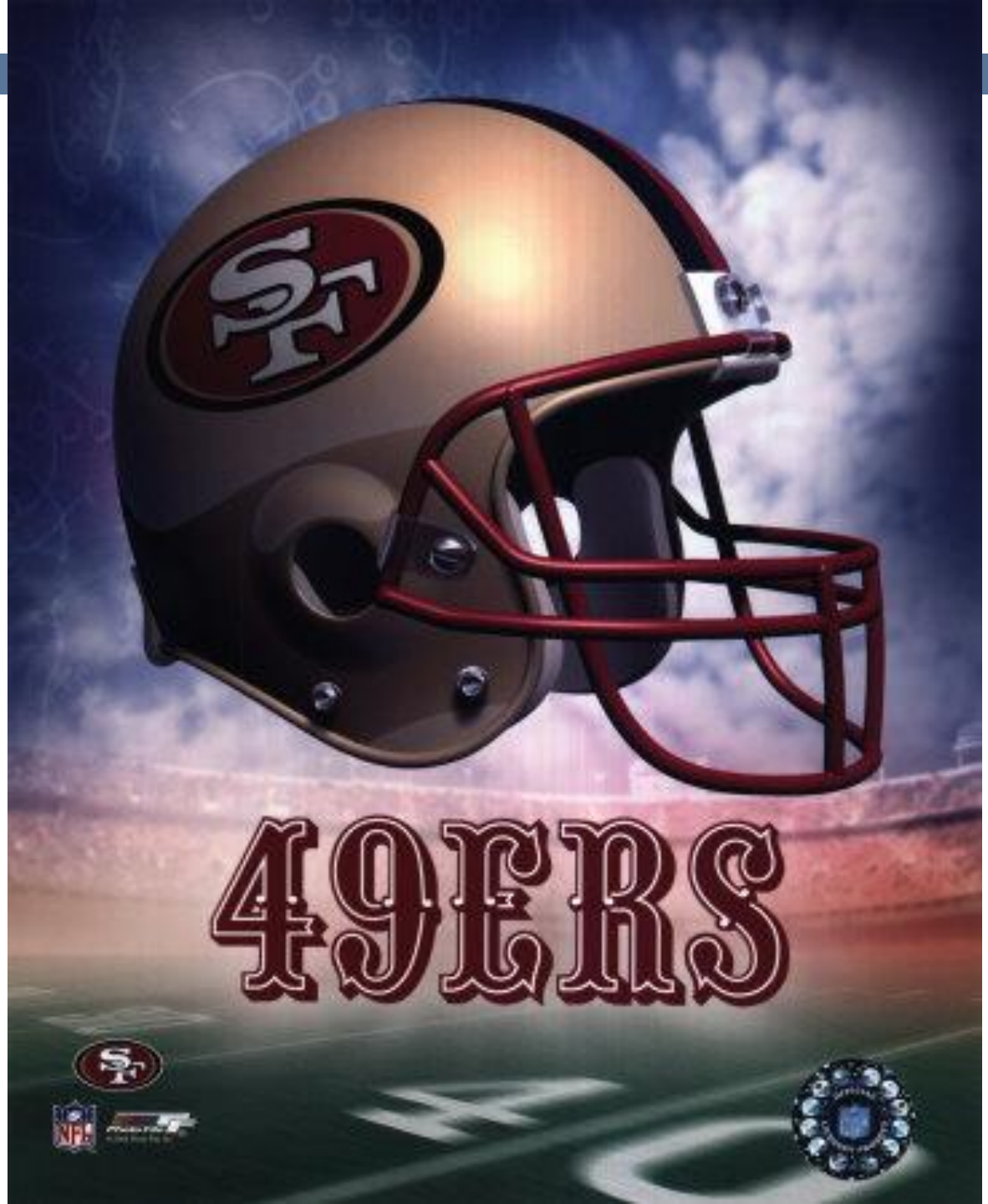
Employer Mandate



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Employer Mandate

- The requirement is a “play or pay” mandate for medium and large employers
- Employers with at least 50 FTEs will generally be subject to an excise tax (“free rider penalty”) if they do not provide sufficient coverage
- The excise tax becomes effective in 2014

Employer Mandate

- Part-time employees must be factored into the calculation as full-time equivalents
- For these purposes, employers must also take into account employees of any other entity under common control
- It is not clear how temporary employees will be treated

Free Rider Penalties

- If the employer has the equivalent of 50 FTEs and does not provide any health coverage, and if at least one full-time employee receives governmental assistance to purchase insurance through a state exchange, the free rider penalty is $2,000 times the total number of FTEs (disregarding the first 30 FTEs)

Free Rider Penalties

- If the employer has at least 50 FTEs and health plan coverage does not meet certain affordability standards, the free rider penalty is $3,000 for each employee who is eligible for governmental assistance and receives coverage through the state exchange (limited to the total penalty for no coverage)

Free Rider Penalties

- Plan does not meet the affordability standards if: (1) the employer does not pay at least 60% of the cost of group health plan coverage or (2) the employee's required contribution for coverage is greater than 9.5% of household income

Free Choice Vouchers

- Effective 2014, employers with plan must provide “free choice vouchers” for exchange purchase if (1) employee meets income standards (income less than 400% of poverty level); (2) employee’s required plan contribution is between 8% and 9.8% of household income; and (3) employee does not enroll in the employer’s group health coverage

Free Choice Vouchers

- The voucher is used to purchase health coverage through a state insurance exchange and it results in the employer paying the amount of the voucher directly to the exchange (if the cost of the exchange coverage is less than the voucher, the difference will be paid to the employee)

Free Choice Vouchers

- The voucher must be for at least the amount the employer would have contributed had the employee enrolled in the highest cost option available under the employer's plan
- The employer will not be assessed a free rider penalty with respect to employees who receive free choice vouchers

The Raised Floor

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Pre-Existing Conditions

- Prohibits pre-existing condition exclusions or limitations (including those that have been lawful under HIPAA)
- Changes apply to insured and self-insured group health plan

Pre-Existing Conditions

- Prohibition effective in two phases:
  - Effective 2011, group health plans may not impose any pre-existing condition limitation or exclusion against a child under age 19
  - Effective 2014, those plans may not impose any pre-existing condition limitation or exclusion on a covered person of any age
- HHS may seek to accelerate the 2011 deadline

Annual / Lifetime Limits

- Effective 2011, no group plan may impose a lifetime dollar limit on the value of "essential health benefits"
- Effective 2011, HHS will establish a restriction on annual limits that may be imposed for "essential health benefits"
- HHS will define "essential health benefits" by regulation

Annual / Lifetime Limits

- Effective 2014, no insured plan or self-insured plan may impose an annual dollar limit for “essential health benefits”
- It appears that plans may be permitted to include annual or lifetime “per beneficiary” limits on specific covered benefits if not under “essential health benefits”

Preventive Care

- Effective 2011, group health plans must cover certain types of preventive care, immunizations, child preventive services, and women's preventive services without any cost sharing
- Cost-sharing for these purposes includes co-payments, co-insurance charges, and deductibles

Preventive Care

- HHS is required to establish a minimum interval for various types of preventive services, which shall not be less than one year
- Grandfathered plans are not subject to these requirements

Rescissions

- Effective 2011, no insured or self-insured health plan may rescind coverage once an enrollee has become covered
- PPACA recognizes an exception for cases involving fraud or intentional misrepresentation

Health Status Discrimination

- Effective 2011, group health plans cannot establish eligibility rules based on
  - Health status
  - Medical condition or disability
  - Claims experience
  - Receipt of health care
  - Medical history
  - Genetic information
  - Evidence of insurability

Health Status Discrimination

- However, plans may continue to offer wellness credits based on health factors – with limitations
- Generally, group health plans already live with these limitations under HIPAA

Dependent Coverage

- Effective 2011, group health plans that offer dependent coverage must make coverage available to any child of a participant until the child reaches age 26
- This extension is not limited to full-time students or unmarried children
- Until 2014, plans may exclude adult children if they are eligible under another employer-sponsored health plan

Dependent Coverage

- PPACA does not require plans
  - to offer dependent coverage
  - to cover the child of a dependent child
- This rule will apply to grandfathered plans
- The tax benefits for covering qualifying tax dependents will also apply to all adult children covered because of PPACA

Dependent Coverage

- According to interim regulations by IRS/DOL/HHS, plans cannot impose a surcharge or increase the employee's cost share based on the age of the child
- Several insurers have voluntarily expanded dependent coverage more quickly than the statute requires

Pay-Based Discrimination

- Effective 2011, insured plans (unless grandfathered) are subject to non-discrimination rules of IRC Section 105(h)
- 105(h) prohibits discrimination in favor of highly compensated employees
- If the plan fails to comply, highly compensated participants are taxed on all or part of their plan benefits

Pay-Based Discrimination

- 105(h) rules already apply to self-insured plans - will “level the playing field”
- This change will raise issues for executive health benefits, commonly structured as insured programs
- Further guidance is expected on the consequences of violations
- Grandfather protection important here

Expanded Plan Appeals Process

- Effective 2011, plans must provide participants with new appeal rights – both internal and external
- The internal process appear to be satisfied by existing ERISA claims procedures
- External review will be new for most plans (likely established through state law or under HHS regulations)

Expanded Plan Appeals Process

- Participants are expected to have the explicit right to review their file and to present evidence and testimony as part of the appeals process
- Does not apply to grandfathered plans

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Health Savings Account Penalty

- Existing health savings account rules apply a penalty tax to distributions taken for non-qualifying expenses
- Effective 2011, the penalty tax will increase from 10% to 20%
- Distributions also are, and will continue to be, subject to regular income tax

Coverage/Benefit Summaries

- Effective 2012, plans must provide uniform summaries of coverage and benefits
- HHS will set standards, but
  - must be 4 pages or less, with type no smaller than 12-point font
  - must be in “culturally and linguistically” appropriate language
  - must use uniform definitions of standard insurance and medical terms

Coverage/Benefit Summaries

- The summary must describe coverage, including cost-sharing, for each category of “essential health benefits”
- The summary must include examples that illustrate common scenarios

Coverage/Benefit Summaries

- Distribution – must be provided to applicants and participants before enrollment; may be distributed in paper or electronic form
- Modifications – the plan must give 60-days' advance notice of a material change
- $1,000 penalty for each failure to provide the summary

Increased Medicare Payroll Tax

- Starting in 2013, individuals with wages of $200,000 and up ($250,000 for joint filers) will be subject to an additional 0.9% tax on wages in excess of those thresholds
- Excess tax applies only to the employee portion of the tax, not the employer portion (increases the employee portion from 1.45% to 2.35%)

Increased Medicare Payroll Tax

- Employers will collect and submit this additional tax
- Additional Medicare tax will apply to unearned income for those wage earners (3.8% of investment income to extent participant's annual income exceeds $250,000)

Wellness Programs

- PPACA codified the HIPAA wellness program requirements contained in HIPAA non-discrimination regulations
- If wellness plan reward is not conditioned on meeting a standard relating to a health status factor, then no additional requirements will apply, so long as participation offered to all similarly situated individuals

Wellness Programs

- Wellness Program Requirements
  - Reward cannot exceed specified percentage of cost of employee-only coverage under the health plan
  - Program must be reasonably designed to promote health and prevent disease
  - Individuals must have opportunity to qualify for reward at least once per year
  - Full reward must be made available to all similarly-situated individuals (including possible alternative standards for certain medical situations)

Wellness Programs

- Currently, the reward may be as high as 20% of the cost of employee-only coverage; will rise to 30% (with HHS/IRS authority to raise that limit to 50%)
- PPACA provides for 10-state demonstration project for programs of health promotion
- These provisions are effective in 2014

Limit On Waiting Periods

- Effective 2014, plans may not apply a waiting period that exceeds 90 days
- Employers should also reconsider related plan provisions, such as admission only on particular days (e.g., first day of month)
- It is not clear how prior time with a leasing company will count for these purposes

Automatic Enrollment

- Large employers (greater than 200 FTE) must provide for automatic enrollment of new full-time employees
- Auto-enrollment must be into the coverage option with the lowest premium (unless employee elects differently)
- Waiting period is permitted

Automatic Enrollment

- Employer must provide employees with adequate notice and an opportunity to opt out
- No explicit effective date, but HHS suggests will become effective upon issuance of implementing regulations

Reporting Requirements

- Effective 2011, employers must disclose the aggregate cost of employer-provided coverage on each Form W-2
- Effective 2014, employers with more than 100 FTEs must file an annual return disclosing whether the employer offers a health plan and describing the waiting period that applies

Reporting Requirements

- Additional annual reporting will be required of plans and insurers with respect of quality of care
- HHS and the states will develop a process for annual review (beginning with 2010 plan year) of unreasonable increases in premiums for coverage

Medicare Part D Subsidy

- Employers that offered retiree drug coverage that is equivalent to Medicare Part D now receive a federal subsidy of 28% of certain charges; the subsidy is currently exempt from taxation and also produces a tax deduction ("double-dip")
- Effective 1/1/2013, PPACA will eliminate the tax deduction for the subsidy amounts

The Lowered Ceiling

FSA, HSA, HRA

- Non-prescription (OTC) drugs (other than insulin) will no longer be eligible for reimbursement from FSA, HSA, or HRA (effective 2011)
- Flexible spending accounts must limit annual contributions to $2,500, indexed for inflation (effective 2013)

Cadillac Health Plans

- Effective 2018, “Cadillac” plans will be subject to 40% tax on the “excess benefit”
- Counts both employer and employee portions, as well as FSA and employer HRA/HSA contributions)
- Annual limit is $10,200 for individuals and $27,500 for families (as of 2018), and amounts are indexed for inflation

The high points

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