

Welcome

Healthcare Reform Impact on Employers

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Health Reform Legislation Overview

- President signed Patient Protection and Affordable Care Act on March 23
- Healthcare and Education Affordability Reconciliation Act signed on March 30
- Interpretation of the legislation requires examining both sources (together, the "Affordable Care Act" or "ACA")
- Effective dates vary - many begin with the first plan year beginning on or after September 23, 2010 (2011 for calendar year plans)

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Health Reform Legislation Overview

- Immediate Changes (2010 and 2011)
 - Sweeping reforms for both insured and self-funded health plans
 - Significant new regulation of the insurance business
 - New federal insurance programs for early retirees and high risk pools
- Longer-term Changes (2014)
 - State insurance exchanges will offer and regulate individual and small group coverage
 - Additional significant regulation of the insurance market, including guaranteed issue and community rating
 - Individuals will be required to have coverage and may be eligible for federal assistance for coverage
 - Large employers may be penalized if employees receive federal assistance for coverage
- This presentation focuses on what employers need to know

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Application of ACA

- Applies to individual and group health plans
- ACA categorizes plans, and some plans receive special treatment
 - Small/large
 - Grandfathered/not grandfathered
 - Insured/self-insured
 - Union/non-union
- Some plans are exempt
 - Retiree-only plans (less than two participants who are current employees)
 - Spin-off retirees to stand-alone retiree plan
 - HIPAA excepted benefits (e.g., stand-alone dental, vision, or disease-specific coverage)
 - Medical FSA plans
 - But some provisions are specifically applicable to Medical FSAs

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Grandfathered Plans

- What is a “grandfathered” plan?
 - In effect on 3/23/10; rules apply separately for each benefit package
- Grandfathered plans are exempt from some (but not all) of ACA provisions
- Regulations make it clear that grandfathered status is expected to be temporary
- Special rule for collectively bargained plans
 - Insured plan – grandfathered until the last CBA relating to coverage terminates
 - Self-funded plan – general grandfather rules apply
- Notice required in all employee communications describing plan benefits (DOL model notice available at www.dol.gov/ebsa/healthreform)

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Provisions That Apply to ALL Plans, Including Grandfathered Plans

- Coverage for adult children up to age 26
- No annual or lifetime limits on essential health benefits
- No pre-existing condition exclusion for enrollees < age 19 – none at all in 2014
- Waiting periods limited to 90 days in 2014

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Provisions That Apply Only To Non-Grandfathered Employer Health Plans

- Preventive care must be covered without cost-sharing
- IRS non-discrimination rules extended to insured employer plans
- Pediatrician may be child's primary care provider
- No authorization or referral required to see OB-GYN
- Pay emergency services at in-network benefit levels and cannot require pre-authorization
- Internal and external claims review processes
- Must disclose certain plan data and design characteristics
- Report to HHS and enrollees regarding benefits that improve wellness
- Limits on annual out-of-pocket costs payable by participants
- Coverage of routine costs associated with clinical trials

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Changes That Cause Loss of Grandfathered Status

- Significant changes reducing benefits (e.g., elimination of coverage for diabetes, cystic fibrosis or HIV/AIDS)
- Significant changes increasing employee cost-sharing
 - **Any** increase in member coinsurance percentage
 - Copays may be increased by the greater of \$5 (adjusted annually for inflation) or a percentage equal to medical inflation plus 15% (cumulative from March 23, 2010)
 - Deductibles may be increased only by a percentage equal to medical inflation plus 15% (cumulative from March 23, 2010)
- Decrease rate of employer contributions by more than 5% of total cost
- Adding or decreasing annual limits on covered services
- Changing insurance carriers
 - Gives leverage to current insurance carriers
 - Exception for collectively bargained plans until CBA expires

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Permissible Changes That Do Not Cause Loss of Grandfathered Status

- Cost adjustments to reflect medical inflation
- Adding new benefits and limited adjustments to existing benefits
- Adding new enrollees
- Voluntary adoption of new consumer protections
- Changes to comply with state or federal laws (e.g., Mental Health Parity and Addiction Equity Act)
- If have lifetime dollar limit, may add annual limit not lower than the lifetime limit until 2014

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Key Determination: Whether To Keep Grandfather Status

Compliance with provisions applicable only to non-grandfathered plans

vs.

Cost of retaining grandfather status and risk of having a Cadillac Plan

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What Must ALL Plans Do?

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Coverage for Adult Children up to Age 26

- General Rule: Plans providing dependent coverage must offer coverage to adult children up to age 26
 - Effective for plan years beginning on or after September 23, 2010 (2011 for calendar year plans)
 - If plan is grandfathered, need not offer before 2014 if child is eligible for employer-sponsored coverage other than a group health plan of a parent
 - Exception is hard to administer
- Coverage required regardless of marital, student, residence or tax-dependent status
 - Issue: Definition of child
 - Tax guidance uses IRC 152(f) definition of child (natural child, step-child, adopted child, foster child)
 - Regulations were issued, but do not define child
 - Without definition, grey area regarding whether the general rule applies to grandchild or custodial child coverage
 - Comments on the regulations have been submitted suggesting the IRC 152(f) definition be adopted

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Coverage for Adult Children up to Age 26

- Not required to cover adult child's spouse or children
- Coverage is tax-free through end of year child turns age 26
- May not charge a different premium or offer different benefits or coverage levels
- Must allow a 30-day open enrollment opportunity to children who aged out or were ineligible or denied coverage due to age restriction
 - Written notice must be provided to eligible adult children
 - Can provide to adult child by providing to parent participant
 - May be part of enrollment materials, but must be PROMINENT
 - DOL model notice available at www.dol.gov/ebsa/healthreform
- Many insurers have agreed to implement the changes before required

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Elimination of Lifetime Limits

- General Rule: No lifetime dollar caps on "essential health benefits"
 - Effective for the first plan year beginning on or after September 23, 2010 (2011 for calendar year plans)
 - Applicable to both grandfathered and non-grandfathered plans
- If individual has been excluded due to previously hitting cap, must allow back in plan
 - Special re-enrollment right
 - Must allow 30 days to re-enroll at start of plan year
 - Similar to HIPAA special enrollment and age 26 rules
 - Required written notice (DOL model notice available at www.dol.gov/ebsa/healthreform)
- Number of visit and per procedure dollar limits appear to be allowed

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Restriction on Annual Limits

- General Rule: No annual dollar caps on “essential health benefits”
 - Effective for the first plan year beginning on or after September 23, 2010 (2011 for calendar year plans)
 - Applicable to both grandfathered and non-grandfathered plans
- Restricted annual limits are permitted before 2014
 - 2011 Plan Year – \$750,000 minimum (per person)
 - 2012 Plan Year – \$1.25 million minimum (per person)
 - 2013 Plan Year – \$2 million minimum (per person)
- Limits on number of visits or per procedure dollar limit may be okay
- Benefit-specific annual dollar limits may not be permitted

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Restricted Annual Limits – Transition Rules

- Only allowed until 2014
- Waiver – only for years before 2014
 - May be requested from HHS
 - Guidance coming on how to apply
 - Standard is if compliance would result in a significant decrease in access to benefits or significant increase in premiums
 - Geared toward limited benefit plans (mini-med)
- If have lifetime limit can add annual limit without losing grandfathered status if:
 - Annual limit must be equal to or greater than existing lifetime limit and
 - Annual limit is not lower than the applicable restricted limit

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Lifetime and Annual Limits

- Essential Health Benefits
 - Statute includes:
 - Ambulatory services
 - Emergency services
 - Hospitalization
 - Maternity & Newborn Care
 - Mental health and substance use disorder services
 - Prescription drugs
 - Rehabilitative & Habilitative Services and Devices
 - Lab Services
 - Preventive & Wellness Services (including disease management)
 - Pediatric services, including dental and vision care
 - Good faith effort required until further defined
 - Regs will further define - only have regs on preventive care

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Lifetime and Annual Limits

- Not applicable to:
 - Health FSA, MSA, HSA
 - HRA integrated with a plan that complies with rule
 - Retiree-only or HIPAA excepted benefits
- Agencies considering whether applicable to non-retiree, stand-alone HRA - requested comments

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Pre-Existing Conditions

- General Rule #1: No pre-existing condition limitations on enrollees < age 19
 - Effective for the first plan year beginning on or after September 23, 2010
 - Applicable to both grandfathered and non-grandfathered plans
- General Rule #2: No pre-existing condition limitations for enrollees regardless of age
 - Effective beginning in 2014
 - Applicable to both grandfathered and non-grandfathered plans
- Not a preexisting condition exclusion if the exclusion applies regardless of when the condition arose relative to commencement of coverage

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Waiting Periods

- General Rule: Eligibility waiting period may not exceed 90 days
 - Effective beginning 2014
 - Applicable to both grandfathered and non-grandfathered plans
- Waiting regulations

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Rescissions

- General Rule: Health plan coverage may not be rescinded unless there is fraud or misrepresentation
 - Effective for the first plan year beginning on or after September 23, 2010 (2011 for calendar year plans)
 - Applicable to both grandfathered and non-grandfathered plans
- Rescission is a cancellation with a *retroactive* effective date; so if prospective only, it is fine
 - Retroactive cancellation is ok if due to nonpayment of premiums
- Inadvertent omission or unintended misrepresentation does not rise to level of fraud or misrepresentation that permits rescission
- Permissible rescission must have 30-day advance notice, but can have retroactive effective date

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Automatic Enrollment

- General Rule: If employer offers one or more health plans, it must automatically enroll new employees in a plan
 - Effective date unknown
 - Applies to both grandfathered and non-grandfathered plans
- Applicable only to employers with > 200 F/T employees
 - Waiting for regulations to define "F/T employee" and provide specifics

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What Must Non-Grandfathered Plans Do?

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Emergency Care

- General Rule: Plans must provide coverage for emergency care without prior authorization and regardless of whether the service was provided in-network or out-of-network
 - Effective for the first plan year beginning on or after September 23, 2010 (2011 for calendar year plans)
 - Grandfathered plans exempt
- Cannot restrict out-of-network more than restrict in-network
- Some cost-sharing okay
 - Deductible or out-of-pocket max for out-of-network is okay if applies to all out-of-network services, not just ER
 - Copayment and coinsurance okay in-network formula
 - Must use base amount that complies (limited by UCR, Medicare & network rate)
 - Out-of-network provider may bill patient balance for charges over base amount
- Only applies to emergency services in a hospital emergency room
- Does not apply to urgent care

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Choice of Providers

- General Rule: May choose any primary care physician available to accept participant
 - Pediatrician
 - Any in-network provider
 - OB/GYN
 - Can see OB/GYN professional without authorization or referral (doesn't have to be physician)
 - Plan may require further treatment to be subject to authorization or referral
 - Effective for the first plan year beginning on or after September 23, 2010 (2011 for calendar year plans)
 - Grandfathered plans are exempt
- Only applies if you must designate primary care physician and be referred to specialists
- Notice must be given to participants
 - DOL model notice available at www.dol.gov/ebsa/healthreform
 - Must be in SPD

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Preventive Care

- General Rule: Must offer and pay 100% for preventive care as determined by federal guidelines
 - Effective for the first plan year beginning on or after September 23, 2010 (2011 for calendar year plans)
 - Grandfathered plans are exempt
- Categories of services include:
 - Evidence-based services
 - Recommended immunizations
 - Screenings for women
 - Screenings and services for children
- Cost-sharing includes co-pays, coinsurance, and deductibles
- Regulations go beyond traditional concept of preventive care. List may be found at:
<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>

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Nondiscrimination

- General Rule: ACA applies IRC 105(h) nondiscrimination rules to insured plans
 - Effective for plan years beginning on or after September 23, 2010 (2011 for calendar year plans)
 - Grandfathered plans exempt
- Tests
 - Eligibility Test - Must offer coverage on non-discriminatory basis
 - Benefits/Coverage Test - May not discriminate in favor of highly compensated individuals
- Employer pays excise tax of \$100 per day, per individual for non-compliance

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Appeals

- General Rule: Mandatory internal and external appeals process
 - Effective for the first plan year beginning on or after September 23, 2010 (2011 for calendar year plans)
 - Grandfathered plans are exempt
- Coverage must continue until conclusion of appeal
- Waiting for regulations
- Notice required

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Annual Limits on Participant Out-of-Pocket Costs

- General Rule: annual out-of-pocket costs for essential health benefits cannot exceed the limits for high deductible health plans
 - Currently \$6,950 for individuals; \$11,900 for families
 - Effective beginning 2014
 - Grandfathered plans are exempt
- Out-of-pocket costs include deductibles, coinsurance, copayments, etc.

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Clinical Trials

- General Rule: Must cover routine costs in federally funded or approved clinical trials (or exempt drug trials) for “qualified individuals”
 - Effective beginning 2014
 - Grandfathered plans are exempt
- “Qualified individual”
 - Eligible to participate in trial for cancer or other life-threatening medical condition
 - Patient referred by network provider who believes patient will benefit
 - Patient provides the plan with medical and scientific evidence that it meets the conditions for participation
- Routine costs include costs the plan would cover, but for the clinical trial, and exclude:
 - Investigational items, devices and services
 - Items and services solely for data collection
 - Service that is clearly inconsistent with established standards of care
- Waiting for regulations

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Wellness Programs

- General Rule: Wellness incentive permitted to be 30% of premium (currently 20%)
 - Effective beginning 2014
 - Grandfathered plans *may* not be able to take advantage of increased incentives
- Regulations may increase the incentive maximum up to 50%

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Consumer Driven Options

- Varying effective dates
- General Rule #1: OTC drugs (without prescription) excluded from FSAs, HRAs, HSAs, and MSAs (except insulin)
 - Effective 2011 calendar year
- General Rule #2: Additional tax on non-qualifying HSA and MSA distributions increased from 10% to 20%
 - Effective 2011 calendar year
- General Rule #3: FSAs limited to \$2,500 (thereafter indexed)
 - Effective 2013 calendar year

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What Happens in 2014?

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Employer “Play or Pay” Penalties

- Effective beginning in 2014
- Coincides with state-sponsored healthcare exchanges
- Two potential penalties:
 - Failure to offer coverage
 - Failure to offer affordable coverage

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Employer Penalties

- Apply only to employers that had ≥ 50 F/T and FTE employees in the prior year
 - Controlled group members are aggregated
 - “FTE” determined by dividing the aggregate number of hours of service of employees who are not F/T employees for the month by 120
 - Employee is “F/T” if averaged 30 or more hours per week each month
- Apply only if one or more F/T employees obtains coverage through an exchange and receives a government subsidy
 - Total household income between one and four times the poverty line (e.g., for 2009, \$22,050 – \$88,200 for a family of four)

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Employer Penalties: Failure to Offer Coverage

- \$2,000 per F/T employee per year
 - FTEs are not counted as F/T employees for purposes of penalty calculation
- Exclude first 30 F/T employees from penalty calculation
 - Applied ratably across controlled group
- 1/12th paid each month
- Penalty amounts indexed for years after 2014

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Employer Penalties: Failure to Offer Affordable Coverage

- Unaffordable if:
 - Plan's share of total cost of benefits is less than 60% or
 - Employee's share of premium is >9.5% of total household income
- \$3,000 per year per F/T employee who receives a subsidy in an exchange
 - 1/12th paid each month
 - Maximum penalty capped at what the penalty would have been had the employer failed to offer minimum essential coverage
 - Indexed for years after 2014

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Employer Penalties: Examples

- Example 1 – Large employer. Assume an employer has 100 P/T employees who, in the aggregate, worked 2,280 hours during the month and 35 F/T employees. The employer would be a “large employer”, because it has 54 F/T and FTE employees: 2,280 divided by 120 = 19 FTEs, plus 35 F/T employees.
- Example 2 – Failure to offer coverage penalty. If the employer in Example 1 does not offer health insurance to its 35 F/T employees and one F/T employee receives government assistance in an exchange, then the employer will be subject to a monthly penalty of approximately \$833 (35 F/T employees less 30, multiplied by \$2,000/12).
- Example 3 – Failure to offer affordable coverage penalty. Assume the employer in the previous examples does offer health insurance, but 10 F/T employees opt out and obtain subsidized coverage through an exchange. The employer's monthly penalty would still be approximately \$833. This is because the penalty for offering unaffordable coverage (10 times \$3000/12 (or \$2,500)) is capped at what the penalty would have been, had the employer failed to offer any coverage (approximately \$833, from the previous example).

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Free Choice Vouchers

- Effective beginning in 2014
- General rule: employers who offer and subsidize coverage must offer “Free Choice Vouchers” to qualified employees
- Employee is “qualified” if:
 - Employee pays between 8 and 9.8% of household income for coverage
 - Employee enrolls in exchange
 - Employee’s household income is between one and four times the poverty level)
- Value = the largest amount the employer would have paid to subsidize the employee’s coverage under the employer plan
 - Excess goes to employee
- Employees receiving voucher are not eligible for government subsidy
 - Therefore, the unaffordable coverage penalty does not apply (i.e. employee’s cost of coverage between 9.5–9.8% of household income)
- Voucher is deductible for employer

What Happens in 2018?

“Cadillac” Tax

- Effective beginning 2018
- General Rule: Employer pays 40% excise tax on value of employer provided coverage exceeding:
 - \$10,200 for individual coverage
 - \$27,500 for other coverage (e.g., EE + 1, family)
- Increased thresholds:
 - Qualified retirees and employees in high risk jobs
 - \$11,850 for individual and \$30,950
 - Collectively bargained employees
 - \$27,500 applies to both individual and other
 - Plans carrying a higher premium cost because of age or gender
 - Regulations to be issued
- Indexing applies after 2018 (unless medical inflation is greater than expected before 2018)
- Includes on-site medical clinic value
- Excise tax is nondeductible
- Employer is subject to penalty equal to amount of underreported excise tax plus interest
- Examples
 - At 7% inflation, \$10,200 in 2018 is \$5,936 today (\$495/mo.)
 - At 7% inflation, \$27,500 in 2018 is \$16,005 today (\$1,334/mo.)

Notice and Reporting Requirements

Notice and Reporting Requirements

- W-2 Reporting
 - Effective for the tax year beginning January 1, 2011
 - Includes
 - Employer and employee portion of major medical, dental, and vision
 - On-site medical clinics and EAP
 - Value (for self-insured benefits) is generally determined the same as for COBRA

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Notice and Reporting Requirements

- Summary of coverage
 - First notice due no later than March 23, 2012
 - HHS required to develop standard form by March 23, 2011
 - 4 pages, 12 pt. font
 - Standard definitions
 - Substance
 - Coverage of and cost-sharing for essential benefits and other benefits determined by regulations
 - Exclusions
 - Information on whether coverage is "minimum essential coverage" and whether plan pays 60% of benefit costs
 - \$1,000 penalty per violation
 - 60 days advance notice of material modifications
- Quality of care reporting
 - Effective sometime after March 23, 2012 (need regulatory guidance)
 - Notice to employees and HHS on quality of care, e.g.
 - Wellness programs
 - Case management programs
 - Use of health information technology
 - Grandfathered plans are exempt

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Notice and Reporting Requirements

- Notice of state run exchanges
 - Current employees must receive a notice by March 1, 2013, and new employees must receive at time of hire
 - Availability of subsidy in the exchange and loss of employer subsidy unless employer provides Free Choice Voucher
- Reporting of health insurance coverage
 - Effective beginning in 2014
 - Report to IRS and employees whether the plan provides minimum essential coverage
 - Individual participant information including period of coverage
 - Employer information
 - F/T and FTE employees
 - Monthly premium and employer subsidy amounts
 - Employer's share of benefit costs

Additional Important Provisions

Early Retiree Reinsurance Program

- Effective for expenses incurred on or after June 1, 2010
- General Rule: Federal reinsurance for coverage of retirees age 55–65 (and dependents)
 - 80% of costs between \$15,000 – \$90,000 (per individual)
 - Expenses incurred prior to June 1, 2010 count toward the \$15,000 minimum
- Limited pool (\$5 billion)
 - Currently accepting applications
 - Incomplete or inaccurate applications rejected
 - Claims period has not begun
 - First to submit claims receives subsidy
- Proceeds received may be used only to reduce an employer’s health care costs or reduce premiums, but may not be used as general revenue (i.e., can’t reduce employer contribution)
- Not available after 2014; may end sooner if limited pool is exhausted

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Medicare Part D Deduction

- Effective beginning in 2013
- Employers lose tax deduction to extent of federal subsidy for Medicare Part D drug coverage for retirees

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Small Business Tax Credit

- Up to 35% of premiums paid for 2010 through 2013 (25% for tax exempt organizations)
- To be eligible for any credit, must have 25 or fewer FTE employees and pay annual average wages of \$50,000 or less
 - Maximum credit will go to employers with 10 or fewer full-time equivalent employees (FTEs) that pay annual average wages of \$25,000 or less
- Credit increases to 50% in 2014
 - Must participate in an exchange
 - Only available for two consecutive years

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Questions



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