Health Care Reform
One Year Later

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The New Health Care Coverage Landscape—General Overview

- Health Care Reforms
  - 2 waves of reforms for Group Health Plans
- Health Care Exchange
- Individual Mandate
- Employer “pay or play” mandate
- Tax Provisions

The New Health Care Coverage Landscape—Changes in Effect Prior to 2014

- Implementation Timeline
  - Changes already effective 2010
    - Change in "dependent" definition for purposes of health plan tax exclusions ("child" through age 26)
    - Small employer tax credit
  - Immediate Health Care Reform (First PY beginning on or after 9/23/10)—Wave #1 of Health Reforms
  - Changes effective January 1, 2011
    - Limits on OTC benefits
    - SIMPLE Cafeteria Plan Rules for Small employers
  - W-2 reporting for coverage cost delayed until 2012 (first report in 2013)
  - Changes effective January 1, 2013
    - Loss of Medicare Part D retiree subsidy deduction
    - $2500 cap on FSA salary reductions

The New Health Care Coverage Landscape—Changes in Effect On and After 2014

- Changes Effective in 2014
  - Individual mandate
  - Employer pay or play requirement
  - Employer Coverage Reporting (first report in 2015 for 2014)
  - Free Choice Vouchers repealed in March 2011
  - Exchange
- Changes generally effective first plan year on/after January 1, 2014—Wave #2 of Health Reforms
- Changes Effective in 2018
  - "Cadillac Plan" excise tax

Health Reforms---What is a group health plan?

- Reforms are added to the HIPAA portability subparts of ERISA and the IRC
- This means that:
  - Liability for failing to comply w/reforms is same as violating HIPAA portability under ERISA/Code
    - Specific performance under ERISA
    - $100/day penalty under IRC and HIPAA
    - Mandatory Self-Reporting and excise tax for violations (Form 8928)
  - The reforms do not apply to:
    - Excepted Benefits (such as stand alone and non-integrated dental, vision, Health FSA)
    - Stand alone retiree plans
    - Delayed effective date for certain requirements for grandfathered plans

Grandfathered Plans

- Interim Final Regulations issued 6/14
  - FAQ Guidance Parts I, II, IV and new guidance issued April 1st (Q/A Part VI)
- A plan is a grandfathered plan with respect to individuals who were enrolled on March 23, 2010. The plan does not stop being a grandfathered plan because individuals enrolled on that date cease to be covered, provided that the plan has continuously covered someone since March 23, 2010.
  - Family members may be added
  - "New employees" (newly eligible and newly hired) may be added
  - Two anti abuse rules
    - Merger and acquisition
    - Employer initiated transfer to another option/plan
- Regulations apply separately to each benefit package option offered under a plan
  - A single ERISA plan may have multiple benefit options

Grandfathered Health Plans

- Quick review of grandfather rules
  - Grandfathered GHPs are excused from compliance with certain PHSA mandates
    - Grandfathered health coverage is excused from certain other requirements that apply only to insurers
  - Joint regulations issued June 2010 imposed detailed rules that apply on a "benefits package" basis
    - Grandfather status may be lost for one package (e.g., HMO) but not another (e.g., PPO)
    - Preamble states that changes to premiums, changing TPAs, and changes to comply with law are permitted

Grandfathered Health Plans

- Clarifications regarding basic requirements
  - Notices to participants of grandfather status

Update

    - FAQ Part IV clarifies that notice to participants is not required for every communication to participants
      - Required whenever a "summary of benefits" is provided
  - Regulations describe changes that will cause loss of grandfather status—
    - Changes not prohibited should not impact status

Update

    - Any new rules from agencies will be applied prospectively
    - FAQ Part VI clarifies that grandfather status is lost on effective date of amendment that causes loss of status, not date amendment was adopted

Grandfathered Health Plans

- What changes cause loss of grandfather status?
  - Bucket #1: Elimination of all or substantially all benefits to diagnose or treat particular condition (no recent guidance)
  - Bucket #2: Any increase in percentage cost-sharing

Update

- FAQs Part VI provide that reclassifying band-name drug to new cost-sharing tier when generic alternative becomes available does not cause loss of grandfather status

Grandfathered Health Plans

- What changes cause loss of grandfather status?
  - Bucket #3: Increase in fixed-amount cost-sharing of more than $5 or 15% above medical inflation

Update

    - FAQ Part II clarifies that this applies even to co-payments that are for a single category of service
    - FAQ Part VI provides that certain changes to implement a value-based insurance design do not cause loss of grandfather status [later slide]

Update

Grandfathered Health Plans

- What changes cause loss of grandfather status?
  - Bucket #4: Decrease in employer contribution rate of more than 5 percentage points below rate on 3/23/10

Update

- Applies to rate for any tier of similarly situated individuals
- FAQ Part II clarifies that if tiers are restructured (e.g., single/family to single, plus one, family), then each new tier must be evaluated against corresponding prior tier

Update

- FAQ Part VI provides that if employer's contribution rate changes as a result of increases in costs but not increases in the formula, it is not considered a decrease for this purpose
  - Example: Retiree formula that is fixed dollar multiplied by years of service subject to flat dollar cap

Grandfathered Health Plans

- What changes cause loss of grandfather status?
  - Bucket #5: Certain changes to annual limits (no recent guidance)
    - Lowering an annual limit in place on 3/23/10
    - For a plan with no limits on 3/23/10, adding an annual or lifetime limit
    - For a plan with a lifetime (but no annual) limit on 3/23/10, imposing an annual limit that is lower than the lifetime limit
    - Still unclear how newly added treatment specific limits would be measured under these rules

Implementation Issues related to GF Status

- What about . . .
  - Change from fully insured to self-funded
  - Change from one carrier to another
    - New Q/a 6 muddies the water
  - Change from one TPA to another
  - Changes in stop-loss
  - Changes to network or formulary
  - What is a separate coverage option
  - Dropping one of many coverage options
    - FAQ Part VI recognizes real world applications of the anti-abuse rule
  - Implementing new coverage categories (spouse, children)
  - Moving retirees into free-standing plan

Auto-enrollment for employers with more than 200 employees

- Effective date?
  - Provision has no separate effective date, so general rule that effective date is date of enactment would seem to control
  - But FAQ guidance confirms that compliance is delayed until regulations are issued
- What plans does it apply to?
  - Excepted benefits ? Likely not.
- How does it apply with regard to cafeteria plan rules

Prohibition on Lifetime and Annual Limits (ALL)

- Interim final regulations
  - Essential benefits defined by statute -- no further clarification yet
  - Minimum allowable annual restrictions
    - $750k PY before 9/23/2011
    - $1.25M PY before 9/23/2012
    - $2M PY before 9/23/2014
- Implementation Issues related to Scope of prohibition
  - Financial limits only
    - While day or treatment limits generally "ok" be wary of impact on GF status and combination of financial cap and per day/treatment limit
  - Is prohibition on aggregate benefits only or specific benefits too
  - What benefits are "essential" ? Carriers are sending mixed signals . . .
    - Chiro
    - Fertility treatment
    - Transplants
  - Scope of special enrollment rights for newly eligibles
  - Impact on HRAs
  - Waiver program for "mini-med" plans

Prohibition on Rescissions (ALL)

- No rescission of coverage is permitted except in cases of fraud or intentional misrepresentation
  - Interim final regulations define rescission as any retroactive termination of coverage other than for non-payment of premium
  - Permissible rescission (e.g., for fraud, intentional misrepresentation) requires at least 30 days notice.
  - Termination for nonpayment of premiums not a rescission
- Implementation issues
  - How to handle ineligible participant/dependent terminations
    - Some good informal FAQ guidance for COBRA events
    - What about immediately eligible dependents
  - How to handle administrative errors

New Claim Appeals Process (GF)

- Changes for ERISA plans
  - Definition of "adverse benefit determination"
    - Now includes rescission determinations
  - Urgent Care Timeframe
    - Amended regulations retain 72 hour period
  - Appeals Procedure
    - Access to documents
    - Right to present "testimony"
  - Conflicts of Interest
  - Denial Notice Content
    - Certain additional content applicable FPY on/after July 1, 2011
    - Amended regulations clarify that treatment/diagnosis codes need not be provided in claims and appeal determinations unless requested
    - CLA requirement clarified based on county-wide statistics
  - Strict Adherence
    - Modified consistent with court decisions (deminimis, good faith, for cause exceptions)
  - External review
    - Modified so that only applies to rescissions and decisions requiring medical judgment

External Review: FYA 9/23/10

- External review applies for both GHPs and insurers
  - State or federal external review process must be followed
- No grace period for external review rules
- Only issues that involve medical judgment or rescission are subject to external review
  - Medical necessity, experimental/investigational, medical appropriateness, etc.
  - Other adverse benefit determinations not subject o external review

Implementation Issues: New Claim Appeals Process

- Challenges in implementing “external review”
- Should all plans (e.g., dental, vision) keep same appeal process or differentiate
- SPD disclosure issues (what and when)
- Who hires external review entity (hub and spokes)
- Who pays for external review

Age 26 Coverage Mandate (ALL)

- Plans that cover dependent children must provide for coverage of a dependent "child" *to* age 26
  - There is no requirement to cover children of covered dependent children (i.e., grandchildren)
  - Applies to "married" children
  - Consider impact on disabled coverage extensions and Michelle's Law
  - FAQ q/a guidance (q/a 14) defines child consistent with IRC 152(f) – son, daughter, stepson/daughter, adopted child and eligible foster child
    - Extremely important for "other child" bucket
  - For grandfathered plans only, no requirement to cover if eligible for other coverage as employee (until 1/1/2014)
    - Administration issues
  - Tax exclusion under 105(b) (and 501(c)(9) and 401(h)) expanded to include a "child" (as defined by IRC 152(f)(1) *through* 12/31 in which turn age 26.
    - Potential immediate impact for FSAs/HRAs that define eligibility based on 105(b)

Dependent Coverage Mandate

- Required coverage for children until age 26
  - Plans that cover children must make coverage available for employees' children until age 26
    - Marital status of the child is not relevant (but a child's children/spouse need not be covered)
    - Eligibility is definable only by the child's relationship with the employee (residency, financial dependence, student status, or employment cannot be used—because of age correlation)
  - Terms and conditions of coverage cannot vary based on age ("uniformity requirement")
    - Example: Premium surcharge for over age 18 not OK
  - Effective for plan years beginning on or after 9/23/10
    - Until 2014, grandfathered plans need not cover child with other employer coverage available (not through parent)

Dependent Coverage Mandate

- Under related tax rule, coverage is nontaxable until December 31st in year that child turns 26
  - Tax rule defines "child" using Code §152(f)(1) definition—
    - Son or daughter (generally biological)
    - Legally adopted son or daughter (or one placed for adoption)
    - Stepson or stepdaughter
    - Eligible foster child
  - The new rules do not affect state tax treatment of coverage provided to employees' children
    - Some states do not conform to federal tax treatment—thus, coverage potentially taxable for state income tax purposes

Dependent Coverage Mandate

- Lack of "child" definition for dependent coverage mandate may leave flexibility, but also uncertainty
  - FAQ: Will a plan violate mandate if it imposes conditions (support, residency, other dependency factors) on individuals under age 26 who are outside the Code §152(f)(1) definition?

Update

  - Two part answer:
    - A plan will not violate the mandate by limiting health coverage for children under age 26 to children within the Code §152(f)(1) definition
    - A plan may impose "additional conditions" on eligibility for individuals outside of Code §152(f)(1) definition (e.g., grandchild or niece must be tax dependent)

Dependent Coverage Mandate

- Other practical issues in complying with mandate
  - Grandfathered plans can limit, but is it worth it?
    - Only available until 2014
    - May be cumbersome to track other coverage
    - Transient coverage could increase special enrollments
  - Mandate is not applicable to "excepted benefits"
    - But employers may prefer to apply uniform eligibility and extend dependent coverage under other plans (e.g., health FSA, stand-alone dental)
      - Tax rule will make most coverage nontaxable
  - Mandate and tax rule applies to HDHPs, but not HSAs
    - Expenses of nondependent children are not reimbursable by HSA because HSA rules not yet amended
    - But nondependent child could have his or her own HSA

Additional FYA 9/23/2010 Mandates

- (ALL) No pre-existing condition exclusions on enrollees under age 19
  - Could apply to young employees, spouse or dependent children
  - Implementation issues
    - Determine if any pre-ex in plan may apply to children

- (GF) First dollar coverage (i.e., no cost-sharing) must be provided for certain evidence-based preventive care (including well-child care) and certain immunizations
  - Regulations allow for network and medical management restrictions
  - Implementation issues
    - Conform wellness/preventive care to list and ensure no cost sharing applies
    - How to communicate list of covered expenses to participants
    - Difficulty with interplay between essential benefits (no lifetime cap) and preventive care caps.

Additional FYA 9/23/2010 Mandates

- (ALL) Prepare and distribute a new "Summary of Coverage"
  - Distributed at enrollment, no more than 4 pages, and 12pt font
  - Notice of material changes in Summary required 60 days prior to effective date
  - Agencies will identify additional requirements within 12 months
  - Plans will have an additional 12 months to distribute
- (GF) Fully insured plans sponsored by employers will generally be required to satisfy the same Section 105(h) discrimination requirements that apply to self-funded plans
  - Impact on executive comp arrangements designed to avoid 409A
  - Likely no small employer exception
  - New FAQ guidance provides for delay until FPY after regulations
  - Applicable to premium reimbursement plans (not subject to 105(h)?
  - Penalty is $100 per day excise tax (self reported) for affected participant

Additional FYA 9/23/2010 Mandates

- (GF) Special rules regarding health care providers:
  - Plan enrollees are allowed to select their primary care provider, or pediatrician, from any available participating providers;
  - Precludes prior authorization or increased cost-sharing for emergency services, whether in-network or out-of-network
    - Interim final regulations require payment at greater of network rate, out of network rate, or Medicare rate; and
  - Precludes plans from requiring authorization or referral by the plan for obstetrical or gynecological care
  - Interim final regulations impose notice requirements

Effective in 2011

- No reimbursement of OTC medicines or drugs (except insulin) by health FSA, HRA, or HSA without prescription
  - Related to expenses incurred in calendar year 2011; not based on "plan year"
  - Recent IRS Guidance on health debit cards

Effective in 2012

- Employers must report aggregate value of employer-sponsored coverage on Form W-2 (first report due in 2013)
  - Includes COBRA rate of all health coverage subject to Cadillac tax
  - Are payroll systems in place to capture amounts
  - Retirees not already required to receive W2 not subject to this requirement

Form W-2 Reporting of Employer Coverage

- Requires report of "aggregate cost" of "applicable employer sponsored coverage"
  - Includes private-sector and governmental employers
  - Employers filing fewer than 250 Forms W-2 for preceding calendar-year not subject (for transition period)
  - W-2 reporting interim guidance issued in March 2011
    - Reporting of employer coverage not required for 2011
      - But employers may voluntarily report in Box 12, Code DD
    - Addressed some open issues (handling reporting for retirees, non-calendar year plans)
    - Addressed how to determine cost (using rules similar to COBRA)
- JOHN: not sure how much you were thinking about here . . .

Update

Update

Effective in 2013

- Health FSA salary reductions limited to $2,500 each year
  - The cap is indexed to the CPI starting in 2014
- Deduction previously permitted for amounts allocable to the Medicare Part D subsidy for prescription drug plans is eliminated
  - FAS 106 impact and impact on balance sheets

Reforms Effective Plan Years On/After 2014

- (ALL) No preexisting condition exclusions or limitations are permitted
- (ALL) Prohibition on excessive waiting periods—i.e. no waiting period in excess of 90 days
- Fair Health Insurance Premiums (applicable only to health insurers)
  - Limitations on premium setting (e.g. limitations on premium setting based on age, tobacco use)
  - Indirect impact on self insured plans?

Reforms Effective Plan Years On/After 2014

- No discrimination based on health status is permitted
  - Essentially, the same rules that currently exist under HIPAA
  - The bill raises maximum incentive amount for wellness programs that provide the incentive based on achieving a health standard from 20 to 30 percent of the COBRA cost of coverage
    - Also gives the Secretaries of Labor, HHS, and the Treasury leeway to increase the percentage to 50 percent
- Cost limitations
  - Out-of-pocket expenses do not exceed the amount applicable to coverage related to health savings accounts (HSAs)
  - Deductibles do not exceed $2,000 for single coverage and $4,000 for family coverage (as indexed)
    - Unclear whether deductible requirement may only apply to fully insured plans in small group market
    - Query: Can you ever have a “bronze plan” once this requirement applies?

Reforms Effective Plan Years On/After 2014

- Fully insured plans in small group market must provide essential benefits
  - Not applicable to fully insured plans in large group market and self insured plans
  - Self insured plans NOT required to provide essential benefits
- Group and individual plans are required to cover routine costs of participation in certain clinical trials by qualified individuals
- No nondiscrimination against providers who act within the scope of their license
  - Not an any willing provider statute

Health Insurance Exchange

- PPACA provides funds to states to establish a health insurance exchange through which individuals may purchase health insurance beginning in 2014
- Exchange-related provisions in PPACA impact employers in the following ways:
  - Beginning in 2017, states may allow all employers of any size to offer coverage through the exchange
    - Prior to 2017, only small employers - employers with 100 employees or less (except in states that limit small employers to employers with 50 or fewer employees)—may participate
  - Employers who offer coverage through the exchange may permit employees to pay for such coverage with pre-tax dollars through the employer's cafeteria plan

Employer Responsibility

- Effective January 1, 2014 - play or pay mandate #1:
  - Employers with 50 or more full-time "applicable" employees are subject to the following penalties related to coverage that they offer or fail to offer to full-time employees:
    - Applicable employers who fail to offer full-time employees health coverage must pay a penalty with respect to each full-time employee in any month in which any full-time employee receives a federal subsidy for the exchange
      - The penalty is determined on a monthly basis and is the product of the total number of full-time employees of the employer (over 30) for that month and 1/12 of $2000 (up from $750)
        - » For example, a business with 51 employees that does not offer coverage is subject to tax equal to 21 times the applicable payment amount

Employer Responsibility

- Effective January 1, 2014 - play or pay mandate #1 (cont'd):
  - Part-time employees are taken into account solely for the purpose of determining if an employer has at least 50 employees
    - The number of full-time employees otherwise determined is increased by dividing the aggregate number of hours of service of employees who are not full-time employees by 120
  - Employers who are "applicable large employers" solely because of seasonal employees who are otherwise full-time employees and that work less than 120 days during the year are NOT considered "applicable large employers"

Employer Responsibility

- Effective January 1, 2014 - play or pay mandate #2:
  - Even when coverage is extended, applicable employers who offer coverage for any month to a full-time employee who is certified as having enrolled in the exchange and received a tax subsidy is subject to a penalty equal to the product of the total number of such employees who have received a tax subsidy and 1/12 of $3000 (capped at 1/12 of $2000 times the total number of full-time employees during such month)
    - Note: employees offered employer coverage are not eligible for a credit unless their required premium exceeds 9.5% of household income or the plan's share of allowed costs is less than 60%.

Cadillac Plan Tax

- Beginning in 2018, PPACA (as modified by the Reconciliation Bill) imposes a 40 percent excise tax on:
  - "Coverage providers:" for the sum of months in which the aggregate value of employer sponsored health coverage for the employee exceeds:
    - 1/12 of $10,200 for single coverage and $27,500 for family coverage
      - The higher family threshold applies to both single and family coverage offered under a multiemployer plan
      - These amounts are to be adjusted automatically if health costs increase by more than anticipated before 2018
      - The thresholds are increased by CPI + 1 in 2019, and by CPI thereafter
      - An employer may make an adjustment to reduce the cost of plans when calculating the tax if the employer's age and gender demographics are not representative of a national average
      - The PPACA transition rule for high cost states does not apply
    - The annual limit for retirees between ages 55 and 64, individuals engaged in certain high-risk professions (e.g., law enforcement professionals, EMTs, longshoremen, construction workers, and miners), and those employed to install electrical or telecommunication lines is increased to $11,850 for individual coverage and $30,950 for family coverage

Cadillac Plan Tax

- Determined by the employer and assessed against “coverage providers”
- “Coverage providers” are defined to include the following:
  - In the case of fully insured plans, the health insurer
  - In the case of HSA or medical savings account (MSA) contributions, the employer making the contributions
  - In the case of a self-insured plan or flexible spending account (FSA), the person that administers the plan (e.g., the TPA)
- In many cases, employer-sponsored coverage will include both fully insured and self-insured contributions (it may also include HSA contributions)
  - The coverage provider’s applicable share of the tax will bear the same ratio to the total excess benefit as the cost of the coverage provider’s coverage to the total value of employer-sponsored coverage

Cadillac Plan Tax

- The coverage subject to the excise tax rule includes:
  - The applicable premium (determined in accordance with COBRA rules) for all accident and health coverage provided by the employer, even if paid for with after-tax dollars by the employee (except vision only insurance, dental insurance, accident and disability insurance, long-term care insurance, and after-tax funded hospital indemnity and/or specified disease coverage)
  - Both non-elective and salary reduction contributions to a health FSA
  - Employer contributions (presumably including salary reductions) to an HSA

Other New Taxes

- Several new taxes are imposed, including:
  - Indoor tanning procedures effective for services performed on or after July 1, 2010)
  - New sector tax on health insurers (but not self-insured plans or TPAs) beginning in 2014
  - 0.9 percent increase in Medicare taxes for those earning more than $200,000 for single individuals and $250,000 for joint filers (effective beginning in 2013)
    - Such individuals would also be subject to a 3.8% tax on their net investment income (to the extent that total income exceeds the thresholds)
    - This new tax would be effective starting in 2013
  - CER fee: A fee equal to $2 ($1 in 2013) multiplied by average number of covered lives imposed. Applies to both fully insured and self insured plans.

Is ACA Constitutional?

- Four court decisions: two declared unconstitutional and two declared constitutional
- March 3 Florida judge stayed and clarified its decision, telling Administration to file its appeal within 7 days to US Court of Appeals
- This clarification allows implementation to move forward, but keeps the pressure on the Administration move the case towards a final decision, whether US Court of Appeals or Supreme Court
- If the case ultimately moves to the Supreme Court, a decision could be several years away, and there is no way to predict whether they will consider the full law, or just the mandate provision