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Health Care Reform: What Employers Need to Know Now

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OVERVIEW

What is a Grandfathered Health Plan?

- A “grandfathered health plan” is a group health plan in which an individual was enrolled on March 23, 2010.
- A “grandfathered health plan” may, in addition to participants who were enrolled on March 23, 2010, cover newly enrolled family members of such participants as well as newly hired and newly enrolled employees and their families.
- The “grandfathered health plan” rules apply separately to each benefit package made available under a group health plan.

Provisions **NOT** Applicable to Grandfathered Plans

- § 2701 - Fair health insurance premiums (small group market)
- § 2702 - Guaranteed availability of coverage
- § 2703 - Guaranteed renewability of coverage
- § 2705 - Prohibiting discrimination against individual participants and beneficiaries based on health status
- § 2706 - Nondiscrimination in health care
- § 2707 - Comprehensive health insurance coverage (applicable to issuers in the individual and small group markets)
- § 2709 - Coverage for individuals participating in approved clinical trials
- § 2713 - Coverage of preventive health
- § 2715A - Provision of additional information

Provisions **NOT** Applicable to Grandfathered Plans (cont'd)

- § 2716 - Prohibition on discrimination in favor of highly compensated individuals for insured plans
- § 2717 - Ensuring quality of care
- § 2719 - Appeals process
- § 2719A - Patient protections

Provisions Applicable to Grandfathered Plans

- § 2704 - Prohibition on preexisting condition exclusion or other discrimination based on health status (not applicable to individual health insurance coverage)
- § 2708 - Prohibition on excessive waiting periods
- § 2711 - No lifetime or annual limits (annual limits not applicable to individual health insurance coverage)
- § 2712 - Prohibition on rescissions
- § 2714 - Extension of adult child coverage to age 26 (except for plan years beginning before 1/1/14, coverage is required only if adult child is not eligible for other employer-sponsored health plan coverage)
- § 2715 - Development and utilization of uniform explanation of coverage documents and standardized definitions (benefit summaries)
- § 2718 - Bringing down the cost of health care coverage (applicable to insured plans only)

How Does a Grandfathered Health Plan Lose its Grandfathered Status?

- If it:
  - Enters into a new policy, certificate or contract of insurance;
  - Eliminates all or substantially all benefits to diagnose or treat a particular condition, including the elimination of benefits for any necessary element to diagnose or treat a condition;
  - Increases the percentage of employees' cost-sharing payment;
  - Increases a fixed-amount cost-sharing requirement other than a copayment by more than medical inflation plus 15 percentage points;
  - Increases a fixed amount copayment by an amount that exceeds the greater of (i) $5, increased by medical inflation, and (ii) the sum of medical inflation plus 15 percentage points; or
  - Imposes for the first time, subject to a limited exception for plans with a pre-existing overall lifetime limit, or decreases an overall annual limit on benefits.
- If the employer sponsor or employee organization decreases its contribution rate by more than 5 percentage points.

What Changes May Be Made Without the Loss of Grandfathered Status?

The following changes will not, by themselves, cause a plan to lose its grandfathered status:

- Changes to voluntarily increase benefits;
- Changes to premiums;
- Changes to comply with federal or state legal requirements;
- Changes to voluntarily comply with the provisions of the Affordable Care Act;
- Changes in third party administrators.

Grandfathered Collectively Bargained Plans

- Health insurance coverage offered pursuant to one or more collectively bargained agreements ratified before 3/23/2010 is grandfathered until the date on which the last CBA terminates.
  - Plan amendments adopted to comply with the PPACA will not cause the plan to lose grandfathered status.
- When the last CBA expires, the terms of the plan then in effect are compared to the coverage in effect on 3/23/2010 to determine whether the plan continues to be grandfathered.

Disclosure and Recordkeeping Requirements for Grandfathered Health Plans

- A grandfathered plan must disclose that it is intended to be a grandfathered plan
  - Model disclosure language
- Must maintain plan documents in effect on 03/23/2010 and other documents verifying, explaining or clarifying status as a grandfathered plan
  - Records must be available for inspection

Benefits Not Covered by New Health Plan Standards

- retiree-only plans
- stand-alone dental
- stand-alone vision
- AD&D
- workers compensation
- automobile medical payment insurance
- on-site medical clinics
- coverage only for a specified disease

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Early Retiree Health Claims Reimbursement Program

- Reimbursements of 80% of certain retiree health claims filed under employer plans, provided the employer implements programs and procedures to generate cost-savings for participants with chronic and high-cost conditions.
- Eligible Retirees: over age 55 & not yet eligible for Medicare
- Eligible Claims: claims of the retiree or the retiree's spouse, surviving spouse and dependents that are between $15,000 & $90,000. Amounts will be adjusted for the medical care component of the CPI-U starting for P.Y.s on or after 10/1/2011.
- Can't use reimbursements as general revenue of plan sponsor; must be used to lower plan costs.

Effective 6/1/2010 through 12/31/2013, subject to program not running out of funding ($5B).

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Early Retiree Health Claims Reimbursement Program (cont'd)

Programs and procedures to address chronic and high cost conditions:

- needn't address all chronic and high cost conditions
- must be designed to lower cost and regulations suggest should improve the quality of care

2 examples:

1. Diabetes management program providing behavioral counseling to prevent complications and unnecessary hospitalization
2. Plan covers all or a large portion of a participant's co-pays for cancer treatments or eliminates or reduces the deductible for cancer treatments.

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Early Retiree Health Claims Reimbursement Program (cont'd)

Draft Program Application Highlights:

- must say how the reimbursements will be used, either:
  - ➢ to offset increased costs for sponsor
    - ❖ must explain how sponsor will maintain its "level of support for the plan"
  - ➢ to reduce premium contributions, co-pays, deductibles, coinsurance or other out-of-pocket costs
- must have policies and procedures in place to detect and reduce fraud, waste and abuse and be prepared to submit them to HHS upon request

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Early Retiree Health Claims Reimbursement Program (cont'd)

Draft Program Application Highlights (cont'd):

- must identify each "benefit option" under the plan for which reimbursement is sought, and a "unique benefit option identifier"
  - Benefit option: a particular benefit design, category of benefits or cost-sharing arrangement
- programs and procedures must be in place when the application is submitted, and the conditions and programs must be summarized in the application
- must estimate the amount of reimbursements expected to be received in each of the first 2 plan years (can be a range)

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Automatic Enrollment of Full-Time Employees

Applies to "large employers" (more than 200 full-time employees) that offer health plan coverage to employees

- Must:
  1. enroll new full-time employees in any of the health plans the employer offers (subject to applicable waiting periods) and
  2. continue the enrollment of currently covered employees.
- Must give employees notice and opportunity to opt out

HHS to promulgate regulations

Effective: Technically 3/23/2010?, but because the Act provides this provision will be implemented in accordance with HHS regulations, it is assumed that the effective date will be a future date announced in the regulations.

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Reasonable Break Time for Nursing Mothers

Employers are required to provide reasonable break time for an employee to express breast milk for her nursing child for up to one year after the child's birth.

- A place, other than a bathroom, must be available that is shielded from view and free from intrusion from co-workers and the public.
- The employer is not required to compensate employees for these breaks.
- State laws may have additional or more stringent requirements.
- Employers with fewer than 50 employees are not subject to this requirement if it would cause undue hardship in light of the "size, financial resources, nature or structure of the employer's business."

Effective: 3/23/2010

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Adoption Assistance

- The income exclusion for employer-provided adoption assistance was scheduled to sunset for taxable years after 2010
- The program is extended for one year
- The income exclusion for qualified adoption expenses is increased to $13,170 per child from $12,170
- Under prior law, the income exclusion was phased out for taxpayers with modified AGI between $182,520 - $222,520
- The AGI limitations in 2011 are adjusted for inflation
- Adoption credit available to individual taxpayers also extended for one year and increased in amount to $13,170 per child
- These changes are effective for tax years 2010 and 2011

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PROVISIONS EFFECTIVE in 2011

The provisions discussed in this section become effective for plan years beginning 6 months after March 23, 2010.

For calendar year plans, January 1, 2011.

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Coverage of Children Until Age 26

Plans that cover employees' children are required to offer coverage until they attain age 26.

- no requirement that the child be an employee's dependent for tax purposes
  - ➢ HHS is directed to promulgate regulations defining "dependent" for this purpose
- no requirement that the child be unmarried
- the Joint Committee on Taxation's explanation states that "child" means a son, daughter, stepson, stepdaughter or foster child who is placed with the taxpayer by an authorized placement agency or by judgment, decree or to her order of any court of competent jurisdiction
- this rule also applies to VEBAs and 401(h) accounts
- no requirement to cover the adult child's children

Effective: Plan years beginning on and after 9/23/2010, except that before 1/1/2014 grandfathered plans are not required to extend coverage to children until they attain age 26 if the child is eligible to enroll in another employer-sponsored plan.

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Tax Implications for Covering Adult Children

Reimbursements for medical care given to an employee's child under an employer's health plan are excluded from the employee's income, provided that the child has not attained age 27 as of the end of the calendar year.

- Cafeteria plan regulations will be amended to permit a mid-year election change to include new eligibility for adult children.
- Cafeteria plans will probably need to be amended to cover adult children. Amendments must be made by December 31, 2010, and can be retroactive to March 30, 2010.
- Treasury regulations will be amended to provide *coverage* of an adult child under an employer's health plan will be excluded from the employee's income.
- If the plan also covers the adult child's spouse or children, the fair market value of the spouse's or children's coverage is included in the employee's income.

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Example

Assume an employee covers his child under the his employer's group health plan. The child will attain age 26 on 6/15/2011.

- The plan must cover the child until 6/14/2011, if coverage is elected by the employee.
- The coverage of the adult child under the plan is excluded from the employee's income until 12/31/2011.

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No Lifetime Dollar Limits

- Applies to “essential health benefits” only
- Even applies to out-of-network limits
- Seems to mean that plans must begin covering those who previously reached lifetime maximum

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Essential Health Benefits

Listed in the Act:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative service and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

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Essential Health Benefits (cont'd)

HHS, based on DOL survey of employer-sponsored plans, must ensure that the scope of essential health benefits is equal to the scope of benefits provided under a typical employer plan

- Secretary must provide notice of definition of essential health benefits and an opportunity for public comment
- Secretary also must obtain certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the essential benefits meets the requirements above
- In defining essential benefits, the Secretary, among other things, must (1) take into account the health needs of diverse segments of the population, including women, children and persons with disabilities (2) not make coverage decisions in a manner that discriminates based on an individual's age, disability or expected length of life, (3) ensure that emergency services are provided without the need for prior authorization
- The Secretary also must periodically update the essential health benefits to address gaps in coverage discovered through periodic reviews

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Annual Limits

- A plan can provide annual limits on benefits that are not "essential benefits"
- For plan years beginning on and after six months after the date of enactment and before 2014, the ability to apply annual limits will be restricted through HHS regulations
- In restricting annual limits, HHS must ensure access to needed services with minimal impact on premiums
- Beginning in 2014, group health plans will be prohibited from applying any annual limits on essential benefits

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No Rescission of Coverage

- Group health plans are prohibited from rescinding coverage
  - exception for fraud or intentional misrepresentation of material fact
- Coverage can be cancelled only with prior notice and only as permitted by the Public Health Service Act (generally permits cancellation due to termination of plan or an individual's failure to pay premiums, fraud or movement out of service area)

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Pre-existing Condition Exclusions

- Group health plans are prohibited from using pre-existing condition exclusions to limit coverage of enrollees under the age of 19.
- Effective 1/1/2014, group health plans cannot impose a pre-existing condition exclusion with respect to the plan or coverage under the plan.

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Restrictions on Drug Reimbursements

- Amounts paid for over-the-counter drugs will not be eligible for reimbursement
- Only prescribed drugs and insulin are eligible

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Increased Tax on Certain HSA Distributions

Taxes on distributions that are not used for qualified medical expenses are increased from 10% to 20%

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Loss of Deduction for Subsidized Medicare Prescription Drug Coverage

The amount that is otherwise allowed as a deduction to an employer that has a retiree prescription drug plan with an actuarial value at least as great as the Medicare Part D standard plan (and satisfies certain other requirements) is reduced by the amount of the subsidy received from HHS that is excludible from the employer's income.

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Information Reporting

Employers must disclose on each employee's W-2 the aggregate value of the employee's health coverage, excluding salary reduction contributions to health FSAs.

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Benefit Summaries

By March 23, 2011, HHS must develop standards for use by group health plans (and insurers) in providing applicants and enrollees with a summary of benefits, not more than 4 pages long, using at least 12-point font, that is culturally and linguistically appropriate.

The summary must describe the coverage, including the exceptions, reductions, limitations, cost-sharing amounts, renewability, and certain common benefit scenarios.

Group health plans (and insurers) must provide the summary to the required individuals no later than March 23, 2012.

If a material benefit modification occurs, notification must be provided to enrollees no later than 60 days *before* the modification becomes effective.

Willful failure to comply will subject a plan sponsor to a $1,000 fine for each failure to provide the information to an enrollee.

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Preventive Services Must Be Covered With No Cost Sharing

- Preventive care services recommended by the U.S. Preventive Services Task Force.
- Immunizations recommended by the Centers for Disease Control
- Preventive care and screenings for infants, children, adolescents
- Preventive care and screenings for women

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Emergency Services

- Cannot require preauthorization
- Cannot be limited to in-network providers
- Cannot impose higher cost sharing for out-of-network

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Plans Requiring Designation of Primary Care Physician

- Must allow participant to designate any participating primary care physician or pediatrician
- Cannot require preauthorization or referral for OB/GYN services

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Nondiscrimination Rules Apply to Insured Health Plans

Insured group health plans must satisfy the requirements of Code § 105(h), which prohibits self-funded plans from discriminating in favor of highly compensated employees.

- Effect on "top-hat" health plans
- Effect on severance agreements paying COBRA premiums

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Forms 1099s for Payments to Corporations

Companies that pay amounts aggregating at least $600 to corporations will be required to report payments to IRS on Form 1099

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Temporary Tax on Health Insurance Policies & Employers Sponsoring Self-Funded Plans

- Tax will fund the "Patient-Centered Outcomes Research Institute" to evaluate and compare the health outcomes and clinical effectiveness of health care interventions, protocols for treatment, case management, etc., used in the treatment diagnosis or prevention of an illness or injury.
- Tax is equal to $2 ($1 for years ending during fiscal year 2013) times average numbers of covered lives.
  - Effective for plan years ending after 9/30/2010 and before 10/1/2019
  - Tax will be increased for plan years ending in any fiscal year beginning after 9/30/2014 by projected increases in national health expenditures

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Additional Taxes on High-Income Taxpayers

1. The employee portion of the hospital insurance part of the FICA tax is increased from 1.45% to 2.35% of wages in excess of $250,000 for taxpayers filing a joint return and $200,000 for all other taxpayers (self-employment taxes)

2. An additional 3.8% tax on individuals applies to the lesser of (i) an individual's "net investment income" and (ii) the excess of the individual's modified AGI over the threshold amount ($250,000 for joint returns and $200,000 for single returns)
   - "Net investment income" generally includes interest, dividends, annuities, royalties, rents, and other "passive" income
   - Tax also imposed on trust income

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Limitation on Health FSAs

Health FSAs must limit salary reduction contributions to no more than $2,500

- Consequences for noncompliance: distributions are taxed to employee
- Beginning in 2014, the $2,500 limit is adjusted annually for inflation in accordance with CPI-U

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Itemized Deductions For Medical Expenses

- The threshold for itemized deductions for unreimbursed medical expenses is increased from 7.5% of AGI to 10% of AGI
- Exception for years 2013-2016 if the taxpayer has attained age 65 before the end of the year: the threshold remains at 7.5%

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Employers Must Notify Employees of Exchanges

Notice must go to both new hires and existing employees of:

- existence of exchanges
- services available under the exchanges
- how to contact the exchange
- Employee's loss of employer contribution under employer's plan (which contribution is excludible from income) if employee purchases coverage through an exchange

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Medical Device Excise Tax

2.3% excise tax on sales of medical devices, except eyeglasses, contact lenses, hearing aids and devices sold at retail for public use.

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Health Insurance Provider Excise Tax

The excise tax on health insurance providers is equal to their pro rata share of $8B in 2011, gradually increasing to $14.3B in 2018.

Thereafter, increases are linked to the rate of premium growth.

Each pro-rata share is equal to the ratio of the provider's net premiums taken into account for the previous year to the aggregate net premiums for the previous year that are taken into account for all health insurance providers subject to the tax.

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Health Insurance Provider Excise Tax (cont'd)

The percentage of net premiums taken into account for a year ranges from 0% to 100% (if net premiums are no more than $25M, 0%; if net premiums are more than $25M but no more than $50M, 50%; if net premiums are more than $50M, 100%).

Only 50% of a provider's net premiums from tax-exempt activities is taken into account. Exempt from the tax are non-profit providers with more than 80% of gross revenues from SSA funds for the purpose of serving low income, elderly, or disabled populations.

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PROVISIONS THAT BECOME EFFECTIVE in 2014 AND BEYOND

Waiting Periods

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not apply any waiting period that exceeds 90 days.

Effective 1/1/2014

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Pay or Play Mandate

If a large employer does not offer minimum essential coverage to its full-time employees and their dependents *and*

at least one full-time employee has subsidized coverage under an Exchange in a month, then the employer must pay an excise tax equal to 1/12 of $2,000 ($166.67) for each of its full-time employees for that month (the first 30 full-time employees are excluded).

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Excise Tax On Large Employers Offering Coverage If Employee Receives Exchange-Subsidized Coverage

Tax applies if any of the employer's full-time employees receives subsidized coverage under an Exchange and if the employer's coverage:

- is offered to all full-time employees and dependents
- and either:
  - the coverage is not "affordable" minimum essential coverage, or
  - the plan pays less than 60% of the cost of benefits.

Coverage is unaffordable if it exceeds 9.5% of the employee's household income.

Tax is payable monthly, equal to the number of the employer's full-time employees in that month in excess of 30 (regardless of the number of employees receiving the premium tax credit or cost-sharing reduction) multiplied by 1/12 of $3,000 (i.e., $250.00).

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Annual Reports to IRS

- Employers (and insurers) that provide "minimum essential coverage" will be required to file an annual report with the following information
    1. name, address & TIN of primary insured and name and TIN of each other individual enrolled by the primary insured
    2. the dates during which each was covered by the plan
    3. other information
- A copy must be furnished to the employee

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Large Employer Annual Returns to IRS

Large employers must file an annual return with the IRS regarding health coverage of employees, with a copy to employee, no later than 1/31 of the year following the year to which the return and information statements apply.

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Clinical Trial Participation

Prohibits group health plans (and insurers) (i) from dropping coverage or otherwise discriminate against an individual because the individual chooses to participate in a clinical trial and (ii) from denying coverage for routine care that they would otherwise provide just because an individual is enrolled in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases.

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Wellness Programs

Employers may provide wellness programs either (i) that reward individuals who satisfy a health standard or (ii) without regard to satisfaction of any health standard.

A compliant wellness program that does not provide rewards based on satisfying a health standard may

(i) reimburse fitness center memberships,

(ii) provide a reward for participation in diagnostic testing,

(iii) waive cost-sharing for preventative services,

(iv) reimburse for participation in a smoking cessation program, or

(v) reward attendance of periodic health education seminars.

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Wellness Programs (cont'd)

Compliant wellness programs that do reward individuals for attaining a health standard may not provide a reward that is more than a 30% reduction (may be increased to 50% by DOL, HHS, & Treasury if deemed appropriate) reduction in the total employer and employee cost for the benefit package.

In addition, a wellness program that provides such a reward must

(i) be reasonably designed to promote health or prevent disease without discrimination,

(ii) provide individuals with an opportunity to qualify for the reward,

(iii) ensure the full reward is made available to all similarly situated individuals, and

(iv) disclose the terms of the wellness program, as well as the availability of reasonable alternative standards.

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Wellness Programs (cont'd)

Wellness programs currently in effect that comply with current regulations will be deemed compliant so long as those regulations remain in effect.

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Excise Tax on Cadillac Plans

40% nondeductible excise tax on the "aggregate value" of employer-sponsored coverage in excess of $10,200 for individual coverage and $27,500 for family coverage.

- For retirees and high-risk professions, the threshold is $11,850 for individual coverage and $30,950 for families
- Stand alone dental and vision plans are excluded from aggregate value
- Beginning in 2019, the thresholds are increased by CPI-U plus 1%

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Excise Tax on Cadillac Plans (cont'd)

- Thresholds can be increased if age and gender demographics of the employer's employees exceed the national workforce age and gender demographics
- If CBO is wrong in its forecasts of premium inflation between now and 2018, the thresholds will automatically be increased.

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