



Health Reform and the Employer: Planning for the Future

Employee Benefit Provisions



*A Broader Perspective*SM

Health Care Reform Overview

- Health care reform is a product of two statutes
 - Patient Protection and Affordable Care Act (“PPACA”)
 - Health Care and Education Reconciliation Act of 2010 (“Reconciliation Act”)
- Law is extremely complex and will be shaped and developed by subsequent guidance from IRS, DOL and HHS
- Does not effect other pending GHP compliance obligations (e.g., MHP, GINA, MSP Reporting, HIPAA, CHIPRA and COBRA)

The Health Care Umbrella of Coverage Post - PPACA:



Who is Covered?

And Who is Not?



UNDOCUMENTED
ALIEN

PENALTY-PAYORS

NO INCOME &
DECLINE
COVERAGE



Revenue: Who Bears the Burden?

Drug Manufacturers



Increased tax on nonqualifying health account distribution

MSA HSA tax!



Increased FICA on upper class people

Tanning Booths



Medical Device Manufacturers



Loss of deduction

Over the Counter Medicine



Medicaid Part



Premium Subsidy



Cadillac Plan

Health Care Reform Overview

- Focus: Group health plans and related provisions
- New ERISA § 715 and Code § 9815
- Effective Date: Three phases
 - First Phase: 2010 & 2011
 - Second Phase: 2013 & 2014
 - Third Phase: 2018
- Special Effective Dates
 - Grandfathered Plans & Collectively Bargained Plans
 - Rules discussed below

Health Care Reform Overview

Key Features

- **Mandated Coverage for Individuals**
 - Taxes apply for non-compliance
 - Government subsidies (tax credits and cost sharing) will assist lower income individuals obtain coverage
- **Expanded Coverage Market**
 - **Coverage Limitations Restricted**
 - Insurers and, in many cases, self-funded plans must offer coverage without pre-existing conditions, annual or lifetime limits or other limitations
 - **Employers Play or Pay**
 - Employers must provide affordable, qualifying coverage or pay tax
 - Small employer exception (under 50 employees)
 - Employers who provide coverage may still be subject to tax if lower income employees obtain coverage through the exchange
 - Employers must provide vouchers for use by certain lower income employees to purchase coverage through the exchange
 - **State Exchanges**
 - States must establish health benefit exchanges where individuals and employers can compare and purchase coverage on guaranteed issuance and blended rate basis
 - **High Risk Pools**
 - New temporary pools discussed below
- **Revenue Raisers**

Health Care Reform Overview

Grandfathered Plans

- Generally plans in effect on March 23, 2010
 - New employees and family members can be added without losing “Grandfathered” status
 - Effect of other changes addressed in regulations released on June 14, 2010
 - Must include a statement regarding grandfathered status in plan materials
- Grandfathered plans are generally exempt from:
 - Limits on annual cost-sharing requirements for self-only and family coverage
 - Limits on annual deductibles (\$2,000 for an individual or \$4,000 for a family)
 - Covering routine costs of participation in certain clinical trials
 - Play or Pay rules
 - Code Section 105(h) nondiscrimination
 - Preventive Health Mandates (no cost)
 - Patient Protections (individual choice of primary care provider and pediatrician, no preauthorization for emergency or OB-GYN)
 - Appeals and external review procedures

Health Care Reform Overview

Grandfathered Plans, continued

- Provisions applicable regardless of grandfathered status:
 - Required coverage of adult children until age 26
 - for grandfathered plans in plan years before 2014, coverage is required only if child is not eligible for employer plan
 - Prohibition on Lifetime and Annual Limits
 - Prohibition on pre-existing condition exclusions, rescission, and excessive waiting periods
 - New summary of benefits and coverage
 - Increased taxes on non-qualifying distributions from HSAs and Archer MSAs
 - W-2 and health coverage reporting
 - New FSA limits
 - Prohibition on over the counter drug reimbursements
 - Cadillac Plan Tax

Grandfathered Plans: Loss of Grandfathered Status

- **Insured Plans:** Entering into a new policy or insurance contract after 3/23/10 (not a renewal)
- **Reduction of Benefits:** Elimination of all or substantially all benefits to diagnose or treat a particular condition
- **Cost-Sharing Increase:** Any increase in a percentage cost-sharing requirement
 - e.g., coinsurance increases from 20 to 30%
- **Other Cost-Sharing Increase:** For fixed-amount cost-sharing other than copayments (e.g., deductibles, out-of-pocket max), any increase since 3/23/10 greater than the *maximum percentage increase* (medical inflation + 15% pts)
- **Co-payment Increase:** For fixed-amount copayments, any increase since 3/23/10 that exceeds greater of
 - (A) *maximum percentage increase* or
 - (B) \$5 increased by *medical inflation*
- **Decreased Contribution Rate:** Employer or employer organization decreases *contribution rate* toward cost of any tier of coverage for any class of individuals by more than 5% pts below rate on 3/23/10

Grandfathered Plans: Loss of Grandfathered Status

- Certain Changes to Annual or Lifetime Limits on Dollar Value of Benefits
 - Plan that on 3/23/10
 - did not impose overall annual or lifetime limit on dollar value of benefits, imposes an overall annual limit
 - imposed an overall lifetime limit on dollar value of benefits but no overall annual limit on dollar value of benefits, imposes an overall annual limit lower than the lifetime limit in effect on 3/23/10
 - imposed an overall annual limit of dollar value of benefits, decreases the dollar value of the annual limit
- Exclusive list of impermissible changes contained in regulations
 - Any change other than those listed in the regulations will not cause a plan to lose grandfathered status, including changes to premiums, changes required to comply with law, voluntary changes to comply with PPACA, and changing third party administrators
- Grandfathering rules apply separately to each benefit package
 - Status of insured benefit considered separately from status of self-funded benefit
 - One plan can have a grandfathered package and a non-grandfathered package

First Phase Health Reform

Effective in 2010

Large Employer Auto-Enrollment

- For employers with more than 200 full-time employees, who offer enrollment in 1 or more health benefit plans, employees are automatically enrolled in coverage
 - Subject to reasonable, approved waiting period
- Must provide notice and opportunity for employees to opt out
- Automatic re-enrollment for current employees
- Compliance delayed until regulations issued (target date 2014)

First Phase Health Reform

Effective plan years after September 23, 2010

- **Extension of Dependent Child Coverage**

Plans need not cover dependents but if they do...

- Must cover adult children until age 26
- Marital, student and tax dependent status are irrelevant
- Tax exclusion is extended to adult children who have not attained age 27 before the end of the taxable year and is effective immediately
- FSA Plan document may be amended retroactively no later than 12/31/10 to permit expanded coverage
 - Regulations will be amended to provide that if a non-dependent child becomes eligible for coverage, this is permissible change in status that will enable election changes mid-year
- Plans need not cover dependents of adult children
- For insured plans, state mandates may require additional coverage

- **Grandfathered Plans Must Comply**

- For years before 2014, need not cover child who is eligible for other employer coverage

First Phase Health Reform

Effective plan years after September 23, 2010

- **Lifetime Limits and Annual Limits**
 - Prohibited on dollar value of “essential health benefits”, defined below
 - For plan years before 1/1/2014, may establish *restricted* annual limit on “essential health benefits” as permitted by HHS regulation
 - May impose limits on non-essential benefits
- **Grandfathered Plans must comply**

First Phase Health Reform

- **“Essential Health Benefits”**
 - Ambulatory patient services
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Mental health and substance use disorder services
 - Prescription drugs
 - Rehabilitative and habilitative services and devices
 - Laboratory services
 - Preventive and wellness services
 - Chronic disease management
 - Pediatric services, including oral and vision care
 - Others as determined by HHS

First Phase Health Reform

Effective plan years after September 23, 2010

- **Pre-existing Condition Exclusions**
 - May not be imposed with respect to plan enrollment or coverage for specific conditions
 - Prohibited for children under 19 (not just dependents)
 - Prohibition applies to all individuals in 2014
- **Rescission**
 - Plans may not rescind coverage for an enrollee once covered, except in cases of fraud or material misrepresentation of material fact, as provided in plan
- **Grandfathered Plans must comply**

First Phase Health Reform

Effective plan years after September 23, 2010

- **New Summary of Benefits and Coverage**
 - Standards to be developed by HHS with NAIC
 - Paper or electronic
 - Provided to applicants and enrollees
 - Significant modifications must be communicated at least 60 days before the effective date of the change effective 2012
 - \$1,000 per day for each willful failure
 - For self-insured plans, plan administrator is responsible; For fully insured, issuer is responsible
- **Grandfathered Plans Must Comply**

First Phase Health Reform

Effective for plan years after September 23, 2010

- **Preventive Services Mandates for Group Health Plans**
 - Must provide coverage, without cost-sharing by participant, for certain preventive care services and screenings and certain immunizations
 - Plans must follow recommendations with respect to preventive care for children and women according to guidelines of Health Resources and Services Administration
- **Grandfathered Plans Exempt**

First Phase Health Reform

Effective for plan years after September 23, 2010

- **Patient Protections**
 - Plan enrollees must be allowed to select their own primary care provider or pediatrician, provided that physician is a participating provider
 - No preauthorization or increased cost sharing for emergency services (whether in or out of network)
 - No preauthorization or referral may be required for OB/GYN services
- **Grandfathered Plans Exempt**

First Phase Health Reform

Effective for plan years after September 23, 2010

- **Extension of Code § 105(h) Nondiscrimination Rules**
 - Code Section 105(h): cannot discriminate in favor of highly compensated individuals as to eligibility or benefits
 - Insured employer-sponsored group health plans that are not grandfathered will have to comply with the nondiscrimination requirements of Code Section 105(h)
 - Non-compliance penalty appears to be \$100 per day excise tax, although historically, noncompliance triggers income inclusion of value of coverage or benefits
- **Grandfathered Plans Exempt**

First Phase Health Reform

Effective for plan years after September 23, 2010

- **New Appeals Process**
 - A group health plan must have an internal and external claims process
 - An internal process that complies with ERISA claims procedures is deemed sufficient
 - Self-funded plans must implement external claims process according to HHS standards (to be developed)
 - Insured plans must comply with state external review laws
 - Process should advise enrollees “in a culturally and linguistically appropriate manner” of available internal and external processes
 - Plans must allow continued coverage during appeals process
- **Grandfathered Plans Exempt**

First Phase Health Reform

Effective in 2011

- **Form W-2 Reporting**
 - Employers must report aggregate “value” of health coverage on Form W-2
 - Includes value of care received at employer on-site medical clinics
- **Over-The-Counter Drug Reimbursements**
 - OTC drug expenses no longer qualified expenses under HRAs, health FSAs, HSAs, or Archer MSAs unless prescribed by a doctor
 - Exception - insulin
- **Non-Qualifying HSA and Archer MSA Distributions**
 - Non-qualified distributions from these accounts subject to an increased penalty tax of 20%
 - Current penalty taxes are 10% for HSAs and 15% for Archer MSAs
- **“Simple” Cafeteria Plans**
 - For eligible small employers (100 or fewer employees during either of 2 preceding years)
 - Provides non-discrimination safe harbor under IRC Sections 105(h), 125 and 129 provided specified contribution, eligibility and participation requirements are satisfied
 - Contribution requirements: at least 2% of compensation or lesser of 6% of compensation or twice the employee’s contributions
- **Grandfathered Plans Must Comply**

Second Phase Health Reform

Effective January 1, 2013

- **Health FSA Salary Reductions**
 - Limited to \$2,500 per year (adjusted for changes in cost of living)
 - \$2,500 limit does not include employer non-elective contributions
- **Medicare Part D Subsidy**
 - Deduction previously permitted for expenses allocable to prescription drug subsidy eliminated
- **Grandfathered Plans Must Comply**

Second Phase Health Reform

Effective January 1, 2013

- **Employer Notice Requirement**

- Employers must provide employees notice at time of hiring of:
 - Existence of state Exchanges, including description of services offered and how to contact the Exchange for assistance
 - Employee's eligibility for a tax credit under the Exchange if the employer's share of total costs is less than 60%
 - Potential loss of employer contribution to health benefits the employer offers if the employee purchased a policy through the Exchange without a voucher
- Existing Employees must receive this notice no later than March 1, 2013

- **Grandfathered Plans Must Comply**

Second Phase Health Reform

Effective January 1, 2014

- **No pre-existing condition exclusions or annual limits***
- **90-day maximum waiting period***
- **Wellness program incentives increased from 20% to 30% of COBRA premium amount**
 - Not available to grandfathered plans
- **Annual deductibles limited to \$2,000 for single and \$4,000 for other (indexed in future years)**
 - Grandfathered plans exempt
- **Out-of-pocket amounts cannot exceed those in effect for HDHPs**
 - 2010, \$5,950 single and \$11,900 family
 - Grandfathered plans exempt
- **Guaranteed availability and renewability of coverage**
 - Insurers must accept every individual and employer in the state and continue coverage by renewing if elected by the individual or employer
 - HIPAA nondiscrimination requirements apply in the individual market
- **Mandated coverage of routine costs of participation in clinical trials by “qualified individuals”**
 - Grandfathered plans exempt

***Grandfathered Plans Must Comply**

Second Phase Health Reform

Effective in 2014

State Health Benefit Exchanges

- States will establish and run Exchanges
- Individuals and small employers (generally <101 employees) may purchase insurance through the Exchange (before 2016, a State may elect to treat employers with < 51 employees as small)
 - Plans available must offer essential health benefits
 - Participants not to pay more than 40% of the cost of benefits under the plan
 - Exchanges may include large employers beginning January 1, 2017
 - Employers who purchase coverage through Exchange may permit employees to pay for it with pre-tax dollars under employer's cafeteria plan
 - Employer required to provide notice (described in prior slide) regarding Exchange

Second Phase Health Reform

Effective January 1, 2014

Individual Responsibility

- Individuals not enrolled in qualifying coverage must pay a penalty
 - Penalty generally starts at \$95 per person in 2014 (\$325 in 2015 and \$695 in 2016) or up to 1% of income over the threshold amount of income required to file a tax return (2% in 2015 and 2.5% in 2016)
 - Families pay half the amount for children
 - Total household penalty shall not exceed 300% of the per adult penalty (\$2,085) or the national average premium for the “bronze level” health plan offered through the exchange that year
 - After 2016, applicable dollar amount is increased
- Certain individuals will be exempt from the penalty, including individuals who cannot afford coverage, individuals exempt for religious reasons, and individuals residing outside of the U.S.

Second Phase Health Reform

Effective in 2014

Vouchers for Qualified Employees

- Employer offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage must provide free choice voucher to employees with total household incomes of not more than 400% of the federal poverty level (about \$88,200 for a family of 4) where
 - Required premium under the employer plan is between 8% and 9.8% of the employee's household income, the employee elects to participate in the exchange, and the employee does not participate in the employer health plan
- Voucher must be for no less than the amount that the employer would have contributed to the employee's coverage and is used to offset the cost of coverage under the exchange
- Voucher is deductible for the employer, and excluded from employee's income (to extent used for healthcare)
- Voucher recipients are not eligible for tax credits through the exchange and do not trigger play or pay penalty

Second Phase Health Reform

Effective January 14, 2014

Health Coverage Reporting

- Employers with more than 50 full-time/FTE employees generally must report to the government on health coverage, including:
 - certification of minimum essential coverage
 - name of each covered employee and dependent
 - number of full-time employees
 - length of any waiting period
 - monthly premium for the lowest cost option
 - employer's share of the cost
 - option for which employer pays largest share of the cost and share it pays for each enrollment option (Free Choice Voucher employers only)
 - Government will provide form or mechanism for reporting
 - Summary of the above report must be provided to employees
- **Grandfathered Plans must comply**

Second Phase Health Reform

Effective January 1, 2014

Employer Play or Pay Mandate

- **Play Mandate: Employer must offer full-time employees “minimum essential coverage”**
 - Coverage offering “essential health benefits” as described earlier
 - Coverage under a Grandfathered Plan
 - **Thus Grandfathered Plans exempt**
- **Applies to employers with 50 or more full-time/FTE employees**
 - Full-time employee = working an average of at least 30 hours a week
 - Employer = all controlled group members (Code section 414 aggregation rules)

Second Phase Health Reform

Effective January 1, 2014
Employer Play or Pay Mandate (*cont.*)

- **Pay Mandate #1 (Coverage Penalty)**
 - Applies to employers who do not offer minimum essential coverage
 - \$2,000 annual penalty applies if employer has at least one full-time employee who receives a premium tax credit or cost-sharing reduction for coverage through a Health Insurance Exchange
 - Premium tax credits are available for individuals and families with incomes between 133-400% of federal poverty level
 - Cost-sharing subsidies are available for individuals and families with incomes between 100%-400% of federal poverty level
 - 400% of the federal poverty level is \$43,320 for an individual and \$88,200 for a family of 4 based on 2009 figures
 - Penalty is assessed monthly at \$167 per employee (1/12 of \$2,000)
 - To calculate penalty, reduce number of full-time employees by 30

Second Phase Health Reform

Effective January 1, 2014

Employer Play or Pay Mandate (*cont.*)

- **Pay Mandate #2 (Affordability Penalty)**

- Applies to employers who offer minimum essential coverage (even if the coverage does not satisfy Federal requirement to cover $\geq 60\%$ of total allowed cost)
- \$3,000 annual penalty for each full-time employee receiving a premium tax credit or cost-sharing reduction for coverage through a Health Insurance Exchange
- Penalty is measured and assessed monthly (\$250 per full-time employee receiving the subsidy)
 - Monthly Penalty may not exceed $\$167 \times (\text{number of full-time employees minus } 30)$
 - Penalty does not apply with respect to any employee who receives a free choice voucher from employer

Third Phase Health Reform

Effective January 1, 2018

Cadillac Plan Tax

- **Excise tax of 40% on cost of coverage over:**
 - \$10,200 for individual coverage
 - \$27,500 for other coverage
 - Limits will be adjusted if health care costs increase more than expected before 2018 (55%)
- **Limits increased by \$1,650 and \$3,450 respectively for:**
 - Retirees age 55 or older who are not eligible for Medicare
 - Plans with majority of participants in certain high-risk professions
 - Increase limited to \$1,650/\$3,450 even if both conditions apply
- **Limits may be increased by age and gender characteristics**
- **Limits increase by CPI-U + 1% in 2019 and by CPI-U thereafter**
- **Grandfathered Plans are subject to this tax**

Third Phase Health Reform

Effective January 1, 2018

Cadillac Plan Tax (*cont.*)

- **Cost of Coverage**
 - Applicable premium determined under COBRA rules
 - Includes employer-paid and employee-paid (after-tax) coverage
 - Includes employer and salary reduction contributions to health FSAs, HRAs, HSAs and MSAs
 - Includes supplementary insurance coverage
 - Excludes stand-alone dental or vision insurance, accident, disability or long-term care insurance and employee-paid hospital indemnity or specified disease coverages

Third Phase Health Reform

Effective January 1, 2018

Cadillac Plan Tax (*cont.*)

- **Liability for Tax**
 - Coverage providers taxed on applicable share of excess benefit
 - Insurers (insured plans)
 - Employers (HSAs and MSAs)
 - Plan administrators (self-funded plans, FSAs and HRAs)
 - Excess benefit is allocated among coverage providers in same ratio that cost of each coverage provider's coverage bears to total cost of all employer-sponsored coverages
- **Employer Responsibilities**
 - Calculation and allocation of excess benefit
 - Notification of coverage providers and IRS

Third Phase Health Reform

Effective January 1, 2018

Cadillac Plan Tax (*cont.*)

- **Failure to Properly Calculate Excess Benefit**
 - Coverage providers liable for additional tax, but not subject to penalty
 - Employer subject to penalty equal to additional tax, plus interest
 - Penalty does not apply if
 - Employer reasonably did not know of failure
 - Failure is due to reasonable cause and corrected within 30 days
 - IRS may waive penalty if excessive or inequitable and failure is due to reasonable cause

Revenue Raising: Medicare Taxes

Effective January 1, 2013

- **Earned income:** 0.9% increase on wages or earnings above \$200K (\$250K for joint filers/\$125K for married filing separately)
 - Withholding only required on wages above \$200K
 - Employee pays shortfall
 - Deduction for one-half of self-employment taxes does not apply
- **Unearned income:** new 3.8% tax on lesser of
 - Net investment income (e.g., interest, dividends, capital gains)
 - Modified adjusted gross income above \$200K (\$250K for joint filers/\$125K for married filing separately)
- Other revenue raisers are summarized in Appendix 4

Revenue Raising: Other Taxes and Fees

Effective July 1, 2010

- **Indoor Tanning Services**
 - 10% of cost
 - Collected by service provider, who is secondarily liable

Effective January 1, 2011

- **Effective Fee on Drug Manufacturers and Importers**
 - Aggregate annual amount (starting at \$2.5 billion in 2011)
 - Allocated based on sales to government programs in prior year

Revenue Raising: Other Taxes and Fees

Effective January 1, 2013

- **Excise Tax on Medical Device Manufacturers**
 - 2.3% of sales price
 - Excludes glasses, contact lenses, hearing aids, other retail items

Effective January 1, 2013

- **Itemized Deduction for Medical Expenses**
 - Threshold increased from 7.5% to 10% of adjusted gross income
 - Remains at 7.5% for regular income tax for years prior to 2017 in which taxpayer or spouse is age 65 or older (does not affect treatment for alternative minimum tax)

Effective January 1, 2014

- **Fee on Health Insurance Providers**
 - Aggregate annual amount (starting at \$8 billion in 2014)
 - Allocated based on net health insurance premiums in prior year