Ballard Spahr LLP

Health Care Reform for Employers

PEBA Presentation

Brian M. Pinheiro
pinheiro@ballardspahr.com
215.864.8511

September 14, 2010

Scope of Today's Discussion

- Overview of the health care reform law and its timelines
- Review pre-2014 requirements for employment-based plans and employers
- Summarize specific regulations to date
- 2014 and beyond
- Explore "Grandfathered Plan" issues in more depth

The Health Care Reform Law(s)

- Patient Protection and Affordable Care Act (“PPACA”) (Public Law 111-148) and Health Care and Education Reconciliation Act of 2010 (“HCERA”) (Public Law 111-152)
  - Improve access to health insurance coverage
  - Improve quality and efficiency of health care
  - Promote wellness
  - Reform the insurance market and public programs (Medicare, Medicaid, CHIP)
  - Pay for itself

Framework of Coverage Reform

- Focuses primarily on the development of the private insurance market subject to state insurance regulation with uniform minimum Federal standards
- Preserves employment-based coverage (in the short-run)
- Minimum Federal standards for essential coverage, quality of care, affordability (through pooled risk) and information access

Individuals – Enroll or Pay

- To avoid a penalty, individuals must have minimum essential coverage from one of the following sources:
  - Employer-sponsored plan (including a governmental plan)
  - An individual policy (purchased through a private insurer or through an Exchange)
  - Government program (Medicare, Medicaid, Veterans, CHIP)
- Those without coverage face the greater of a dollar penalty or a percentage of household income penalty
  - Dollar penalty equals ½ of the amount listed below for each uninsured dependent under the age of 18
  - Total dollar penalty for a family is capped at 300% of the normal penalty

Year	Individual $ Penalty	% Income Penalty
2014	$95	1.0%
2015	$325	2.0%
2016 (and after)	$695 (as indexed)	2.5%

Exemptions from Enroll or Pay

- Individuals who cannot afford coverage
  - Required contribution for the lowest cost plan option would be in excess of 8% of household income, as adjusted
- Low income taxpayers
  - Individuals who do not need to file a Form 1040 because they do not earn enough money
- Individuals who experience short coverage gaps
  - Individuals who were not covered by minimum essential coverage for a continuous period of **less** than 3 months
- Individuals with a hardship
  - Individuals for whom there is no affordable (i) employer-sponsored coverage; or (ii) qualified health plan through an Exchange
- Members of Indian tribes

Health Insurance Exchanges

- **What is an Exchange?**
  - A marketplace of health insurance issuers (traditional, for-profit insurance companies and non-profit cooperatives) that will offer qualified health plans to individuals/small ERs
    - Exchanges will be operational by January 1, 2014
    - Large employers may be eligible to purchase coverage through Exchanges in 2017
- **Who creates an Exchange?**
  - Each state must create an Exchange (funded by $6 billion in federal grants)
- **What is the goal of an Exchange?**
  - Reduces the need for employer-sponsored coverage
  - Enhance consumer choice
  - Creation of single risk pools
  - "Apples to apples" comparison of health insurance coverage
- **What are the features of an Exchange?**
  - Issuers must be certified by the Exchange
  - Rating system based on quality and price
  - Enrollee satisfaction system
  - Premium rate limits - Age (3:1), tobacco use (1.5:1), family structure and geographic area

Health Insurance Exchanges

Tier	Includes Essential Benefits	Percentage of Covered Benefit Costs	Out-of-Pocket Limit for Individual/Family*
Bronze	Yes	60%	$5,950 / $11,900
Silver	Yes	70%	$5,950 / $11,900
Gold	Yes	80%	$5,950 / $11,900
Platinum	Yes	90%	$5,950 / $11,900

- Essential benefits include
  - Preventive care
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance abuse
  - Prescription drugs

*This will be reduced for those with incomes between 100– 400% of FPL.

Ballard Spahr LLP

Subsidies for Individuals in Exchanges

- Three types of subsidies for individuals with coverage through Exchanges
  - Premium limits
  - Cost-sharing limits (*e.g.*, limits on deductibles, copays and co-insurance that will increase the actuarial value of the benefits of the plan)
  - Out-of-pocket spending limits

Income Level (in terms of FPL)	Max. % of Income Paid Toward Health Care Coverage
Up to 133%	2%
133 - 150%	3 - 4%
150 - 200%	4 - 6.3%
200 - 250%	6.3% - 8.05%
250 - 300%	8.05% - 9.5%
300 - 400%	9.5%

Income Level (in terms of FPL)	Cost Sharing Limit
150 - 200%	6%
200 - 250%	13%
250 - 300%	27%
300 - 400%	30%

Income Level (in terms of FPL)	Out-of-pocket spending limits
100 - 200%	$1,983 (I) / $3,967 (F)
200 - 300%	$2,975 (I) / $5,950 (F)
300 - 400%	$3,987 (I) / $7,973 (F)

Employers – Pay or Play

- Large employers (at least 50 FTEs)
  - that do not offer health coverage and have at least one FT EE who receives premium tax credit must pay a penalty
    - $2,000 per FT EE (excludes the first 30 EEs)
  - that offer health coverage and have at least one FT EE who receives a subsidy through an Exchange because employment-related health coverage is not adequate or affordable (plan covers less than 60% of costs or EE's contribution to ER coverage > 9.5% of household income) must pay the lesser of
    - $3,000 per employee who is receiving a premium tax credit
    - $2,000 for each FT EE
- What is a full-time employee for "pay or play" purposes?
  - FT EEs (30 or more hours/week)
  - FT Equivalent Employees (total monthly part-time hours / 120)
- What about part-time employees?
  - ERs not subject to "pay or play" for PT EEs

Small Employer Incentives for Providing Coverage

- **Amount of tax credits**
  - Phase I (2010- 2013)
    - Credit up to 35% of ER contribution toward EE's health insurance premium
  - Phase II (2014 and later)
    - Credit up to 50% of ER contribution toward EE's health insurance premium
- **Tax exempt entities are eligible for FICA credits**
  - Up to 25% (2010-2013)
  - Up to 35% (2014 and later)
- **ER criteria for tax credits**
  - ER must pay at least 50% of EE health care coverage
  - ER must have no more than 25 FT Equivalent EEs
    - Maximum credit for ERs with 10 or fewer FT Equivalent EEs
  - ER must pay average wage < $50K/year
    - Maximum credit for ERs that pay average wage < $25,000

What Do I Need To Worry About Right Now?

- Health care reform seeks to improve access and quality of coverage right away
  - Put all forms of coverage on the same playing field by 2014 when the Exchanges open

- Transition Period: 2011-2014
  - All employer-sponsored plans must satisfy a series of <u>immediate reforms</u>
    - Insured plans
    - Self-funded plans
    - Limited exceptions for "grandfathered health plans"
    - Exception for retiree-only plans and "excepted benefits"
- Grandfathered health plans: continue coverage that existed as of 3/23/2010
  - ''Grandfathered health plan'' is defined as
    - any group health plan
    - in which an individual was enrolled on March 23, 2010
    - that continuously covered at least one individual since March 23, 2010

Immediate Reforms

* Green indicates that requirement applies to Grandfathered Plans

Requirement*	PHSA Sec.	1st Plan Yr. after
Pre-existing exclusions prohibited for children under age 19	2704	9/23/2010
Prohibition on lifetime dollar maximum on benefits	2711	9/23/2010
Prohibition on annual dollar limits on restricted benefits	2711	9/23/2010
Rescissions of coverage for reasons other than fraud or non-payment	2712	9/23/2010
Required preventive health services without cost-sharing	2713	9/23/2010
Extension of dependent coverage to age 26	2714	9/23/2010
No discrimination based on salary permitted	2716	9/23/2010
Insured plans must rebate premiums if medical claims ratios too low	2718	9/23/2010
Mandated appeals process with binding external review	2719	9/23/2010

Medium-Term Reforms

*Yellow indicates employer responsibility; green indicates requirement applies to Grandfathered Plans

Requirement*	**PHSA Sec.**	**1st Plan Yr. after**
Automatic enrollment for large employers	FLSA 1511	1/1/2012
Summary communication for enrollees	2715	3/23/2012
Reporting to HHS (quality outcomes, etc.)	2717	3/23/2012
Employee notice re: coverage options	FLSA 1512	3/23/2013

Ballard Spahr LLP

2014 Reforms

* Green indicates that requirement applies to Grandfathered Plans

Requirement*	PHSA Sec.	1st Plan Yr. after
Insured plans subject to premium underwriting restrictions	2701	1/1/2014
Insured plans must guarantee eligibility and renewability	2702; 2703	1/1/2014
All pre-existing exclusions prohibited	2704	1/1/2014
Prohibitions on health status discrimination	2705	1/1/2014
Non-discrimination in health care providers	2706	1/1/2014
Comprehensive health insurance requirements include annual cost-sharing limits	2707	1/1/2014
No waiting period in excess of 90 days	2708	1/1/2014
Coverage for clinical trials	2709	1/1/2014

Prohibitions on Pre-existing Conditions

- Plan may not impose any pre-existing condition exclusion upon coverage for an individual under age 19
- Beginning January 1, 2014, the restriction will apply to all individuals, not just those under age 19

Coverage Of Children Up To Age 26

- Plans that provide for dependent coverage must extend such coverage to an adult child (married or unmarried) until the child reaches age 26
- Coverage for children may not be conditioned on <u>any</u> factor other than the child's relationship to the employee
  - Not required to cover a child or spouse of a child receiving coverage
- Identical coverage must be provided at identical cost
  - Children, whether or not adults, must be offered all of the benefit options under the plan that are available to similarly situated dependents
  - They cannot be required to pay more for coverage than other similarly situated dependents are required to pay
- Special enrollment period required to elect to cover the child
  - Special enrollment period must last a minimum of 30 days
  - For a calendar year plan, the coverage, if elected, must be effective no later than January 1, 2011

Coverage Of Children Up To Age 26

- COBRA continuation coverage processes may be affected
  - If a child eligible for the special enrollment period is currently or was previously a COBRA participant and the child reenrolls in the plan, any future COBRA coverage resulting from a subsequent qualifying event (including aging out of the plan at 26) will result in another, new COBRA election
  - The subsequent COBRA continuation period will be determined without reference to any prior COBRA continuation coverage period
- Code amended to exclude expanded coverage from income tax
  - Tax exclusion until year the child turns age 27
  - **Cafeteria plan must be amended by the end of the 2010 plan year**
- Special exception for grandfathered plans
  - Prior to January 1, 2014, a grandfathered plan may exclude a child who has not attained age 26 from coverage only if the child is eligible to enroll in an employer-sponsored health plan (other than the plan of a parent)
- State laws may also apply and require coverage beyond age 26

Coverage Of Children Up To Age 26

- When will employers be required to allow coverage of non-student children who are under age 26?
- Based on your plan years; effective for plan years beginning on or after September 23, 2010
  - If you have a calendar year plan year
    - The requirement is effective January 1, 2011
  - If you have a September 1 – August 31 plan year
    - The requirement is effective September 1, 2011
  - If you have a October 1 – September 30 plan year
    - The requirement is effective October 1, 2010

Lifetime and Annual Limits

- No lifetime limits on benefits, except for limits on specific non-essential covered benefits
- Annual limits on essential benefits will be phased out, ending completely in 2014
  - Annual limit of $750,000 for the first plan year beginning on or after September 23, 2010
  - Annual limit ceiling increases over the next two years, first to $1.25 million, then to $2 million
- Individuals who are subject to lifetime limits need to be notified that they will once again be eligible for benefits and of the right to re-enroll (if they are no longer enrolled in the plan).
  - Notice must be provided before January 1, 2011 (for calendar year plans)
  - Enrollment period of at least 30 days must be provided
  - Notice may be provided individually or in applicable annual enrollment materials
- May apply to HHS for waivers to allow annual limits in certain circumstances

Rescission of Coverage

- Coverage may be rescinded only for fraud or the intentional misrepresentation of a material fact
- A "rescission" is defined to be the retroactive discontinuance of coverage (the rules do not apply to prospective terminations)
- Retroactive termination for the failure to pay premiums timely will be permitted
- At least 30 days' advance written notice must be provided for a rescission (even though the effect will be retroactive)

Patient Protections

- If a plan requires a participant to pick a primary care provider (PCP), notice must be provided informing each participant of its terms
  - Can be included in summary description of benefits or SPD – model language provided
- Emergency services must be covered without pre-authorization and without regard to network provider status

Preventive Health Benefits

- Plan must cover, without any cost-sharing requirements:
  - Evidence-based items and services (currently recommended by U.S. Preventive Services Task Force)
  - Immunizations
  - Pediatric preventive care and screenings
  - Women's health preventive care and screenings including breast cancer screening, mammography
- Not applicable to Grandfathered Plans

Appeals Process

- Plan must implement a modified claims appeals process that, at a minimum, provides
  - Internal claims appeal process
  - Notice of appeal process and availability of assistance
  - Enrollee allowed to review file, present evidence and testimony as part of process and receive continued coverage pending outcome of the appeals process
  - A binding external review process (minimum standards NAIC consumer protection standards)
- Not applicable to Grandfathered Plans

Appeals Process

- Internal Appeals
  - Plans subject to ERISA may continue to use DOL safe harbor procedures, subject to certain modifications
    - Urgent claims determinations must be made within 24 hours (down from 72 hours)
    - Additional items to be included in notice of adverse benefit determination
      - Identifying information (date of service, name of provider, diagnosis code and meaning, treatment code and meaning)
      - Denial code and meaning, standard used in denying the claim
      - Description of internal and external appeals process
      - Disclose contact information for applicable office of health insurance consumer assistance or ombudsman
  - Continued coverage pending the outcome of an appeal

Appeals Process

- External Appeals
  - Insured plans will use each state's external appeals process (subject to modifications if it doesn't meet federal requirements)
  - Self-funded plans must meet Federal standards for external appeals
    - DOL has issued an interim safe harbor
      - Claimant has 4 months after adverse benefit determination to request external review
      - Plan has 5 days to conduct preliminary review, and 1 day to notify claimant
      - Plan then assigns an accredited independent review organization (IRO) to review the claim
      - IRO has 45 days to issue a decision
  - Plans will need to contract with at least 3 IROs to rotate assignments of claims

Coverage Summary Requirements

- Plans must provide uniform summary of benefits and coverage
  - Secretary to develop guidance and standard definitions for medical and insurance terms within 12 months of enactment (March 2011)
  - Plans must provide within 24 months of enactment (March 2012)
  - Culturally and linguistically appropriate manner using terms understandable by the average enrollee -- paper or electronic
  - Notice of material modifications within 60 days
  - Fine of not more than $1,000 for each willful failure; each enrollee is a separate offense
- Different from the current disclosure requirements that apply to ERISA plans

Other Changes to Plan Design and Operation

- Reinsurance for early retirees
- Medicare Part D - closing the donut hole
- Health FSA and HSA changes
- Administrative Fees
- Auto enrollment and employer notice
- Additional reporting requirements

Early Retiree Reinsurance Program

- Employer-sponsored retiree health plans can be reimbursed for a portion of the costs of retiree health coverage
  - Retirees must be age 55 or older and not Medicare eligible
- Reimbursement is 80% of costs between $15,000 and $90,000 (as adjusted)
  - Costs include amounts paid by retiree
  - Reimbursement must be used to lower the cost of the plan
- Program only runs through 2013; only $5B in funding

Early Retiree Reinsurance Program

- The Program became effective on June 1, 2010
  - Reimbursements will be made on a first-come, first-served basis so claims must be submitted early to secure limited funds
- Claims eligible for reimbursement include the plan sponsor's net cost of providing health benefits for early retirees
  - In an insured arrangement, this does not include premium costs
- Program particulars
  - Employer-based plans must have in place programs and procedures that generate (or have the potential to generate) cost savings with respect to participants with "chronic and high-cost conditions," such as diabetes and cancer
  - Applicants must explain to HHS how they expect to use any reimbursements received under the Program and must project reimbursements for the next two years
    - Reimbursements must be used to reduce plan costs
    - Plan sponsor must show that the reimbursements will not reduce its level of support for the plan
- Transition rules will apply in determining reimbursements for the plan year that includes June 1, 2010

Medicare Part D

- Medicare Part D prescription benefits
  - Currently, no coverage for prescription drugs between the initial coverage limit and the out-of-pocket expense limit
    - For 2010, this means expenses between $2,830 and $4,550
  - In 2010, one-time, tax free $250 rebate for those who pay for drugs in the "donut hole"
  - Extends coinsurance to drug costs incurred in the donut hole
    - Starts at a high level (93% for generics in 2011); reduced to 25% by 2020
    - 50% manufacturer rebate for brand-name drugs begins in 2011
  - Retiree drug subsidy (RDS) payments no longer excludable beginning in 2013

Health FSA and HSA Changes

- Health FSA contributions limited to $2,500 (as adjusted)
  - Limit is effective in 2013
- Increased excise tax on ineligible distributions from health savings accounts (HSAs)
  - Increases from 10% to 20%
  - Effective in 2011
- For <u>both</u> Health FSAs and HSAs, over-the-counter (OTC) drugs are no longer eligible for reimbursement
  - Effective January 1, 2011
  - Cannot reimburse cost of OTC drugs during the grace period for the 2010 plan year

Administrative Fees

- Self-funded plans must pay an annual administrative fee of $2 times the average number of covered lives
  - Applies to plan years ending after September 30, 2012
  - Phase-in of $1 administrative fee for the plan year that ends in 2013
  - Expires for the plan year ending after September 30, 2019
- Similar administrative fee on insured plans, paid by the insurer

Notice to Employees and Auto-Enrollment

- Employers must provide written notice to current and new employees
  - Identify the Exchange and how to contact
  - If employer's health plan is not sufficiently valuable, notify of the existence of premium subsidies and cost-sharing reductions
  - If the employee enrolls in an Exchange plan, indicate that the employee may lose any employer subsidy in the employer plan
  - Effective March 1, 2013
- ERs with more than 200 full-time EEs must automatically enroll new employees if it continues to offer a health plan
  - Employees may opt out; advance notice required
  - No effective date in the legislation – March 23, 2010(?)

Additional Reporting Requirements

- Value of employer-sponsored health coverage (Effective 1/1/2011)
  - ER has to include the value of employer-sponsored health coverage on each employee’s Form W-2
    - Value is calculated using the COBRA rules
    - If an employee enrolls in separate plans for medical, dental and vision coverage, the aggregate value must be reported
    - Not taxable; reporting only
- Minimum essential coverage (Effective 1/1/2014)
  - If employer provides minimum essential coverage to any individual during the year, it must report certain information to the individual and IRS or face a $50 penalty per failure
    - Name, dates, type of coverage (i.e., whether coverage was received through an Exchange) and tax credits/subsidies received by the individual

To Be (Grandfathered) or Not To Be…

Grandfathered

- Certain mandated benefit design changes will apply
- Grandfathered status means less ability to change coverage in effect on March 23, 2010
- Exempt from other changes
  - Preventive services with no cost-sharing
  - New appeals procedure
  - Quality reporting to HHS
  - Coverage for clinical trials

Non-Grandfathered

- All mandated benefit design changes will apply
- More flexibility to make plan design changes

Maintaining Grandfathered Status

- The following individuals are permitted to enroll
  - Family members of existing enrollees (if such enrollment was permitted under the terms in effect as of 3/23/10)
  - "New employees" and their families
  - Current non-enrolled employees and their families
- Grandfathered status is maintained on a benefit package basis
  - A plan that has multiple benefit packages may have both grandfathered and non-grandfathered benefit packages

Maintaining Grandfathered Status

- The following changes will cause a plan to lose its grandfathered status
  - Any increase in an individual's coinsurance requirement
  - Any increase in fixed-dollar cost-sharing other than copayments in excess of the rate of medical inflation since 3/23/10, plus 15%
  - Any increase in co-payments in excess of the greater of (1) the rate of medical inflation, plus 15 percentage points, or (2) $5.00, as adjusted for medical inflation
  - Any decrease in the employer contribution towards the cost of any tier of coverage by more than 5 percent of its contribution rate in effect on 3/23/10
  - Certain changes to lifetime and annual benefit limits that would be adverse to plan participants

Maintaining Grandfathered Status

- Employers must disclose desire to maintain grandfathered status in communications sent to plan participants
- Transition Period
  - Plan changes adopted before March 23, 2010, with an effective date after that date will not cause a loss of grandfathered status.
  - If an employer made changes to a group health plan since March 23, 2010 that would cause a plan to lose its grandfathered status under the new guidance, the employer may reverse those changes before the first plan year beginning on or after September 23, 2010 (generally, the 2011 plan year) and preserve grandfathered status.

Grandfathered Plan Benefits Requirements

- For plan years beginning on or after 9/23/2010:
  - Must extend benefits to children up to age 26
  - Cannot have dollar value limits on lifetime or annual benefits
  - May not rescind coverage, other than for fraud
  - No pre-existing condition provisions may apply to children < 19
  - Must provide uniform benefits summary information
  - May not have a waiting period in excess of 90 days (effective 2014)
  - Insured plans must account for claims/non-claims costs and rebate to enrollees if non-claims costs are too high
- Other market reforms and Exchange requirements do not apply to Grandfathered Plans (before or after 2014)

Collective Bargaining "Exemption"

- **Insured** CB plans ratified before March 23, 2010 are grandfathered until the date on which the last of the CBAs relating to the coverage terminates
  - Contrary to the statute, the regulations provide no broad exemption for insured CB plans that are subject to CBAs in effect on March 23, 2010
    - Insured CB plans are subject to all of the health care reform changes that otherwise apply to grandfathered health plans (e.g., the adult child coverage rules apply, but the new appeal procedures will not apply).
    - Only exemption is for changes in insurance issuers
  - Any CBA coverage amendment which amends coverage solely to conform to any requirement added by the Act shall not be treated as a termination of such CBA
- Self-funded CB Plans would be subject to group health plan grandfather rules

Questions