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Welcome to The Ins and Outs of Health Care Reform: More Changes from Capitol Hill

Presented by

Sapers & Wallack, Inc.

Featuring Guest Speaker

Alden J. Bianchi, Esq., Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C., Boston, Massachusetts

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Today's Guest Speaker

Alden Bianchi

Alden Bianchi is a nationally recognized expert on the subject of Health Care Reform. Alden is the practice group leader of Mintz, Levin, Cohn, Ferris, Glovsky, and Popeo, P.C.'s Employee Benefits and Executive Compensation practice and a member in the Employment, Labor and Benefits Section. He advises corporate, not-for-profit, governmental, and individual clients on a broad range of executive compensation and employee benefits issues, including qualified and non-qualified retirement plans, stock and stock-based compensation arrangements, ERISA fiduciary and prohibited transaction issues, benefit-related aspects of mergers and acquisitions, and health and welfare plans. He has also testified before the Senate Finance Committee on the subject of health care reform.Alden is a graduate of Worcester Polytechnic Institute and the Suffolk University and Georgetown University law schools, and he holds an LL.M. in taxation from Boston University School of Law. He is listed in Woodward & White's *Best Lawyers in America* and Marquis' *Who's Who in American Law*, and was also recognized in the most recent edition of *Chambers USA: America's Leading Lawyers for Business* as a leader in his field. Annually since 2006, Alden has been recognized as a Massachusetts Super Lawyer by the publishers of *Boston Magazine*. He is also a Fellow of the American College of Employee Benefits Counsel.

YOUR KID IS UGLY...
Romney
RomneyCare in Mass.
ObamaCare
MIKE LUCKOVICH

The Legislation

- Patient Protection and Affordable Care Act
  - H.R. 3590, as amended, passed in the Senate December 24, 2009
  - Signed into law March 23, 2010
- The Health Care and Education Reconciliation Act of 2010
  - An amendment/substitute to H.R. 4872, as amended, passed in the House March 23, 2010
  - Signed into law March 30, 2010

Organization

- Insurance market reforms
  - Immediate and permanent insurance reforms
  - Grandfather plan rules
- State-based insurance exchanges
- Individual mandate
- Premium and cost sharing subsidies
- Employer responsibility

Organization (cont'd)

- Other employer requirements
  - Auto enrollment for certain large employers
  - Free choice vouchers
  - Notice and reporting requirements
- Financing

Immediate Insurance Reforms

- PHSA §2711—No annual or lifetime limits
- PHSA §2712—Prohibition on rescissions
- PHSA §2713—Coverage or preventative services
- PHSA §2714—Coverage off adult children
- PHSA §2715—Uniform explanation of benefits

Immediate Reforms (cont'd)

- PHSA §2715A—Provision of additional information
- PHSA § 2716—No discrimination in favor of "highly compensated individuals"
- PHSA § 2717—Ensuring the quality of care
- PHSA § 2718—Minimum loss ratios
- PHSA § 2719—Claims and appeals
- PHSA § 2719A—Patient protections

2014 Insurance Reforms

- PHSA §2704—Ban on pre-existing conditions
- PHSA §2701—Fair health insurance premiums
- PHSA §2702—Guaranteed availability
- PHSA §2703—Guaranteed renewal
- PHSA §2705—Ban on discrimination base on health status

2014 Reforms (cont'd)

- PHSA §2706—ban on discrimination in providers
- PHSA §2707—Comprehensive coverage
- PHSA §2708—Maximum waiting periods
- PHSA §2709 Coverage of individuals participating in clinical trials

Grandfathered Plans

- Certain provisions do not apply to "group health plans or health insurance coverage" (individual and group) in which "an individual was enrolled" on March 23, 2010
- Grandfathered status not affected by
  - Subsequent coverage renewals
  - Addition of new family members
  - Addition of new employees

Grandfather Interim Final Rule

- Clarification re: retiree-only plans
- Notice requirements
- Adding new employees--anti-abuse rule
- Change of carriers
- Benefit-by-benefit determination
- Maintenance of grandfather status
  - Significant reduction of a benefit
  - (Any) increase in co-insurance

Grandfather Rule (cont'd)

- Maintenance of grandfather status (cont')
  - Increase in a co-payment greater than $5 or medical inflation rate plus 15%
  - Increase in deductibles or out-of-pocket limits by more than medical inflation rate plus 15%
  - Reduction in employer contribution
  - Change in overall limits
- Collectively bargained plans

Grandfather Rule (cont'd)

- Permitted changes
  - Changes to comply with law (within limits)
  - Benefit enhancements
  - Enrollment of new employees
- Transition rules
  - Clarification on timing of amendments
  - Certain amendments may be revoked

Grandfather Exceptions

- PHSA § 2701—fair health insurance premiums (insured plans only)
- PHSA § § 2702, 2703—Guaranteed availability and renewability (insured plans only)
- PHSA § 2705—Ban on discrimination based on health status
- PHSA § 2706—Nondiscrimination in health care providers

Exceptions (cont'd)

- PHSA § 2707—Comprehensive health insurance coverage
- PHSA § 2709—Participation in clinical trials
- PHSA § 2713—Coverage of preventive health services
- PHSA § 2715A—Provision of additional information (e.g., claims data, OON benefits)

Exceptions (cont'd)

- PHSA § 2716—No discrimination in favor of highly paid individuals (insured plans only)
- PHSA § 2717—Ensuring quality of care
- PHSA § 2719—claims and external appeals
- PHSA § 2719A—Patient protections

Universal Provisions

- PHSA § 2704—Ban on preexisting conditions
- PHSA § 2708—Maximum waiting periods
- PHSA § 2711—No lifetime or annual limits
- PHSA § 2712—Ban on rescissions
- PHSA § 2701—Coverage of adult children
- PHSA § 2715—Uniform explanations
- PHSA § 2718—MLRs (insured plans only)

State-Based Exchanges

- Eligible individuals and small groups can purchase coverage through State-based exchanges (2014)
  - Small group is 1 – 50 employees in 2014 and 2015, and 1-100 employees in 2016
  - States can expand to employers with >100 employees as of January 1, 2017
- States must establish exchanges by 2014, or HHS must do so (directly or through a tax-exempt)

Exchanges (cont'd)

- Plans must satisfy standards
  - Bronze, silver, gold and platinum plans must cover 60%, 70%, 80% and 90% of benefit costs, subject to out-of-pocket limits
  - "Essential health benefits" package
  - HDHP with HSA account permitted
- HHS develops uniform standards; States provide oversight

Essential Health Benefits Package

- Insurance carriers offering health coverage in the *individual or small group market* must include an "essential health benefits package"
- "Essential health benefits package" means coverage that provides "essential health benefits," limits cost-sharing (i.e., co-pays and deductibles) provides a choice of bronze, silver, gold, or platinum level of coverage in the exchanges

Essential Health Benefits

"Essential health benefits" includes: 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 services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care

Individual Mandate

- Beginning in 2014, U.S. citizens and resident aliens must have health coverage for themselves and family members under age 18
- Must cover “minimum essential benefits”
- Penalties for noncompliance – lesser of
  - Monthly penalty amounts
  - Nat’l average premium for bronze coverage

Minimum Essential Coverage

- "Minimum essential coverage" includes
  - An "eligible employer-sponsored plan"
  - A government plan
  - Individual market plans
- "Eligible employer-sponsored plan" includes a group health plan offered in the small or large group market, including grandfathered plans

Minimum Essential Coverage

- An *individual* is does not have minimum essential coverage if
  - The employee's share of the cost is unaffordable (exceeds 9.5% of Household income) and
  - The plan's share of the cost is less than 60%
- Minimum essential coverage does *not* include excepted benefits

"Excepted Benefits"

- Accident, or disability income insurance
- Supplement to liability insurance
- Automobile liability or medical payment insurance
- Workers' compensation
- Credit-only insurance
- On-site medical clinics
- Limited scope dental or vision benefits

Premium Assistance Credits

- Effective in 2014, a refundable tax credit is available for eligible individuals and families who buy health insurance through an exchange
  - The credit is refundable and payable in advance directly to the insurer and subsidizes the purchase of certain health plans through an exchange

Premium Assistance (cont'd)

- Credit is available for individuals (single or joint filers) with household incomes between 100 and 400% of the Federal poverty level for the family size involved who don't receive health insurance through an employer or a spouse's employer
- Credit is based on the percentage of income the cost of premiums represents

Subsidy Limitations

- Employees are not eligible for tax credits or cost-sharing reductions if eligible for employer coverage, unless
  - Employer plan covers 60% or more of plan's "total allowed cost of benefits" and
  - Employee premium exceeds 9.5% of household income (i.e., the coverage is deemed to be "unaffordable")

Cost Sharing Reductions

- A cost-sharing subsidy is provided to reduce annual out-of-pocket cost-sharing for individuals and households between 100 and 400% percent of FPL for the family size involved
  - Reductions are made in reference to the dollar cap on annual deductibles for high-deductible health plans
  - Further actuarial limits imposed

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Cost Sharing Reductions (cont'd)

- Applies to individuals who enroll in qualified health plans under an exchange
- Out of pocket limits reduced by
  - 2/3 for HI between 100% and 200% of FPL
  - 1/2 for HI between 201% and 300% of FPL
  - 1/3 for HI between 301% and 400% of FPL
- Additional reductions to increase plan's share to costs to between 70% and 94%

Employer Responsibility

- Rules apply to "large employers"
  - 50 or more "full-time equivalent" (FTE) employees
  - FTE s included in determining whether an employer has 50 or more full-time employees (but not for the purpose of calculating the employer penalties)
  - Determination based on controlled group under Code §§ 414(b)(c) and (m)

Counting FTEs

- Full-time equivalent status based on 120 hours/month
  - *General rule*: a full-time employee is an employee who works on average 30 hrs/week
  - *Exception*: Where (i) workforce exceeds 50 full-time employees for not more than 120 days during the year and (ii) the employees in excess of 50 are seasonal employees (as defined by current DOL regulations)
- HHS (in consultation with DOL) to issue regulations

No Offer of Coverage

- Applies to—
  - Large employers who make no offer of coverage to full-time employees under a group health plan (including a grandfathered plan), which includes "minimum essential coverage" under an "eligible employer sponsored plan" and
  - At least one employee is certified as having enrolled for coverage under an exchange and receives a premium tax credit or cost-sharing subsidy

No Offer of Coverage (cont'd)

- Individual is eligible for premium subsidy or cost sharing if
  - Household income is less than 400% of the FPL or
  - Individual is eligible for trade adjustment assistance

No Offer of Coverage (cont'd)

- Penalty is
  - $166.67 per month ($2,000 per year) multiplied by
  - The number of full-time employees
- Penalties assessed monthly
- HHS certifies penalty and time for payment under to-be-issued rules

Offer of Coverage

- Where an employer offers "minimum essential coverage", the penalty is the lesser of:
  - $250 per month ($3,000 per year) for each full-time employee (i) for whom coverage is unaffordable (and (ii) who receives a premium tax credit or cost-sharing reduction tax credit and (iii) declines employer coverage, or
  - Total number of full-time employees multiplied by $166.67 per month ($2,000 per year) for every full-time employee

Offer of Coverage (cont'd)

- First 30 full-time employees are excluded for purposes of—
  - "No coverage" prong, and
  - "Offer of coverage" outside limit

Offer of Coverage (cont'd)

- "Minimum Essential Coverage" for the employer responsibility rule does *not* require that plan to cover 60% of total plan benefits
- Employer needs only to provide the *coverage* under an employer-sponsored group health plan; it does not need to pay for it

Offer of Coverage (cont'd)

- Employee must apply for tax credit
- Salary reductions treated as employee-paid (even though treated as "employer" contributions for other tax purposes)
- Penalty does not apply to any employee to whom the employer provides a free choice voucher (discussed below)

Summary of Exchange Access

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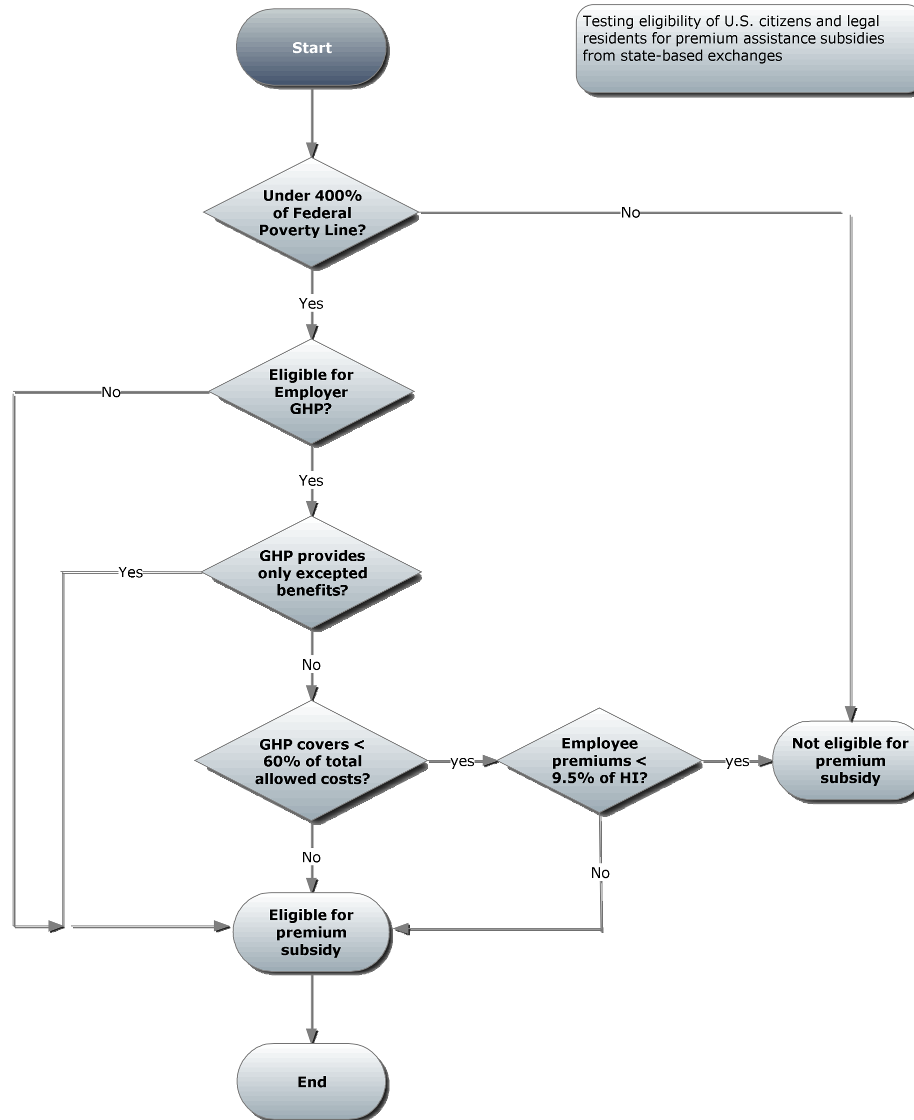

Automatic Enrollment

- Employers with more than 200 full-time employees must automatically enroll new full-time employees (subject to authorized waiting periods of up to 90 days)
- Employees may opt out

Free Choice Vouchers

- An employer offering coverage must provide "qualified employees" with a voucher toward the purchase of a health plan through an exchange
- "Qualified employees" are those
  - With household income of less than 400% of the FPL
  - Whose "required contribution" to his or her employer's group health plan exceeds 8%, but is not in excess of 9.8%, of household income
  - Employee declines to participate in employer's plan

Vouchers (cont'd)

- Vouchers are equal to amount employer would have provided toward employee's coverage (self-only or family, depending on employee's election) under option for which employer paying largest cost
- Cost determined under rules similar to COBRA rules, adjusted for age and coverage tiers
- Employers pay vouchers to Exchange; if coverage through Exchange is less than voucher amount, Exchange pays difference to employee

Employer Notice/Reporting

- Employers must disclose the value of health benefits on the employee's Form W-2: December 31, 2010
- A "uniform notice of coverage requirements" must be issued by March 23, 2012
- Information to Secretary of HHS re: claims payments, etc.: plan years commencing after September 23, 2010 (does not apply to grandfathered plans)

Employer Notice/Reporting

- HHS must issue a model "quality of care" report by March 23, 2012; plans and carriers will need to file such reports commencing in 2013
- Employer notice regarding exchanges takes effect March 1, 2013
- Employer notice re: minimum essential coverage—takes effect in 2014
- Large employer reporting to IRS re: coverage offered also takes effect in 2014

Employer Notice/Reporting

- Detailed report of health coverage, including whether plan offers minimum essential coverage, length of waiting periods, premium cost data, employer contributions, and number of full-time employees covered
- Notice to employees re: plan information including whether plan covers 60% of total allowed costs, information about exchanges, and information about premium subsidies

Limitations on FSAs, etc.

- Beginning in 2013, elective contributions to medical FSAs capped at $2,500, indexed of cost-of-living increases beginning in 2014
- Beginning in 2011: Over-the-counter drugs may no longer be reimbursed under medical FSAs, HRAs, HSAs and Archer MSAs

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Revenue Provisions

- 2013: 1.45% Medicare tax increased by 0.9 % for "high income" individuals
  - $250,000 married filing jointly
  - $200,000 single filers
- 2013: 3.8% tax on passive income
  - Net investment income from interest, dividends, annuities, royalties, and rents
  - Excess of modified AGI over $250,000 (joint returns), $125,000 (married filing separately), or $200,000 (single filers)

Revenue Provisions (cont'd)

- Tax treatment of reimbursements under the Medicare Retiree Drug Subsidy ("RDS") program
  - Before 2013, RDS payments were not taxable
  - From 2013 forward, RDS payments are taxable
  - Balance sheet impact
- Tax on medical device manufactures

Excise Tax on High Cost Plans

- January 1, 2018: 40% excise tax on insurers/plan sponsors of self-funded plans if the value of employer plan exceeds $10,200 (individual) $27,500 (family)
- Thresholds increase for certain retirees and individuals in "high-risk" professions (e.g., police and fire, mining, construction, forestry and fishing)
- HRAs, medical FSAs, included; free standing dental and vision excluded

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Questions & Answers

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