Indiana Benefits Conference

The PPACA and Its Impact on Employee Benefit Plans

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Christopher S. Sears
Ice Miller LLP
One American Square
Suite 2900
Indianapolis, IN 46282
(317) 236-5891
Christopher.Sears@icemiller.com

ICE MILLER LLP
LEGAL COUNSEL

PPACA Overview

- **Patient Protection And Affordable Care Act**
  - Signed March 23, 2010
- **Health Care and Education Affordability Reconciliation Act**
  - Signed March 30, 2010
- **Overview and Background**
  - Individual Mandate
  - Exchanges
  - Low Income Tax Credits and Cost Sharing Assistance
- **Penalty on Uninsured**

Employer Responsibilities

- Not required to provide coverage, but penalty assessment starting January 1, 2014 based on whether “minimal essential coverage” is offered.
- Applies to employers with 50 or more full-time employees (including FTEs)

Employer Responsibilities *(cont'd)*

- **Calculating Size of Employer's Workforce**
  - Determined based on average in **previous** calendar year
    - If not in existence during previous year, reasonable expectations
    - Special seasonal employee exemption
  - Full-time employee = works 30 hours per week
  - Part-time employee monthly hours totaled and divided by 120 – add to number of full-time employees to determine FTEs
  - "Independent Contractors" and leased employees may count toward total
  - Common ownership rules ("control group" and affiliated company rules) apply both to determination of size and penalty owed

Employer Responsibilities *(cont'd)*

- **If minimum essential coverage is <u>not</u> offered to all full-time employees (and their dependents) AND**

  one or more full-time employees purchase coverage from an exchange and qualifies for taxpayer subsidized coverage, …

  - Penalty of $166.67 per month (or $2,000 per year) for each full-time employee (subject to inflation adjustments)
  - First 30 full-time employees exempted

Employer Responsibilities *(cont'd)*

- **Even if coverage <u>is</u> offered,…**
  - **<u>if</u>** any employees opt-out of employer coverage and obtain coverage through the Exchange,

    <u>and</u> that employee qualifies for a premium credit or cost-sharing reduction (employee's contribution under employer plan must exceed 9.5% of his household income or the employer's plan covers less than 60% of total allowed costs),
  - **<u>then</u>** the assessment = $250 per month ($3,000 per year) for each such opting-out employee, capped at $2000 per year x total number of full-time employees.

Employer Responsibilities *(cont'd)*

- **Penalty Not Assessed For Employees to Whom Vouchers to Purchase Coverage Provided**
  - Employers required to provide vouchers to eligible employees for purchase of coverage in an Exchange.
  - To be eligible:
    - The employee's required premium contribution under the employer plan must be between 8%-9.8% of the employee's household income, AND
    - The employee's household income cannot exceed 400% of FPL (which is currently $88,200/year for a family of four and $43,320 for individuals) AND
    - The employee does not participate in employer's plan

Employer Responsibilities *(cont'd)*

- **Vouchers (cont'd)**
  - Amount of Voucher
    - The maximum amount the employer would have paid to provide coverage to the employee under the employer's plan, AND
    - Is not taxable to employee if used to pay for coverage on Exchange.
  - Paid into Exchange
  - Employee keeps excess portion of voucher not used to obtain coverage, but is taxable.

Threshold Issue: What is a Grandfathered Plan?

- **Two Types:**
  - **General**:
    - An employer sponsored group health plan (fully or self insured) that was in existence on 3/23/10
    - Grandfathered indefinitely (subject to regulations) from certain coverage and reporting mandates under Subtitles A and C
  - **Union**:
    - Health insurance coverage (fully insured) maintained pursuant to one or more collective bargaining agreements ratified before 3/23/10,
    - Grandfathered until date last agreement relating to the coverage terminates from ALL coverage and reporting mandates under Subtitles A and C
- **Critical for understanding what coverage mandates and reporting responsibilities apply.**

Threshold Issue: What is a Grandfathered Plan?

- **Maintaining grandfathered status under <u>general rule</u> going forward (or at least until sufficient regulations that know whether worth it to try):**
  - <u>Plan won't lose grandfathered status if</u>:
    - enroll new employees and their families
    - enroll "family members" of existing participants
  - <u>Will plan lose grandfathered status if</u>:
    - the plan is amended (required/discretionary)?
    - enrolls existing employees not currently enrolled?
    - enrolls a domestic partner of an existing participant?
    - changes service providers?

New Requirements Applicable to All Plans

- **New Coverage Mandates**
  - No pre-existing conditions
  - No lifetime or annual dollar limits
  - Adult dependent coverage
  - No waiting period in excess of 90 days
- **New Reporting/Disclosure Requirements**
  - Uniform benefit summary
  - Form W-2 reporting
  - Reporting to employees
  - Reporting to IRS

New Requirements Applicable to all Plans Other Than Grandfathered Plans

- **New Coverage Mandates**
  - Internal and external appeals process
  - First dollar preventive health care coverage
  - Mandated patient protections
  - Non-discrimination rules extended to insured plans
  - Limits on cost-sharing and deductibles
  - No discrimination based on health status
  - Mandated coverage of clinical trials
- **New Reporting Requirements**
  - Reporting to participants and Secretary of HHS

New Coverage Mandates Applicable to All Plans

- **No Pre-Existing Conditions**
  - GHPs may not impose any pre-existing conditions to enrollees age 19 or younger, effective for plan years beginning on or after 9/23/10
  - GHPs may not impose any pre-existing conditions to any enrollee, effective for plan years beginning on or after 1/1/14.
  - HHS will set up temporary high-risk pool through 2014 to cover people who are excluded from coverage between 2010 and 2014.

New Coverage Mandates Applicable to All Plans

- **No Lifetime or Annual Dollar Limits**
  - GHPs may not establish any lifetime limits or annual limits on the dollar value for any participant or beneficiary
    - GHPs may still place lifetime or annual limits on specific covered benefits that are not Essential Health Benefits.
    - For plan years that begin prior to 1/1/14, GHPs may place reasonable restrictions on annual limits (but not lifetime limits) that apply to Essential Health Benefits. The Secretary of HHS to issue regulations defining what is "reasonable restriction."
  - Effective for plan years beginning on or after 9/23/10

New Coverage Mandates Applicable to All Plans

- **Extension of Dependent Coverage to Age 26**
  - GHPs that provide dependent coverage of children must "continue to make such coverage available" for an adult child until the child turns 26 years of age.
    - If plan does not cover dependents, this mandate does not apply
    - Adult child can be married, but the plan does not have to cover the child's spouse or children
    - "Dependent" for purposes of this extended coverage is not tied to Section 152 of the IRC, but is to be defined by the Secretary of HHS
  - Effective for plan years beginning on or after 9/23/10
  - However, for plan years beginning before 1/1/14, this rule applies to Grandfathered Plans only if the adult child is not eligible to enroll in any other employer health plan.

New Coverage Mandates Applicable to All Plans

- **Extension of Dependent Coverage to Age 26 (cont'd)**
  - Coverage provided to adult children who as of the end of the year have not turned age 27 will not result in imputed income to the employee
    - For this purpose, "adult child" is defined to include the employee's son, daughter, stepson, stepdaughter, legally adopted child or eligible foster child
  - This change is effective 3/23/10, so employers can take advantage of it now to the extent that their plan covers children who are not tax dependents under Section 152 of the IRC
  - Since this tax result is accomplished through amending Section 105, not Section 152 of the IRC, question as to impact on HSA/HDHP, since HSA can be used only for 152 tax dependents.

New Coverage Mandates Applicable to All Plans

- **Waiting Periods**
  - GHPs may not impose any waiting period in excess of 90 days
  - This could significantly impact plans in the retail and food service sectors, as well as collectively bargained plans
  - Could increase costs and administrative burden because of short-term employees
  - Effective for plan years beginning on or after 1/1/14

New Coverage Mandates Applicable to All Plans

- **Automatic Enrollment**
  - Employers must automatically enroll new full-time employees in the employer's health plan if:
    - Employer has more than 200 full-time employees; and
    - Employer offers employees enrollment in 1 or more health benefits plans
  - Employers may still enforce waiting period if the plan imposes them
  - The automatic enrollment program must include adequate notice and the opportunity for an employee to opt out of any coverage in which the individual was enrolled
  - Pre-empts state wage payment laws if prevents automatic enrollment
  - Act does not provide an effective date – will be effective according to regulations to be issued by Department of Labor
  - Not yet clear into which of an employer's plan options an individual will be automatically enrolled

New Reporting/Disclosure Applicable to All Plans

- **Uniform Benefit Summary (the "Summary, Summary Plan Description")**
  - Summary of benefits and coverage explanation that accurately describes the benefits and coverage under the plan
  - Standards for the summary to be developed by HHS by 3/23/11 and will include standards for appearance, language, and content
  - Employers with self-funded plans and insurers must distribute the summary to enrollees by 3/23/12
  - If a plan is materially modified after the summary is distributed, notice of the modification must be provided 60 days before the date modification is effective (impact on open enrollment timing?)
  - Penalty of $1,000 per each enrollee for willful failure to provide

New Reporting/Disclosure Applicable to All Plans

❑ Form W-2 Reporting

- Employers are required to report on employees' Form W-2 the aggregate cost of employer sponsored health coverage
  - The "aggregate cost" will generally be the cost calculated for COBRA purposes and includes both employee and employer contributions
  - Not clear whether dental/vision reported if standalone plans
  - Aggregate cost does not include amounts contributed by an employer or employee to Archer MSAs or health savings accounts
  - Aggregate cost does not include employee contributions to a medical flexible spending account
- This reporting requirement is applicable for taxable years beginning after 12/31/10 (generally 1/1/11)

New Reporting/Disclosure Applicable to All Plans

- **New Reporting to IRS and Employees**
  - Reporting minimum essential coverage
    - Purpose is to ensure that individuals are complying with the individual mandate and obtaining minimum essential coverage
    - Provides information on the individual, dates covered, employer information, portion of premium paid by employer, and whether coverage is through SHOP
  - Reporting to determine employer penalties
    - Purpose is to determine whether employer provides adequate coverage to avoid IRS penalties
    - Provides information on whether coverage is minimum essential coverage, cost, waiting periods, availability, number of FTEs, and identification of covered FTEs
  - Both reports effective 1/1/14

New Reporting/Disclosure Applicable to All Plans

- **New Reporting to Employees**
  - Notice of Coverage Options
    - Purpose of notice is to provide employees with information about the availability of coverage on the Exchange and will include:
      - Information about the Exchange and its services
      - Whether the employer's plan's share of total allowed costs is less than 60% of such costs
      - Notification that the employee might be eligible for premium assistance or cost sharing reductions for coverage on the Exchange
      - Notification that if the if the employee purchases Exchange coverage, he or she will lose the employer contribution (if any) to any employer-provided plan
    - Notice must be provided by 3/1/13 and upon new employment thereafter.

New Coverage Mandates Applicable to all Plans Other Than Grandfathered Plans

- **Preventive Care**
  - GHPs must provide first dollar coverage, without any cost sharing requirements (*e.g.*, deductibles, co-pays, co-insurance, etc.) for
    - preventive care services recommended by the U.S. Preventive Services Task Force,
    - immunizations recommended by the Centers for Disease Control and Prevention, and
    - preventive care for children and women supported by the Health Resources and Services Administration.
  - At least one year period between the time a recommendation is made and plan year when it must be covered by a GHP
  - Effective for plan years beginning on or after 9/23/10
  - Uncertain how coordinates with the requirements relating to preventive care that apply to HSAs/HDHPs.

New Coverage Mandates Applicable to all Plans Other Than Grandfathered Plans

- **Internal and External Appeals**
  - GHPs are required to have an internal appeals process for appeals of coverage determinations
    - Initially similar to ERISA claims rules
    - Must provide notice to participants of appeals process
    - Must allow participants to review their file, present evidence and testimony, and receive continued coverage pending outcome of appeal
  - GHPs are required to have an external review process
    - Fully insured plans must meet State external review standards that satisfy NAIC model act
    - Other fully insured plans and self-insured plans must meet similar minimum standards set by Secretary of HHS
  - Effective for plan years beginning on or after 9/23/10

New Coverage Mandates Applicable to all Plans Other Than Grandfathered Plans

- **Mandated Patient Protections**
  - GHPs must contain certain patient protections
    - Participants may designate a participating primary care provider of choice for themselves and children
    - If GHP covers hospital emergency department services, must do so without requiring prior authorization regardless of whether the provider is a participating provider and with same requirements and costs imposed on in-network participating providers
    - If GHP covers OB/GYN care, participants are required to have access to such care without referral or authorization
  - Effective for plan years beginning on or after 9/23/10

New Coverage Mandates Applicable to all Plans other than Grandfathered Plans

❑ Cost-Sharing Requirements

- GHPs must limit the out-of-pocket expenses (*e.g.*, deductibles, co-pays, co-insurance, etc.) incurred by participants to the limits on HDHPs.
  - Current HDHP limit is:
    - for single coverage = $5,950
    - for family coverage = $11,900
  - Limit indexed after 2014
- GHPs cannot have deductibles that exceed $2,000 for single coverage and $4,000 for any other coverage
  - Increased by employee and employer contributions to a flexible spending account
  - Limits indexed after 2014
- Effective for plan years beginning on or after 1/1/14

New Coverage Mandates Applicable to all Plans Other Than Grandfathered Plans

- **Prohibition on Discrimination Based on Salary**
  - Nondiscrimination rules under Section 105(h) of the IRC already apply to self-insured GHPs
  - Extension of similar rules relating to eligibility and benefits to fully-insured GHPs
  - Effective for plan years beginning on or after 9/23/10
  - Could impact fully-insured plans for executives
  - Treasury expected to issue new regulations under Section 105(h) - expect new emphasis on compliance

New Coverage Mandates Applicable to all Plans Other Than Grandfathered Plans

- **Prohibition on Discrimination Based on Health Status**
  - GHPs may not establish rules for eligibility (including continued eligibility) to enroll based on health status related factors such as health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability
  - Codification of ERISA, IRC and PHSA regulations that already prevent discrimination in eligibility on the basis of health status since 1996 passage of HIPAA
  - Effective for plan years beginning on or after 9/23/10

New Coverage Mandates Applicable to all Plans Other Than Grandfathered Plans

- **Mandated Coverage of Clinical Trials**
  - GHPs cannot deny participation of a qualified individual in a clinical trial, deny coverage of routine costs in connection with a clinical trial, or discriminate on the basis of a clinical trial
  - "Qualified individual" is a participant in a GHP who is:
    - Eligible to participate in an approved clinical trial with respect to treatment of cancer or other life-threatening disease or condition, and
    - Referred by a provider or provides information establishing that participation would be appropriate
  - Effective for plan years beginning on or after 1/1/14

New Reporting/Disclosure Applicable to all Plans Other Than Grandfathered Plans

- **Reporting to Participants and HHS**
  - Annual Report on Quality
    - GHPs must provide an annual report to participants at open enrollment and to the Secretary of HHS regarding GHP and health care provider reimbursement structures that improve the quality of care, including wellness and health promotion activities.
    - The Secretary of Health and Human Services is required to develop reporting requirements and issue regulations by March 23, 2012.

New Reporting/Disclosure Applicable to all Plans Other Than Grandfathered Plans

❑ Reporting to Participants and HHS (cont'd)

- GHPs must provide information regarding the following to the Secretary of HHS and make such information publicly available:
  - Claims payment policies and practices
  - Periodic financial disclosures
  - Data on enrollment, disenrollment, number of denied claims, and rating practices
  - Information on out-of-network cost-sharing and payments
  - Information on enrollee and participant rights
  - Other information determined appropriate by the Secretary of Health and Human Services
- The GHP must also provide a participant information regarding the amount of cost-sharing that the participant would be responsible for paying with respect to a specific service in a timely manner at the request of the participant.

Health FSA/HSAs/Archer MSAs

- Over the counter drugs are no longer qualified for purposes of distributions/ reimbursements under HSAs, Archer MSAs, health FSAs, and HRAs, except for prescription medicines and insulin. This provision is effective January 1, 2011.
- The tax on distributions from HSAs for nonqualified medical expenses is increased from 10% to 20% (Archer MSA penalty increased from 15% to 20%). This provision is effective January 1, 2011.
- Contributions to a health FSA under a cafeteria plan is limited to $2,500 per year, indexed for inflation after 2013. This provision is effective January 1, 2013.

Retiree Issues

- **Temporary Reinsurance Program**
  - For employers providing retiree coverage to retirees between 55 and 64.
  - Program reimburses 80% of retiree claims between $15,000 and $90,000.
  - This program would end when Exchanges are established because reasonable coverage would then be available.
- Elimination of Tax Exclusion for Medicare Part D Subsidy (2013)

Retiree Issues

Elimination of Medicare Part D Donut Hole

- Part D Medicare enrollees are responsible for 25 percent of their drug costs until they incur $2,700 in costs, then they are responsible for 100 percent of their drug costs until they incur $4,350 in costs, at which time they are responsible for only five percent of their drug costs. This gap between $2,700 and $4,350 is referred to as the “donut hole.”
- The doughnut hole will be eliminated by 2020.
- The elimination of the donut hole, in combination with the elimination of the tax deduction for the retiree drug subsidy, may cause many employers to rethink whether they wish to continue providing retiree prescription drug benefits due to the actuarial increase in the Part D benefit and the loss of the tax exclusion of the subsidy.

Wellness Programs

- Increases amount that an employer can reward employees for participation in a wellness program to up to 30% of the cost of health coverage. (Effective 1/1/2014)
- Requires that wellness programs provide individuals with a reasonable alternative to achieve the full reward if they cannot satisfy a condition based on their health status.
- Permits the Secretaries of Labor, Health and Human Services, and the Treasury to increase by regulation the reward available to up to 50% of the cost of coverage.
- Provides grants for up to 5 years to small employers that establish wellness programs.

Medical Loss Ratio

- **Medical Loss Ratio Requirements**
  - Apply to insurance complies
  - Requires that 85 cents of every premium dollar be used for clinical services or healthcare quality improvements
  - If not, rebates must be provided to enrollees
  - Questions related to whom rebates must be given if employer pays for all or some of premium cost
  - Effective for plan years after 9/23/10

New Taxes

- **Increase in Medicare Hospital Tax**
  - .9% Increase on **Wages** Over $200,000 (Single) or $250,000 (Married)
    - Effective: 2013
- **Increase in Medicare Hospital Tax**
  - 3.8% Tax on Unearned Income on Individuals With **Adjusted Gross Income** Over $200,000 (Single) or $250,000 (Married)
    - Effective: 2013