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Health Care Reform: Impact on Employers and Their Group Health Plans

Amy Christen

Kathrin Kudner

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PPACA - Health Reform Legislation

- Patient Protection and Affordable Care Act (PPACA) was enacted on 3/23/2010
- Health Care and Education Reconciliation Act of 2010 was enacted on 3/30/2010 and amended certain provisions of PPACA

Supreme Court Decision

- National Federation of Independent Business et al. *v*. Sebelius, Secretary of Health and Human Services, et al., decided 6/28/2012
- Upheld majority of PPACA, except Medicaid expansion

Re-election of President Obama

- Neutralized efforts to repeal PPACA
- Means full steam ahead for employers and their group health plans

Key Concepts

- Group Health Plan means a health plan (either fully-insured or self-insured) maintained by an employer for its employees (referred to as “plan”)
- Fully-insured means the benefits under the plan are provided through insurance or HMO/PPO contracts that are purchased by employer
- Self-insured means the benefits under the plan are paid for out of the employer’s general assets, often with a stop loss insurance policy insuring the employer against losses for large claims

Key Concepts (cont'd)

- Grandfathered Status: A plan with grandfathered status must comply with some, but not all, of the new market reform provisions of PPACA
- A plan that was in existence on 3/23/2010 generally has grandfathered status as long as the plan does not make certain changes to its cost sharing structure and coverage provisions and the plan complies with participant notification and record retention requirements

Provisions Already in Effect for All Plans (Regardless of Grandfathered Status)

- Adult children covered until age 26
- Removal of lifetime dollar limits on essential health benefits
- Restrictions on annual dollar limits
- No rescission of coverage except fraud, intentional misrepresentation, or non-payment
- May not impose preexisting condition exclusions on dependent children who are under age 19

Additional Reform Provisions Already in Effect for Plans Without Grandfathered Status

- Provide coverage for all “recommended preventive services” without imposing any cost-sharing requirements for in-network services (e.g., deductibles, coinsurance or copayments)
- Comply with patient protection rights, including right to designate primary care providers, including pediatricians, obstetricians or gynecologists, without referrals and right to access emergency services without prior authorization, network restrictions or higher cost-sharing for out-of-network
- New enhanced appeals procedures and external review requirements (generally effective for calendar year plans on 1/1/2011, with some delayed provisions – see below)

Other Past Provisions Generally Impacting Employers

- OTC medications (other than insulin and those prescribed by a physician) may no longer be reimbursed from FSA, HRA, HSA or MSA
- Nonqualified distributions from HSA and MSA subject to an increased excise tax of 20%
- Temporary large claim reinsurance assistance for early retirement health benefits
- States and Secretary of HHS must establish a process for annual review of increases in health insurance premiums
- Temporary high risk insurance pools for uninsured individuals with pre-existing conditions and employer prohibited from offering incentives to disenroll in employer's plan to shift coverage to high risk pool

Other Past Provisions (cont'd)

- Small employer (10 to 24 FTE) with low-paid employees may be eligible for a tax credit if purchases health care insurance for employees
- Simple cafeteria plans available for small employers (≤100 employees)
- Wellness grant may be available from DHHS to assist employer in establishing a wellness program if employer is small (<100 employees who work 25 or more hours per week) and did not provide a workplace wellness program as of 3/23/2010

No Rest for the Weary

- The remaining slides describe the additional PPACA provisions effective during 2012 and future years

Clarification to the Enhanced Claim Procedures for Non-Grandfathered Plans

- Self-funded plans relying on safe-harbor external review rules must have hired at least two independent review organizations by 1/1/2012 and a third by 7/1/2012

Summary of Benefits and Coverage (SBC)

- Provide SBC to all participants and all eligible employees generally beginning with open enrollment on or after 9/23/2012 and subsequently at various times set forth by regulation
- Significant penalties for failure to provide

PCORI Fee

- Self-funded plans and health insurance issuers must pay the Patient-Centered Outcomes Research Institute (PCORI) fee
- The PCORI fee is intended to fund, on a short-term basis, comparative effectiveness research
- The fee is $1 per covered life per plan year beginning on or after 10/1/2012, and increases to $2 (indexed) each plan year thereafter until the entire fee is phased out 10/1/2019
- The fee is paid to the IRS on Form 720 by the employer if the plan is self-funded and by the insurance issuer if the plan is fully-insured

W-2 Reporting

- Report the cost of group health coverage on employees' 2012 Form W-2 (must be issued by employers no later than 1/31/2013) (both employee and employer portions included)
- May use the applicable COBRA premium to determine cost (minus the 2% administrative cost), but other methods are available under IRS guidance
- Stand-alone dental or vision plans or pre-tax employee contributions to FSA may be excluded
- Cost of coverage under an employee assistance plan, wellness program, or on-site medical clinic may be excluded as long as employer does not charge a premium with respect to that type of coverage provided under COBRA to a qualifying beneficiary
- Until contrary guidance is issued, this reporting rule applies only to employers that issued ≥ 250 W-2s for previous year

Women's Preventive Health Services for Non-Grandfathered Plans

- For plan years beginning on or after 8/1/2012, women participants must have coverage, without cost-sharing, for well-women visits, counseling for sexually transmitted infections, screening for gestational diabetes, contraceptive methods and counseling, HPV DNA testing, breastfeeding support, supplies and counseling, counseling and screening for HIV, and screening and counseling for interpersonal and domestic violence
- The entire list of "recommended preventive services" can be found at www.HealthCare.gov/center/regulations/preventive.html, including any newly added services to the list which the plan must cover at no cost as of the first plan year beginning on or after the date that is one year after the new recommendation went into effect
- Religious safe-harbor exemption may be available

Retiree Prescription Drug

- Prior to PPACA, employers could receive a Retiree Drug Subsidy (RDS) from CMS if they provided a retiree health plan that offered prescription drug coverage actuarially equivalent to Medicare Part D coverage
- Effective 1/1/2013, the amount of the deduction that an employer claims for the health care expenses of employees/retirees must be offset by the amount of any RDS received by the employer

Flexible Spending Arrangements

- Effective for plan years beginning on or after 1/1/2013, a Health FSA provided under an employer's Section 125 cafeteria plan must limit the employee's pre-tax salary reduction contributions to no more than $2,500 per plan year (adjusted for COL)

FICA Tax

- Effective for tax years beginning 1/1/2013, the health insurance portion of FICA is increased by 0.9% on the portion of wages in excess of $200,000 ($250,000 for a joint return, or $125,000 for married filed separately)
- Employers are required to withhold/collect the employee's share with respect to wages paid by employer to the employee in excess of $200,000 for the calendar year (this must be done regardless of the employee's tax filing status and whether the employee is ultimately liable to pay the tax (e.g., if the employee is married and files jointly, and their total compensation is less than $250,000)).
- The employer's share of health insurance tax is not increased

OPM and Deductible Limitations for Non-Grandfathered Plans

- Limit the out-of-pocket maximums (OPM) (these levels are consistent with HSA-compatible HDHP limits as indexed for inflation (2013 level is $6,250 for self-only and $12,500 for family))
- Deductibles cannot exceed $2,000 for single coverage and $4,000 for any other coverage
- These caps are effective for plan years beginning on or after 1/1/2014

Clinical Trials for Non-Grandfathered Plans

- Cover routine patient costs associated with participation in clinical trials effective for plan years beginning on or after 1/1/2014

Wellness Program

- If an employer maintains a health standard-based wellness program, the employer may decide to increase the amount of the reward offered or surcharge imposed under such program from 20% to 30% of the premium cost for self-only coverage, beginning in 2014 (which may be increased to 50% by agency regulations)

Annual Limits

- Eliminate any remaining annual dollar limits on essential health benefits (i.e. the transitional rule phasing out existing annual dollar limits will expire 2014)

Pre-Existing Conditions

- Remove any pre-existing condition exclusions that apply for adults for plan year beginning on or after 1/1/2014 (pre-existing conditions removed for children in 2011)

Waiting Periods

- Effective for plan years beginning on or after 1/1/2014, plan may not impose waiting periods in excess of 90 days
- Preliminary guidance under agencies' FAQ:
  - ✓ rule applies to all *eligible* employees (i.e. employer can decide which groups of employees are eligible to participate, but once within *eligible* employee group, the waiting period rule applies);
  - ✓ waiting period begins when individual otherwise becomes eligible (except due to the waiting period);
  - ✓ delay in employer play or pay mandate during the 90-day waiting period

Automatic Enrollment

- Employers subject to the FLSA with ≥200 FTE must automatically enroll new full-time employees and continue existing coverage, unless employee affirmatively opts out coverage
- Not effective until guidance issued

Non-Discrimination for Non-Grandfathered Plans

- Fully-insured plans may not discriminate in favor of highly compensated individuals as to eligibility to participate and benefits under the plan
- Not effective until guidance issued

Medical Loss Ratio (MLR) Requirements for Fully-Insured Plans

- Insurers are required to spend a minimum percentage of insurance premiums (generally 85% in large group market and 80% in small group market) on medical care and quality improvement
  - Referred to as the “medical loss ratio” or “MLR”
- If MLR minimum is not met, insurers must rebate a portion of premium to policyholder
- Policyholder must determine if and how to allocate rebate to employees
- Self-funded plans are not subject to MLR requirements

Medical Loss Ratio Rebate (cont'd)

- Unless specifically addressed in plan language, general rule is that the rebate is allocated between the employer and plan participants based on their relative contributions to premium
- Distribution/allocation of rebate to employee
  - Proper use of MLR rebate depends on plan type and structure
  - Determine the plan and plan year to which the rebate applies

Medical Loss Ratio Rebate (cont'd)

- DOL Technical Release 2011-04
- IRS FAQs on tax treatment of rebates
  - Depends on whether employees paid premiums on pre- or post-tax basis
- Rules effective 1/1/2012
- First set of rebates should have been distributed by insurers by 8/1/2012

Health Benefit Exchange

- By 1/1/2014, states are required to establish health insurance exchanges to permit individuals and small businesses to purchase health insurance
- HHS will operate a public exchange in states determined to be “not on track” by 1/2013
- States can choose how many exchanges there will be, whether there will be separate exchanges for individual and group markets, whether the exchange will be a government or nonprofit entity, whether the exchange will be regulated by state agencies, and the type of products to be offered
- Exchanges must define eligibility criteria, develop process for enrollment, certify “qualified health plans,” develop process for notifying employers of employee eligibility for subsidy and make certain government notifications

Health Benefit Exchange (cont'd)

- Initially available to small employers (generally <100 employees); beginning in 2017, states may allow insurance issuers in large group market to participate
- Open to "qualified health plans"
  - Licensed in state
  - Offers "essential health benefits"
  - Must offer platinum, gold, silver and bronze benefit levels and catastrophic
  - Guaranteed availability; no medical underwriting; no pre-existing condition, preventive care at 100%, maximum out-of-pocket and no lifetime or annual limits

Employer Play or Pay

- No requirement for employers to offer coverage, but effective 1/1/2014, large employers may be subject to a monthly penalty tax under the following circumstances:
  - Do not offer full-time employees (FTEs) (and their dependents) minimum essential coverage under an employer-sponsored group health plan;
  - Offer some, but not all, FTEs the opportunity to enroll in minimum essential coverage under an employer-sponsored group health plan; or
  - Offer minimum essential health coverage to FTEs but that coverage is not affordable or does not provide minimum value to participants

Employer Play or Pay (cont'd) -- Definitions

- Large employers = those employing on average at least 50 FTEs on business days during the preceding CY
  - An FTE is an individual working 30 or more hours a week
  - Additional guidance expected

Employer Play or Pay (cont'd) – No Coverage Offered

- For a large employer that fails to offer *all* FTEs the opportunity to enroll in minimum essential health coverage for a month AND at least one FTE has been certified as enrolling for that month in the Exchange with the premium tax credit or cost sharing reduction, the monthly penalty is:
  - $166.67 x the number of FTEs in excess of 30 during that month -- (the $166.67 (annually $2,000) will be adjusted for inflation after 2014)
- This penalty tax presumably applies when some, but not all, FTEs are offered coverage…awaiting guidance

Employer Play or Pay (cont'd) – Coverage Offered, But…

- If the **employer** does offer minimum essential coverage under an employer-sponsored group health plan to all its FTEs and their dependents, but the offered coverage is unaffordable **or** doesn't have sufficient value AND at least one FTE has been certified as enrolling for that month in the Exchange with the premium tax credit or cost-sharing reduction, the monthly penalty is the lesser of:
  - $250 x the number of FTEs for that month who receive premium tax credits **or** cost-sharing reductions; **or**
  - $166.67 x the number of FTEs in excess of 30 for that month, but taking into account all of the employer's FTEs and not just those receiving tax credits and cost-sharing reductions
  - (dollar amounts are adjusted for inflation after 2014)

Employer Play or Pay (cont'd)

- Coverage is unaffordable if the amount the employee must **pay** to obtain the coverage exceeds 9.5% of an employee's household income
- Coverage does not have minimum value if the plan fails to pick up at least 60% percent of the overall cost of the benefits being covered by the plan
- Employer may not discriminate or retaliate against employee for receiving premium credit assistance or providing information to Secretary regarding employer violations of the requirements under this legislation

Employer Play or Pay (cont'd) – Employee Options

- Most employees would be eligible to elect coverage from an Exchange, even in lieu of employer-sponsored coverage, but employees would not be eligible for premium tax credits or cost-sharing reductions if they are offered affordable minimum essential coverage under the employer-sponsored plan

Employer Play or Pay (cont'd) – Options for Employers

- PLAY
  - Comply with PPACA requirements
  - Maintain employer sponsored plan
- PLAY BUT
  - Comply with most PPACA requirements
  - Structure contributions for low wage earners to qualify for subsidies
- PLAY SOME
  - Offer employer-sponsored plan to some employees
  - Direct employees who are not eligible for plan coverage to the Exchanges
  - Pay $2,000 per FTE penalty
  - Address discrimination issues, if any

Employer Play or Pay (cont'd) – Option for Employers

- PAY BUT
  - Terminate employer sponsored plan
  - Pay $2,000 per FTE penalty
  - Direct employees to Exchanges
  - Provide some additional compensation
- PAY AND GET OUT OF HEALTH BENEFIT BUSINESS
  - Terminate employer sponsored plan
  - Pay $2,000 per FTE penalty
  - Direct employees to Exchanges
  - Provide no additional compensation or subsidy

Excise Tax on High Cost Plans

- 40% excise tax on excess aggregate value above $10,200 for individual coverage or $27,500 for family coverage (adjusted annually). Aggregate value includes employee and employer share of cost for medical, dental, vision, Rx, FSA, HRA, HSAs using concepts similar to determining COBRA premium
- Threshold value is increased for certain high risk professions (police or fire) or employed to repair/install electrical or telecommunication lines or states with highest coverage cost
- Effective 2018

Excise Tax on High Cost Plans (cont'd)

- Amount subject to tax does not include fixed indemnity health coverage purchased by employee with after-tax $
- Employers could elect to treat pre-65 retirees with post-65 retirees
- Insurer of fully-insured group "cadillac" plan, or the administrator (sponsor) of self-funded group "cadillac" plan would pay this excise tax (but not insurers in individual health insurance market)
- Employer responsible to calculate excess value and report to insurer and IRS, and is subject to penalty for underreporting unless good faith waiver by Secretary

Individual Mandate

- Effective 2013, all citizens and legal residents required to purchase “qualifying” health insurance coverage
- Penalty of:
  - $95 in 2014
  - $350 in 2105
  - $750 in 2016
- Exceptions: Native Americans; financial hardship; religious objection; illegal immigrants

www.dykema.com

Amy M. Christen
395700 N. Woodward Ave, Ste. 300
Bloomfield Hills, Michigan 48304
(248) 203-0760
achristen@dykema.com

Kathrin E. Kudner
2723 South State St, Ste. 400
Ann Arbor, Michigan 48104
(734) 214-7697
kkudner@dykema.com