PRACTICAL ADVICE FOR THE REAL WORLD

COX | SMITH

ATTORNEYS

# HEALTH CARE REFORM

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# Caveats

- I am providing a general overview of the health care reform – this will be education, not legal advice
- Because of limited information about your plans, and because your individual needs and situations may vary, I cannot advise on any specific situation. I do welcome questions, and will address those for general discussion purposes only. I encourage you to consult the lawyers of your choice about your health plan needs.

# Setting the Stage

- Reform passed in two bills
- Patient Protection and Affordable Care Act – March 23, 2010 (“PPACA”)
- Health Care and Education Reconciliation Act of 2010 – March 30, 2010

# Constitutional Issues

- Florida v. United States Department of Health and Human Resources
- Commonwealth of Virginia v. Sebelius
- Thomas More Law Center v. Obama
- Liberty University, Inc v. Geithner
- Mead v. Holder
- Seven-Sky v. Holder
- Supreme Court has granted Cert. and will hear arguments in March.
- Supreme Court hearings 3/26/12 – 3/28/12

# Overall Impact

- Who plans must cover
- What plans must cover
- How much plans must cover
- New reporting/disclosure requirements
- New subsidies/incentives

# Grandfather Detour

- Some of changes to be discussed do not apply to grandfathered coverage.
- Grandfathered coverage is benefit package (i.e. HMO, PPO) that existed March 23, 2010.

# Grandfather Detour (cont'd)

- Lots of ways to lose status:
  - Changing insurance companies before 11/15/10
  - Increasing cost sharing or reducing employer contribution beyond prescribed limits
  - Substantially reducing or eliminating benefits to diagnose or treat a particular condition

# Grandfather Detour (cont'd)

- Okay to:
  - Add new participants
  - Change insurance companies after 11/15/10
  - Change TPAs
  - Increase premiums
  - Amend plan to comply with reform

Action items: Don't forget Notice requirement

# Who Plans Must Cover

- Until 2014, no requirement to offer plan
- Employers with > 50 FTEs must provide “minimum essential coverage” starting in 2014 or pay penalty
- If do offer health plan, must follow:
  - new dependent coverage rules
  - Once regulations issued, new automatic enrollment rules

# Effective Dates

- For slides with 2010-2011 in title, mandates apply beginning first plan year beginning on or after September 23, 2010
- Subject to possible exception for grandfathering

# 2010 - 2011: Adult Dependent Coverage

- **If** plan covers dependent children, must cover them through 26th birthday
- Catches both married and unmarried dependents
- Does not apply to a dependent child's spouse or own child
- Regulations recently issued by Treasury, DOL, and HHS
- Plans must define dependent only in terms of relationship between child and participant.

# 2010 - 2011: Adult Dependent Coverage (cont'd)

- Cannot vary coverage based on age until reach 26 (eg no premium disparity)
- Must provide written notice to employees on behalf of eligible, unenrolled children
  - No later than first day of plan year beginning on or after September 23, 2010. Coverage effective no later than that day (even if elected after).
  - Minimum election period of 30 days.
  - May include prominent notice with other enrollment materials.

# 2010 - 2011: Adult Dependent Coverage (cont'd)

- Corresponding change to Tax Code expands exclusion of value of employer provided health coverage
- Can cover dependent children through end of year they turn 26 without tax consequences
- Applies to grandfathered coverage, but before 2014 can exclude children eligible for active employee coverage.

- **Action Item: Revisit dependent coverage provisions.**

# What Plans Must Cover

- More pre-existing conditions
- More preventive care benefits
- More emergency care choices
- Care provided by chosen doctors

# 2010 - 2011: Pre-existing Conditions

- No more pre-existing condition exclusions for enrollees under 19 (or any age starting in 2014)
- Statute not specific. When do you measure age?

# 2010 - 2011: Preventive Care Benefits

- New mandate for minimum preventive care benefits
- No deductibles or co-pays may be charged
- Benefits to include:
  - certain evidence-based items or services;
  - certain immunizations;
  - for minors, certain preventive care and screenings;
  - for women, additional preventive care and screenings including breast cancer screening, mammography, contraception, and prevention

# 2010 - 2011: Preventive Care Benefits (cont'd)

- Required benefits determined periodically by government Task Force, which may be updated
- Will presumably create initial cost spike
- Grandfathered coverage is exempt

- **Action Item: Review preventive care benefits and eliminate deductibles and co-pays if not grandfathered.**

# 2010 - 2011: Emergency Care

- If plan provides emergency care (NOT required):
  - Must guarantee access to emergency care without prior authorization
  - Must allow access at in-network cost, even if provider is out-of-network
- Grandfathered coverage is exempt

- **Action Item: Eliminate prior authorization and in-network requirements for emergency care if not grandfathered.**

# 2010 - 2011: Designation of Primary Care Physician

- Must permit participants to choose any participating primary care physician who agrees to see them
- Grandfathered coverage is exempt

- **Action Item: Eliminate any requirement to prevent choice among in-network primary physicians if not grandfathered.**

# 2010 - 2011: Pediatric Care

- If plan requires designation of primary care provider for children:
  - Must allow choice of any in-network allopathic (conventional) or osteopathic pediatrician
- Grandfathered coverage is exempt

- **Action Item: Eliminate restrictions on designation of primary care pediatricians if not grandfathered.**

# 2010 - 2011: OB/Gyn Coverage

- For OB/Gyn coverage, cannot require preauthorization by a primary care physician to see OB/Gyns
- Grandfathered coverage is exempt

- **Action Item: Eliminate pre-authorization for access to OB/Gyns if not grandfathered.**

# How Much Plans Must Cover

- Reform makes significant alterations to:
  - lifetime limits
  - annual limits
  - Cost sharing limits (Does not apply to grandfathered coverage)
- This will cause cost spike

# 2010 - 2011: Lifetime Limits

- No more lifetime dollar limits on “essential health benefits”
  - But what are they?
- “Essential health benefits” include the following general categories of benefits:
  a. ambulatory patient services;
  b. emergency services;
  c. hospitalization;
  d. maternity and newborn care;

# 2010 - 2011: Lifetime Limits (cont'd)

e. mental health and substance use disorder services, including behavioral health treatment;
f. prescription drugs;
g. rehabilitative and habilitative services and devices;
h. laboratory services;
i. preventive and wellness services and chronic disease management; and
j. pediatric services, including oral and vision care
k. no stand-alone dental or vision

# 2010 - 2011: Lifetime Limits (cont'd)

- Problematic: no detailed description
- For now, can rely on good faith interpretation

- **Action Item: Amend plans for plan year beginning on or after September 23, 2010 to delete all lifetime dollar limitations for benefits other than "essential health benefits."**

# 2010 - 2011: Annual Dollar Limits

- Annual limits for “essential health benefits” are restricted
- No annual limits for “essential health benefits” for plan years on or after January 1, 2014
- Does not affect limits on “nonessential” benefits, but issue is properly identifying “nonessential benefits”

- **Action Item: Revisit plan language.**

# 2014: Cost Sharing Limits

- Beginning January 1, 2014, cost sharing (co-pays, co-insurance, deductibles, etc.) limited to $5,000 for self only coverage and $10,000 for family coverage.
- Also small employers (100 or fewer employees) have separate cap for deductible: $2,000 single/$4,000 family, subject to increase based on availability of FSA.
- Limits are indexed.
- Grandfathered coverage exempt from cost sharing limits

# New Administrative Requirements

- Restrictions on rescission
- More regimented Claims Appeal Process
- W-2 Reporting of Health Coverage
- New Summary of Benefits
- Pre-change issuance of SMMs
- Reporting regarding wellness promotion

# 2010 - 2011: Rescission

- No rescissions once coverage is in force, unless:
  - fraud; or
  - intentional misrepresentation of material fact; and
  - prohibited by plan
- Must give advance notice for permitted rescission

- **Action Item: Amend plans to allow permitted rescission.**

# 2010 - 2011: Internal & External Claims Appeals Process

- A plan must implement an internal claims appeal process if don't have one already
- Surprise, ERISA claims procedure won't suffice!
- All plans will be subject to a state established external appeals process, and federal standard in the meantime

# 2010 - 2011: Internal & External Claims Appeals Process (cont'd)

- New coverage must continue pending outcome of appeal
- Grandfathered coverage is exempt

- **Action Item: Review and amend appeals process for first plan year beginning on/after September 23, 2010, if not grandfathered.**

# 2012: Reporting of Health Coverage

- Employers must report cost of employee's health insurance on Form W-2
- Note: This amount will NOT be included in income
- Cost of coverage under all plans (except Health FSA, HSA, Archer MSA) is aggregated
- For health insurance, use COBRA premium
- For self-funded plans, use COBRA premium (either actuarial or adjusted plan cost for past 12-month period)

# 2012: Reporting of Health Coverage (cont'd)

- Was effective January 1, 2011, recently postponed to January 1, 2012 (i.e., to reports prepared January 2013)
- **Action Item**: **In 2011, establish cost method for each health plan. If a self-insured plan uses past cost method, document calculation.**

# 2012: Uniform Standards of Summary of Benefits

- On the first open enrollment after September 23, 2012, plan sponsor/plan administrator must provide a "summary of benefits" and coverage explanation to enrollees prior to enrollment or reenrollment
- HHS has developed standard definitions for terms used in health insurance coverage
- Template for SBC and Uniform Glossary of Terms is available on HHS website. Use of this template is required.

# 2012: Uniform Standards of Summary of Benefits (cont'd)

- Plan must notify enrollees of material modifications not later than 60 days **before** effective date
- This is big change to current law, which allows SMMs to be provided well after the fact
- SBCs can be either a stand-alone document or in combination with SPDs. If combined with another document, the SBC must be intact and prominently displayed at the beginning of such materials.
- $1,000 per participant penalty for failure

# 2012: Comparative Research Fee

- The IRS recently release proposed regulations
- PPACA imposes a fee on both issuers of insurance and plan sponsors of applicable self-insured health plans for each plan year ending after September 30, 2012, and before October 1, 2019.
- The fee is one dollar per life covered for plan years ending before October 1, 2013**,** then two dollars per life covered.
- "Lives covered" is the average number of lives covered under the plan for the plan year.

# 2012: Comparative Research Fee

- When: Form 720 Quarterly Excise Tax Return must be filed by July 31 of the calendar year immediately following the last day of the plan year. This is effective for all plan years that end after September 30, 2012.
- Plan sponsors of a self-insured plan is liable for the fee. (Issuers of insurance will be liable for fully-insured plans).

# 2012: Efficiency Standards and Wellness Promotion Reporting Requirements

- HHS to develop reporting requirements; and penalties, by mid 2012
- Annual report submitted by group health plan to HHS and made available during open enrollment
- Report must describe activities that:
  - improve health outcomes
  - prevent hospital readmission
  - improve patient safety and reduce medical errors
  - target health and wellness
- Grandfathered Coverage is exempt

# New Subsidies/Incentives

- Early retiree health care subsidy – no longer available
- Small business tax credit
- Grants for wellness programs

# 2010: Small Business Tax Credit

- Nonrefundable credit for nonelective contributions for health insurance
- Qualifying Employers
  - Cover at least 50% of the cost of health care coverage for its employees
  - Have no more than 25 qualified full-time equivalent employees ("FTEs") who have average annual wages of $50K or less
- FTEs = total hours of service of all employees ÷ 2,080

# 2010: Small Business Tax Credit (cont'd)

- Credit
  - 2010 through 2013, maximum of 35% of premiums paid by eligible small business employers (25% for eligible tax-exempt organizations)
  - In 2014, maximum increases to 50% of premiums paid by eligible small business employers (35% for eligible tax-exempt organizations)
  - Phase out – the credit is phased out as the number of FTEs increases from 10 to 25 and as average wages increase from $25K to $50K.

# 2010: Small Business Tax Credit (cont'd)

- Sole proprietors, partners in a partnership, 2% S Corporation shareholders, and 5% owners in any other business are not considered employees for purposes of calculating the credit.
- Form 8941 posted on IRS.gov

- **Action Item: Determine whether your business is eligible for the credit.**

# 2011: Grants to Small Businesses for Wellness Programs

- Grants from 2011 to 2015 for new wellness programs (est. after 3/23/10)
- Only for employers with fewer than 100 employees working 25+ hours per week
- HHS to outline requirements, but will concern:
  - Health awareness initiatives
  - Maximizing employee engagement

# 2011: Grants to Small Businesses for Wellness Programs (cont'd)

- Changing unhealthy behaviors and lifestyle choices
- Providing supportive environment

- **Action Item: If eligible, watch for HHS announcement of program guidelines and application form.**

# Grab Bag Rules

- Anti-dumping
- Discrimination restrictions
- FSA restrictions
- More withholding duties

# 2010: Anti-Dumping Rules for Employers

- Plans/issuers may not encourage participants to drop plan with money or other financial consideration
- Penalty: reimburse pool for participant's medical expenses

- **Action Item**: **Avoid disenrollment incentives.**

# Immediately 2010: Fair Labor Standards Act Amendment

- Employers prohibited from discharging or discriminating against an employee because he or she objected to or refused to participate in any activity, policy, practice, or assigned task that the employee (or another employee) reasonably believed to violate the Act or any rule interpreting the Act.

# 2011: Over-the-Counter Drugs

- No longer payable by an FSA, HRA, HSA, or Archer MSA
- Unless prescribed or insulin
- Effective for expenses incurred after December 31, 2010, even for fiscal year plans
- **Action Item: Amend plans to delete; talk to plan TPA.**

# ???: Discrimination Testing

- Insured health plans must pass some of IRC § 105(h) discrimination testing or employer pays excise tax ($100 per day per person)
- Grandfathered coverage is exempt – this may be the biggest benefit of grandfathered status
- Effective first plan year beginning on or after September 23, 2010, but suspended pending further guidance
- **Action Item: After guidance, and for new plans, review eligible classes, differing waiting periods, differing benefits, and differing premiums to identify and weed out prohibited discrimination.**

# ???: Automatic Enrollment

- Employers with > 200 FTEs that offer health plans must automatically enroll new employees, pending regulations
  - Notice must be provided to employee of opportunity to opt out of automatic enrollment in employer's health plan
  - Watch for Regulations

# 2013: Health FSA Reimbursement Limit

- *Current Law*: no reimbursement limit required – plan sponsors may choose limit they are comfortable with
- *January 1, 2013*: maximum reimbursement of employee must be limited to $2,500 per taxable year
  - Consider changing early if not calendar year plan
  - Other options: short plan year?
  - IRS to release guidance clarifying this restriction
- Adjusted for inflation starting in 2014

# 2013: Increased Hospital Insurance Tax

- *Current Law*: employer must withhold 1.45% for all employees as the employees' portion
- *January 1, 2013*: Employee portion of FICA is increased for high income taxpayers by 0.9%
- Threshold depends on filing status, but employer must withhold extra percentage starting at $200,000

# Reforms Affecting Hospitals and Other EO's

- IRS preparing to implement
- Requirements for hospitals include
  - Adoption of financial assitance policies
  - Limiting charges for emergency care
  - Additional billing and collection rules
  - Conducting community health needs assessments
- Revised hospital schedule accompanying exempt org information return includes a section in which hospitals describe how fulfilling new requirements.

# Recap

- Talk to your brokers, TPAs, attorneys.
- Make sure plan document continuously updated to comply with new requirements.
- Consider value of grandfathered status when evaluating plan changes.
- Don’t panic about long-range requirements!

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