



Health Care Reform—Mapping a Path for Change

February 1, 2012
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Today's agenda

- ❑ Health Care Reform—Mapping a Path for Change
 - ❑ Legislative/Judicial Update
 - ❑ Health Insurance Premium Tax Credit—What it Means To You
 - ❑ Age 26—Common Questions and Misconceptions
 - ❑ Preventive Care, Non Discrimination (***Delayed***), Rescission
 - ❑ Uniform Explanation of Coverage ***Delayed***, Final MLR Rule
 - ❑ W-2 Reporting, Essential Health Benefits Bulletin
 - ❑ Other Mandates Becoming Effective 2012-2014
 - ❑ Note: Materials current as of January 31, 2012

Legislative/Judicial Update



- ❑ Is it going away?
 - ❑ HR 2: “An Act to repeal the job-killing health care law”
 - ❑ HR 9: “Instructing certain committees to report legislation replacing the job-killing health care law”
- ❑ Enacted Legislation
 - ❑ Repeal of Vouchers
 - ❑ 1099 Correction
- ❑ Other Areas Being Considered
 - ❑ Elimination of OTC Prescription Drug Requirement
 - ❑ Elimination of CLASS Act
 - ❑ Medical Loss Ratio Changes



Legislative/Judicial Update

- ❑ Budget Control Act of 2011
 - ❑ Passed August 2, 2011
 - ❑ Increased the federal debt limit
 - ❑ Created Congressional Joint Select Committee charged with developing a plan to cut deficit by \$1.5 trillion
 - ❑ Failure to do so will result in automatic budget sequestration in 2013
 - ❑ Sequestration is an across-the-board cut in federal spending
 - ❑ Likely cut spending for the Exchanges and subsidies
 - ❑ November 21, 2011 – Committee failed to reach bipartisan agreement to reduce deficit



Legislative/Judicial Update

- ✓ 8/03/11 Amended Regulations on Preventive Care
- ✓ 8/17/11 Proposed Regulations on Health Insurance Tax Credit and Premium Subsidies
- ✓ 8/22/11 Proposed Regulations on Summary of Benefits and Coverage (Delayed 11/17)
- ✓ 12/2/11 Medical Loss Ratio Changes
- ✓ 12/16/11 Essential Health Benefits Bulletin
- ✓ 1/03/12 IRS Notice on Form W-2 Reporting

Legislative/Judicial Update



- ❑ Is it legal? Many constitutional challenges
- ❑ Suits filed in most states; six federal court decisions:

- ❑ Thomas More Law Center v. Barack Obama, et al. (MI)
- ❑ Liberty University v. Timothy Geithner (VA)
- ❑ Mead v. Holder (DC)



- ❑ Commonwealth of Virginia v. Sebelius (VA)
- ❑ Goudy-Bachman v. Sebelius (PA)
- ❑ Florida v. Dept. of Health and Human Services (FL)
 - ❑ 22 Attorneys General, 4 Governors



Legislative/Judicial Update



- On June 29th, the **6th Circuit Court** in *Thomas More Law Center v. Obama* ruled that the individual mandate is a **valid exercise** of congressional authority under the Commerce Clause
- On August 12th, the **11th Circuit** Court in *Florida v. Dept. of Health and Human Services* ruled that the individual mandate **exceeds** Congress' power under the Commerce Clause
- On September 8th, **the 4th Circuit** Court ruled that the ACA **prohibited** the *Liberty* case from going forward and also ruled that the Attorney General **lacked standing** to pursue the *Commonwealth of Virginia* case



Legislative/Judicial Update

- On November 14, 2011 the U.S. Supreme Court granted certiorari (judicial review) of three separate cases

1. Constitutionality of the Individual Mandate

- Question presented: “Did Congress have the power under Art. I of the Constitution to enact the Individual Mandate?”





Legislative/Judicial Update

2. If the Individual Mandate is Unconstitutional, is the entire law unconstitutional (severability)?
 - Question presented: “To what extent (if any) can the Individual Mandate be severed from the remainder of PPACA?”
3. The Anti-Injunction Act
 - Added by the Court in its Order granting Certiorari
 - Question presented: “Is the suit brought to challenge the Individual Mandate barred by the Anti-Injunction Act?”



Legislative/Judicial Update

What will the Court decide?

Four Possibilities:

- Individual Mandate is Constitutional
- Entire Law is Unconstitutional
- Individual Mandate is Unconstitutional
- Challenges are Not Ripe for Supreme Court Review





Health Insurance Premium Tax Credit—Why Employers Care

- ❑ Credit or Subsidy Provided to Individuals in the Exchange
- ❑ Proposed regulation—
 - ❑ Clarifies who is eligible for the assistance
 - ❑ Details how the assistance is calculated
 - ❑ Limits the circumstances where an employer is subject to a penalty under the “pay or play” mandate because its employees received assistance
 - ❑ Assistance available only for insurance purchased through an Exchange
 - ❑ Not eligible if insurance purchased through a private Exchange



Health Insurance Premium Tax Credit

- ❑ Individuals eligible for credit
 - ❑ Must be lawfully present in the US
 - ❑ Not available if Medicaid-eligible or incarcerated (ineligible for Exchange coverage)
 - ❑ Income between 100-400% FPL
 - ❑ Income below 100% FPL triggers Medicaid eligibility
 - ❑ In 2014 Medicaid eligibility expands to 133% of FPL (effectively 138% of FPL)
 - ❑ Not eligible for “minimum essential coverage”, which includes:
 - ❑ Coverage under government-sponsored plans (Medicare, Medicaid, CHIP, certain veterans coverage); and
 - ❑ Coverage under an “eligible employer sponsored plan”, which is:
 - ❑ **Quality** — plan’s share of the total allowed costs of benefits provided under the plan is at least 60% of those costs; and
 - ❑ **Affordable** — the contribution for single coverage does not exceed 9.5% of household income (use of current W-2 wages expected as a *safe harbor*)

Age 26—Common Questions and Misconceptions

- ❑ The Rule: All Group Health Plans That Cover Dependents Must Cover Dependents Until Age 26, Without Regard to Financial Support, Marital Status or Abode
 - ❑ ***Grandfathered Plans*** may exclude children under age 26 who are eligible for another employer's insurance
 - ❑ Must be documented in Summary Plan Description

Age 26—Common Questions and Misconceptions

- ❑ Does a plan have to cover children?
- ❑ Can a plan exclude a child who is married?
- ❑ Does a plan that covers children have to cover the children's children (i.e., grandchildren of the employee)?
- ❑ May a plan that covers grandchildren require that the employee be financially responsible for the grandchild?
- ❑ Does a plan that covers children have to cover *step children*?
- ❑ May a plan the covers stepchildren require that the employee be financially responsible for the stepchild or require that the stepchild reside in the employee's home?
- ❑ May a plan that covers stepchildren require that the employee be in a current relationship with the stepchild's mother/father?

Preventive Care



- Applies first plan year beginning on or after September 23, 2010
- Mandate: Preventive care must be covered without cost-sharing
 - Applies to services with an “A” or “B” rating from the United States Preventive Services Task Force (immunization, screenings and preventative care for infants, children and adolescents, additional care for women)
- **Action item**: review current coverage and cost-sharing requirements for preventive care



Preventive Care

- Preventive Care

- August 2011 amendment to Preventive Care regulations
- Effective for plan years beginning on or after **August 1, 2012**, non-grandfathered group health plans must cover certain services as “preventive care” for women, with no cost-sharing, including:
 - Birth control (including intrauterine devices, the “morning-after pill,” and newer forms of long-acting implantable hormonal contraceptives)
 - Breast pumps for nursing mothers
 - Annual “well-woman” physicals
 - Cervical cancer screenings
 - Screening for diabetes during pregnancy
 - Counseling on domestic violence



Preventive Care

- *Preventive Care*

- The August amendment includes a provision that permits religious institutions to opt out of offering birth control coverage
 - Certain groups are supporting legislation that would codify a range of exceptions to PPACA on religious and conscience grounds, as the current exclusion for religious organizations may not cover faith-based groups engaged in social action and other activities that do not involve worship
- The August guidance also confirms that state laws that impose requirements on plans that are stricter than the requirements under PPACA are not superseded

Non-Discrimination Testing



- ❑ Applies first plan year beginning on or after September 23, 2010 when plan is not Grandfathered
- ❑ Delayed Until Further Regulatory Guidance is Available
- ❑ Already applies to self-funded plans
- ❑ For insured plans, penalty is \$100/day with respect to each individual to whom the failure relates, not taxation of benefit payment
- ❑ In 2012: take stock and consider how rule will be applied when written



Rescission

- ❑ PPACA prohibits all plans from rescinding coverage, effective the first day of the first plan year following September 23, 2010
- ❑ Absent **fraud** or **intentional misrepresentation**, prior coverage may not be retroactively cancelled (but may be cancelled prospectively)
 - ❑ So, if a part-time employee or family member, for example, is mistakenly covered, no rescission
- ❑ Cancellation due to failure to timely pay premiums is not rescission
- ❑ Retroactive cancellation of coverage to date employment terminated is not rescission if employee has not paid for coverage (note: COBRA rights still apply)
- ❑ Retroactive cancellation (subject to COBRA) of an ex-spouse's coverage is not a rescission if employer is not timely notified (and plan does not cover ex-spouses absent COBRA)

Uniform Explanation of Coverage



- ❑ Summary of Benefits and Coverage & 60-day notice requirement
- ❑ Effective March 23, 2012 ***Delayed***
 - ❑ Proposed Regulation Released August 18, 2011
 - ❑ Rule delayed under DOL FAQ VII on PPACA
- ❑ 4 page summary of benefits
- ❑ Culturally and linguistically appropriate
- ❑ HHS form available
 - ❑ www.healthcare.gov/news/factsheets/labels08172011b.pdf.
- ❑ The Uniform Explanation *is in addition to* Summary Plan Description requirement

Uniform Explanation of Coverage



- **Under the Proposed Regulation, SBC Must Include**

1. Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;
2. A description of the coverage, including cost-sharing, for each category of benefits identified by the Departments in the guidance;
3. The exceptions, reductions, and limitations of the coverage;
4. The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;
5. The renewability and continuation of coverage provisions;
6. Coverage examples to illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost-sharing based on recognized clinical practice guidelines;

Uniform Explanation of Coverage



- **Under the Proposed Regulation, SBC Must Include**

7. For coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides “minimum essential coverage” and whether the plan’s share of the total allowed costs of benefits provided under the plan meets applicable requirements;
8. A statement that the SBC is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage;
9. Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance);
10. For plans and carriers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;

Uniform Explanation of Coverage



- **Under the Proposed Regulation, SBC Must Include**

11. For plans and carriers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage;
12. An Internet address for obtaining the uniform glossary; and
13. Premiums (or in the case of a self-funded group health plan, cost of coverage).
14. Coverage examples that illustrate benefits provided under the plan for common benefits scenarios (including pregnancy and serious or chronic medical conditions). The Departments may identify up to six coverage examples that may be required in an SBC.

W-2 Reporting of Health Care Costs



- ❑ Applicable employer-sponsored coverage includes the entire cost of the coverage (without any reduction for employee contributions)
 - ❑ Cost of coverage is determined under rules similar to those for determining COBRA premiums (excluding 2% administrative charge)
- ❑ New Guidance Released January 3, 2012, key points:
 - ❑ Notice 2012-9—mandates compliance with the reporting requirement beginning with 2012 Forms (i.e., Forms issued in January 2013)
 - ❑ **Small Employer Exception: those issuing less than 250 W-2's in prior year exempt until further guidance issued**
 - ❑ Must report aggregate cost of health coverage

W-2 Reporting of Health Care Costs



- ❑ Must report aggregate cost of health coverage
 - ❑ All plans except:
 - ❑ long-term care;
 - ❑ Accident/disability coverage, liability insurance, workers' compensation, and other similar coverage;
 - ❑ non-integrated dental and vision plans;
 - ❑ coverage for a specified disease or illness; and
 - ❑ hospital indemnity or other fixed indemnity insurance

W-2 Reporting of Health Care Costs



- ❑ Must report aggregate cost of health coverage
 - ❑ IRS Notice 2012-9 clarifies that:
 - ❑ Employee assistance program (EAP), wellness program, or on-site medical clinic coverage may be excluded from the reporting requirement if the employer does not charge a premium to COBRA qualified beneficiaries with respect to that type of coverage;
 - ❑ Dental or vision coverage is excluded to the extent it qualifies as a HIPAA-excepted benefit; and
 - ❑ Specified disease or illness and hospital indemnity or other fixed indemnity insurance may be excluded from the reporting requirement, so long as the cost of coverage is paid by the employee on an after-tax basis and the coverage is offered as an independent, non-coordinated benefit.

W-2 Reporting of Health Care Costs



- ❑ Must report aggregate cost of health coverage
 - ❑ Generally, dental or vision coverage is an “excepted benefit” under HIPAA if it is either:
 - ❑ offered under a separate policy, certificate, or contract of insurance; or
 - ❑ participants have the right not to elect the dental or vision coverage and if they do so elect it, they must pay an additional premium or contribution for that coverage.

W-2 Reporting of Health Care Costs



- ❑ Must report aggregate cost of health coverage
 - ❑ Aggregate reportable cost does not include:
 - ❑ Amounts contributed to any Archer MSA (reported separately in box 12, code R)
 - ❑ Amounts contributed to any Health Savings Account (reported separately in box 12, code W)
 - ❑ Salary reduction elections to a flexible spending arrangement (but employer match, etc., are included)
 - ❑ Cost of coverage under a Health Reimbursement Arrangement (HRA)
 - ❑ Cost of coverage under a self-insured group health plan that is not subject to any federal continuation coverage requirements (e.g., a church plan that is a self-insured group health plan), or
 - ❑ Cost of coverage provided by a state or the federal government
 - ❑ ***Independent Contractors, retirees (if no W-2 issued)***

W-2 Reporting of Health Care Costs



- ❑ Must report aggregate cost of health coverage
 - ❑ Aggregate reportable cost includes the cost of the employee's coverage and any person covered by the plan because of a relationship to the employee, including any portion of the cost that is includible in an employee's gross income due to that relationship
 - ❑ Terminated Employees: can use a "reasonable method" for including the value
 - ❑ Don't have to include if employee terminated and requested W-2 prior to end of the year in which termination occurs

W-2 Reporting of Health Care Costs



□ Methods for Calculating the Reportable Cost

- The COBRA applicable premium method
- The premium charged method if the employer is determining the cost of coverage for an employee covered by an insured plan
- Employer not required to use the same method for every plan, but must use the same method with respect to a plan for every employee receiving coverage under that plan
- Reportable costs under a plan for a year must reflect any increases and decreases in the cost for the year
- If an employee changes coverage during the year, the reportable cost under the plan for the employee for the year must take into account the change in coverage



Essential Health Benefits Bulletin

- ❑ In December, HHS released essential health benefits bulletin
 - ❑ The Bulletin addresses HHS' planned approach to defining the scope of benefits required to be offered by non-grandfathered plans in the individual and small group health insurance markets both inside and outside of the Exchanges beginning in 2014
 - ❑ Although the Bulletin is not regulatory guidance, it provides a detailed description of HHS' intended regulatory approach toward essential health benefits
 - ❑ The requirements do not apply to self-insured or large group market plans, or to grandfathered plans; however, additional insurance reforms may restrict a group health plan's cost sharing provisions starting in 2014



Essential Health Benefits Bulletin

- ❑ The Bulletin proposes to define EHB on a state-by-state basis, and would require each state to select a “benchmark plan” that would define EHB for that state
- ❑ If a State does not select a benchmark health plan, the Bulletin proposes that the default benchmark plan for that State would be the plan with the most enrollees in the largest product in the State’s small group market.



Essential Health Benefits Bulletin

- The Bulletin suggests for types of benchmark plan types for 2014 and 2015, which best reflect the statutory standards for EHB in the Affordable Care Act:
 1. the largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market;
 2. any of the largest three State employee health benefit plans by enrollment;
 3. any of the largest three national Federal Employees Health Benefit Plan (“FEHBP”) plan options by enrollment; or
 4. the largest insured commercial non-Medicaid HMO operating in the State.



Medical Loss Ratio Requirements

- Health insurance companies must provide rebates to policyholders if their MLR (percent of premium revenue spent on claims/medical care) is less than 85% (large groups) or 80% (small groups or individuals)
 - Small group is defined as under 100 employees on average in prior year
 - States may define small group as under 50 until 2016
 - Starting in 2016, small group will be defined as under 100
 - Rebates must be provided no later than August 1 following the end of the MLR reporting year (which is the calendar year)
 - MLR based on a carrier's overall business by state and group size



Medical Loss Ratio Requirements

- In December 2011, HHS released amended MLR regulations
 - Amended regulations did not address broker commissions
- DOL also issued Technical Release 2011-04, which provides guidance on rebates to ERISA-covered plans
 - Rebates apportioned based on amounts contributed by employer and employees
 - Employers may retain portion of rebate that is not a “plan asset” under ERISA
 - Rebates that are plan assets must be used to benefit participants
 - Reduce premiums, enhance benefits
 - **Technical Release provides relief from ERISA’s trust requirement, but only if rebate is used within three months of receipt by employer**
 - Consult with counsel if a trust is involved

Upcoming Mandates



2012: Quality of Care Reporting

- ❑ No regulations yet
- ❑ Submission of annual reports to HHS and enrollees during open enrollment on whether the plan fulfills certain quality of care measures developed by HHS
- ❑ Does not apply to grandfathered plans
- ❑ HHS to develop appropriate penalties

Upcoming Mandates



2012: Comparative Effectiveness Research Fee

- ❑ Effective for plan years ending after September 30, 2012 and before October 1, 2019
- ❑ \$2 fee per member per year
 - ❑ Paid by insurers if insured plan
 - ❑ Paid by plan sponsor if self-funded plan
- ❑ Fee reduced to \$1 for plan years ending before October 1, 2013
- ❑ For plan years beginning after September 30, 2014, fee increases based on national health expenditures
- ❑ Fee supposed to sunset after 2019

Upcoming Mandates



2013: Health FSA Limit Imposed

- ❑ Annual employee contributions to FSAs capped at \$2,500
- ❑ Indexed to the CPI starting in 2014
- ❑ Does not limit employer contributions
- ❑ To Do:
 - ❑ Plan Amendments by December 31, 2012
 - ❑ Communication to begin in 2012 (2nd half)

Upcoming Mandates



2013: Health FSA Limit Imposed

- ❑ Potential issues for non-calendar year health FSAs
 - ❑ \$2,500 contribution limit applies on calendar year basis
- ❑ Example: April 1 – March 31 Health FSA Plan Year
 - ❑ \$6,000 annual limit, employee elects maximum for 2012
 - ❑ \$500 per month; contributions of \$1,500 from Jan-Mar 2013
 - ❑ Remaining limit in 2013 is \$1,000, or \$111.11 per month

Upcoming Mandates



2013: Health FSA Limit Imposed

- ❑ Potential issues for non-calendar year health FSAs
 - ❑ Front-loading not expressly sanctioned by IRS
 - ❑ Could be burdensome on employees, particularly for plans years beginning late in the calendar year
 - ❑ Communicate changes to participants early to ensure smooth transition

Upcoming Mandates



2013: Employer Notice Requirements

- ❑ Effective March 23, 2013
- ❑ Employers must provide employees with written notice of:
 - ❑ The existence of the health insurance exchange
 - ❑ The potential eligibility for federal assistance if the employer's health plan is “unaffordable”
 - ❑ The possibility that the employer may not contribute to the cost of coverage purchased through an Exchange

Upcoming Mandates



- ❑ 2013: Hospital Insurance Tax / Medicare Payroll Tax
 - ❑ FICA and SECA additional tax of 0.9% on wages of \$200,000 (individual) or \$250,000 (joint)
 - ❑ To Do:
 - ❑ Watch for guidance on how this is to be done
 - ❑ Begin discussing with payroll vendor in 2012
 - ❑ **Also imposes a new 3.8% tax on the lesser of net investment income and the excess of AGI over \$200,000 (individual) or \$250,000 (joint)**

Upcoming Mandates



- ❑ 2014: Perfect Storm – Guarantee Issue / No Pre-Ex
 - ❑ To Do:
 - ❑ Begin thinking **now** about enrollment strategies for the future
 - ❑ Consider self-funding to avoid state law mandates that limit enrollment options

Upcoming Mandates



2014: Play or Pay Mandate

❑ Opting Out

- ❑ Employers with 50 or more full-time equivalent (FTE) employees that do not provide health coverage to employees (and their dependents) are penalized
 - ❑ For FTE, count FT employees then add all PT hours / 120
- ❑ If at least one full time employee (30+hrs/wk or 130+ hrs/mo) receives federal assistance for exchange, penalty of \$2,000 × all full-time employees (i.e., \$167.67 per full-time employee per month (above the first 30))
- ❑ To Do:
 - ❑ Understand timing on regulations – we won't see them soon
 - ❑ Consider financial and employee relations costs
 - ❑ Plan ahead

EXIT

Upcoming Mandates



2014: Play or Pay Mandate

❑ Providing Unaffordable Coverage

- ❑ Employers providing unaffordable coverage are penalized
- ❑ Unaffordable? Premiums exceed 9.5% of household income or plan actuarially expected to pay less than 60% of enrollee's costs (expected safe harbor to permit use of current W-2 wages)
- ❑ Penalty? Lesser of \$3,000 for each full time employee receiving federal assistance to purchase exchange insurance or \$2,000 multiplied by all full time employees (subtracting first 30)
- ❑ To Do:
 - ❑ Understand the rule and ignore those who don't – where in either of these rules does it say cover all part-time employees?
 - ❑ We do not know how this rule will be written
 - ❑ Plan ahead

Upcoming Mandates



2014: Automatic Enrollment

- ❑ Employers with more than 200 employees must auto-enroll full-timers
 - ❑ Must have notice and opt-out opportunity
 - ❑ Watch for future guidance

Upcoming Mandates



2014: Exchanges

- ❑ States required to have exchanges by January 1, 2014
- ❑ If not, federal government will establish
- ❑ Will likely be web-based portal through which eligible individuals will purchase insurance
- ❑ Before 2016, states have the option to define “small employers” either as those with 100 or fewer employees, or 50 or fewer employees
- ❑ Beginning in 2016, small employers will be defined as those with 100 or fewer employees
- ❑ Beginning in 2017, states may allow large employers to obtain coverage through an Exchange (but will not be required to do so)
- ❑ Tiered coverage Bronze (60%), Silver (70%), Gold (80%) and Platinum (90% actuarial value of benefits provided under the plan)



Questions?

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