Welcome to A Professional Development Webinar By Hill Ward Henderson

HEALTH CARE REFORM: Compliance Strategies For Employers

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Welcome & Webinar Overview

Alton C. Ward
Moderator

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Presenter
Timeline: Taxable years beginning on or after December 31, 2009

- Small business tax credit available to employers who:
  - Pay at least 50% of cost of health coverage
  - Have no more than 25 full time equivalent employees with average annual wages of no more than $50,000
  - Full credit available only to those with 10 or fewer FTE employees, and average wages of $25,000 or less
  - Tax credit is equal to 35% (25% for tax exempt entities) of the lesser of
    - the employer contribution and
    - a benchmark premium rate based on the average small employer premium in the state
  - Beginning in 2014, the 35% multiple will increase to 50% (35% for tax exempt entities)
Timeline: 2010

- Early retiree reinsurance
- Recognition of taxation of retiree drug subsidy
- Nursing mothers
- State high risk pools
- Automatic enrollment
Timeline: Plan years beginning on or after September 23, 2010

• Restrictions on rescission
• Dependent coverage for adult children under the age of 26
• Changes to appeals process
• First dollar coverage required for certain evidence based preventative care (including well child care and certain immunizations)
Timeline: Plan years beginning on or after September 23, 2010

- Elimination of the pre-existing condition exclusion for children under age 19
- Elimination of lifetime limits related to essential health benefits
- Reasonable annual limits related to essential health benefits
Timeline: Plan years beginning on or after September 23, 2010

- Participants can select primary care provider
- No preauthorization or increased cost-sharing for emergency
- No preauthorization or referral requirement for OB/GYN services
- **Nondiscrimination requirements** apply to fully insured plans
Timeline: 2011

- Over the counter medications are no longer eligible for reimbursement under a health flexible spending account, health reimbursement arrangement or health savings account
- CLASS ACT: National voluntary employee funded long term care benefit
- Insurance rebates required to the extent that more than 20% of the premium revenue is spent on costs other than benefit claims
Timeline: 2011

- **W-2’s issued for 2011** must disclose cost of employer provided health benefits:
  - No reporting for employee salary-reduction FSAs or employer HSA funding
- **Simple Section 125 cafeteria plans** are available for companies with less than 100 employees
- **Tax on distributions** from a health savings account is increased from 10% to 20%
- **Adoption assistance limits** increased and extended
Timeline: 2012

• 1099 reporting requirements expanded to require a 1099 to be issued to any corporation, other than a tax exempt, for any **property** or services over $600:
  – Currently, only for unincorporated, and only for services
  – Must get tax ID numbers for all suppliers
• Report health care quality and wellness initiatives to HHS
Timeline: Plan years ending on or after September 30, 2012

• Fee of $2 per average number of enrollees/lives ($1 for policy/plan years ending during fiscal year 2013):
  – If fully insured, issuer pays
  – If self-funded, plan sponsor pays
  – Indexed
  – This fee sunsets after 2019
Timeline: 2013

- Additional 0.9% Medicare tax on wages in excess of $250,000 for joint return filers, and $200,000 for others
- 3.8% tax on unearned income for joint filers with modified AGI in excess of $250,000, $200,000 for singles, $120,000 for married filing separately
- Effective January 1, 2013 the maximum amount that can be made available through a health flexible spending account is limited to $2,500, indexed
Timeline: 2013

- **Employer Notice** must be provided beginning on March 1, 2013 to notify employees in writing:
  - Of the existence of the Exchange
  - Of potential eligibility for federal assistance if the employer’s health plan is “unaffordable”
  - That they may lose the employer’s contribution if they purchase health insurance through the Exchange without a voucher

- 60-day advanced notice of material modifications
Timeline: 2014

• Establishment of state health insurance exchanges for individuals and small businesses with 100 or less employees
• Individual mandate requiring all individuals to have health insurance
• Employer mandate regarding coverage
Timeline: 2014

- Elimination of pre-existing condition exclusions for all participants
- No annual dollar limits
- Waiting periods cannot exceed 90 days
- No cost sharing in excess of the limits on high deductible health plans
- Limit on wellness incentives is increased from 20% to 30%
- Cover routine costs of patients who are part of clinical trials
Timeline: 2018

• Cadillac plan tax becomes effective
  – 40% tax on “excess health coverage”
  – Tax imposed on issuers of fully-insured plans and on administrators with respect to self-funded plans
  – $10,200 for single and $27,500 for family
  – Retirees and high risk professions: $11,850 for single and $30,950 for families
  – Adjusted for inflation
Grandfathered Plans &
Action Steps for
Short-Term Compliance

Kirsten L. Vignec
Presenter
Grandfathered Plans

• A grandfathered plan is generally any plan in which an individual was enrolled on March 23, 2010

• Grandfathered plans do not have to comply with the following requirements:
  – Nondiscrimination requirements for fully insured plans
  – Providing participants with the right to select a primary care provider/pediatrician
Grandfathered Plans

– Elimination of any pre-authorization or increased cost sharing for emergency services
– Elimination of preauthorization or referral for OB/GYN services
– Changes to the appeals process
– First dollar coverage for preventative care
Grandfathered Plans

– Reporting health care quality and wellness initiatives to HHS
– Incorporating cost-sharing limits on out of pocket and deductible expenses
– Coverage of routine costs of patients who are part of clinical trials
– Providing for minimum essential benefits
Grandfathered Plans

• To maintain a plan’s grandfathered status only limited changes can be made to the plan as it existed on March 23, 2010

• The following changes to a group health plan will affect a plan’s grandfathered status:
  – Entering into a new policy, certificate or contract of insurance with the insurance issuer or changing the insurance issuer (limited exception applies to collectively bargained plans)
Grandfathered Plans

– Eliminating all or substantially all benefits to diagnose or treat a condition, or any necessary element to diagnose or treat a condition

– Increasing any percentage cost-sharing requirement (coinsurance)

– Increasing a fixed-amount cost-sharing requirement, other than a copayment, by more than the sum of medical inflation plus 15 percentage points
Grandfathered Plans

- Increasing a fixed-amount copayment by more than the greater of: $5 increased by medical inflation or a total percentage that is more than the sum of medical inflation plus 15 percentage points
- Decreasing the employer's contribution rate toward the cost of any tier of coverage by more than 5 percentage points
Grandfathered Plans

– Decreasing or imposing a new annual limit on the dollar value of benefits
  • plans with an existing lifetime limit are permitted to adopt an overall annual limit at a dollar value that is not lower than the dollar value of the plan's lifetime limit

– Anti-abuse rules apply to certain mergers, acquisitions and plan transfers that are completed in order to attempt to maintain grandfathered status
Grandfathered Plans

- The following changes do not affect a plan’s grandfathered status:
  - Changing a self-insured plan's third-party administrator
  - Changes effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010
  - Changes adopted prior to the Regulations that would otherwise cause the plan or coverage to lose grandfathered health plan status, if such changes are revoked or modified effective as of the first day of the first plan year on or after Sept. 23, 2010
Grandfathered Plans

– Voluntary changes to increase benefits, to conform to required legal changes (including health care reform mandates), and to voluntarily adopt health care reform requirements

– Increasing a fixed-amount copayment or other fixed amount cost sharing within provided limits
Grandfathered Plans

• Notice requirement: In order to maintain a grandfathered plan, plan materials must include a statement that the plan is grandfathered and include contact information for questions and complaints
  – Model language is included in the Regulations
Grandfathered Plans
Action Steps

• Employers will need to review the benefits and the costs of maintaining a grandfathered plan as compared to complying with all of the rules of health care reform

• Employers will need to discuss the available options with their consultants, third party administrators

• Review recent changes or proposed changes to the plan to see if it affects the grandfathered status
Short Term Compliance

- Of the many requirements that go into effect over the next 3 years, the following deserve additional attention:
  - Nondiscrimination requirements
  - Coverage of adult dependents
  - Elimination of lifetime and annual limits
  - Rescissions
  - Patient protections
Short Term Compliance: Nondiscrimination

• For plan years beginning on or after September 23, 2010, the nondiscrimination requirements under Section 105(h) of the Internal Revenue Code will apply to fully insured plans

• There are two nondiscrimination tests the "eligibility test" and the "benefits test"
Short Term Compliance: Nondiscrimination

• The eligibility test provides that a plan cannot discriminate in favor of highly compensated individuals (“HCIs”) as to eligibility to participate
  – HCIs are
    • the five highest paid officers, or
    • shareholders who own more than 10% of the value of the employer stock, or
    • the highest paid 25% of all employees
Short Term Compliance: Nondiscrimination

– Three alternative tests can be used to satisfy the eligibility test:
  • the 70% test,
  • the 70%/80% test, and
  • the nondiscriminatory classification test
Short Term Compliance: Nondiscrimination

– Excluded employees:
  • employees who have less than 3 years of service
  • employees who have not attained age 25
  • part-time (under 35 hours -- if everyone else works substantially more) and seasonal employees (less than 9 months)
  • collectively bargained employees and
  • non-resident aliens with no U.S. source income
Short Term Compliance: Nondiscrimination

• The benefits test ensures that benefits provided for participants who are HCIs (and their dependents), are also provided to non-HCIs (and their dependents).

• The benefits test requires that the plan not be discriminatory on its terms or in operation.
Short Term Compliance: Nondiscrimination

– To be nondiscriminatory on its terms:
  • required employee contributions must be identical for each benefit level
  • maximum benefit level must not vary based on age, years of service, or compensation
  • the same type of benefits must be available to HCIs and to non-HCIs
  • different waiting periods must not be imposed

– Whether a plan discriminates in actual operation is a facts and circumstances determination
Short Term Term Compliance: Coverage for Adult Children

• Plans that provide dependent coverage must make coverage available for adult children to age 26 (including married children) for plan years beginning on or after 9/23/10

• Coverage of spouse or children of child NOT required

• Grandfathered plans have until 2014 to provide coverage for a child who is eligible for coverage from his or her own employer
Short Term Compliance: Coverage for Adult Children

- Some plans and most insurance companies are applying this requirement early
- Notices informing participants that children who have previously lost coverage may re-enter the plan are required
Short Term Term Compliance: Coverage for Adult Children

• IRS has issued guidance that permits the payment for coverage of adult children who have not attained age 27 as of the end of the calendar year on a pre-tax basis through a Section 125 plan.
  – Child doesn’t have to meet the current definition of dependent for tax purposes
• Rules apply to coverage under the plan and amounts paid or reimbursed for child who has not attained age 27 as of the end of the tax year are excluded
• No corresponding change to the rules regarding reimbursements for dependents under a health savings account
Short Term Compliance:
Lifetime and Annual Limits

- Health care reform generally prohibits annual and lifetime limits on the dollar value of benefits
- Lifetime limits and annual limits are prohibited with respect to essential health benefits
  - Essential health benefits include (but will more than likely be expanded):
    - Ambulatory patient services
    - Emergency services
    - Hospitalization
    - Maternity and newborn care
    - Mental health and substance abuse
    - Prescription drugs
    - Rehabilitative services
    - Laboratory services
    - Preventative and wellness services and chronic disease management
    - Pediatric services (including oral and vision care)
• Individual annual or lifetime benefits may be imposed with respect to specific covered benefits that are not “essential health benefits”

• Lifetime limits on essential health benefits
  – Before the first day of the plan year beginning after September 23, 2010
    • notices must be sent to individuals who previously reached the lifetime limit and are otherwise eligible for coverage
    • individuals must be offered an enrollment opportunity as a special enrollee
Short Term Compliance: Lifetime and Annual Limits

• Annual limits
  – Restricted annual limits on “essential health benefits” are permitted before 2014
  – Annual limits on the dollar value of benefits that are essential health benefits may not be less than:
    • $750,000 for plan/policy years beginning on or after September 23, 2010 but before September 23, 2011
    • 1.25 million for plan/policy years beginning on or after September 23, 2011 but before September 23, 2012
    • 2.0 million for plan or policy years beginning on or after September 23, 2012 but before January 1, 2014
Short Term Compliance: Lifetime and Annual Limits

• Effect on mini-medical and limited benefit plans:
  – Regulations require HHS to establish a program under which the requirements regarding annual limits can be waived if compliance results in a significant decrease in access to benefits or a significant increase in premiums

• Changes to existing annual limits may effect grandfathered status
Short Term Compliance: Rescission

• Rescission is a cancellation or discontinuance of coverage that has a retroactive effect

• Plans and issuers cannot rescind unless an individual was involved in fraud or made an intentional misrepresentation

• Protects individuals who make a mistake on the forms
Short Term Compliance: Rescission

• Regulations clarify that:
  – Rescission applies to individuals or a group
  – Applies to representations made by an individual or the person seeking coverage on behalf of the individual
  – To the extent that an omission constitutes fraud it would support rescission
Short Term Compliance: Patient Protections

• Choice of Health Care Professional:
  – Participants have the right to select primary care physician and/or pediatrician and to obtain services of an OB/GYN without a referral or prior authorization
  – Regulations require a notice of these rights to be provided to each participant
    • Model language provided
Short Term Compliance: Patient Protections

• Emergency Services:
  – Must be provided without prior authorization and without regard to whether provider is in network
  – Cost sharing requirements for out of network cannot exceed the cost sharing that would be imposed of services provided in network
  – Out of network providers may balance bill for the difference
Short Term Compliance: Patient Protections

– Reasonable amounts must be paid by plan or insurer before a patient becomes responsible for the balance bill

– To be reasonable amount paid must be the greatest of:

  • Amount negotiated with in-network providers
  • Amount calculated using the same method the plan generally uses to determine out of network payment – substituting in network cost sharing
  • Amount that would be paid by Medicare
Short Term Compliance: Action Steps

• Nondiscrimination
  – Review any fully insured plans to ensure that the plans are not discriminatory going into the next plan year
  – Although this is a new requirement for fully insured plans, self insured plans should also take this opportunity to review their plans as there may be a renewed interest in this area
  – Consult with insurers and third party administrators regarding plan design

• Coverage for adult children
  – Decide how and when to implement
  – Cafeteria plans and health plans need to be amended to reflect new dependent definition by the end of 2010
Short Term Compliance: Action Steps

• Generally
  – Amend the health plans and related documentation including benefit descriptions as necessary to comply with the new rules
  – Prepare required notices and establish procedures to provide the notices
Action Steps for Long-Term Compliance – 2014 and Beyond

Melanie J. Hancock
Presenter
Long Term Compliance: State Exchanges

• January 1, 2014: State health exchanges are required to be established for individuals and small businesses of 100 or fewer employees
  – Prior to 2016, states can limit this to businesses with up to 50 employees
  – Beginning 2017, states can allow the state health exchanges to become available for all employers

• Exchange will have a variety of insurance options to satisfy the new mandates
Long Term Compliance: Individual Mandate

• Beginning in 2014, to avoid penalty, nearly all individuals will be required to have “minimum essential coverage:”
  – Subsidies for those up to 400% of federal poverty level, or if employer coverage is not “affordable”
  – Medicaid will be expanded
• For 2014, penalty is $95/uninsured adult or 1% of household income over filing threshold
• For 2015, penalty $325 or 2%
• For 2016 and after, penalty increases to $695* or 2.5%
Long Term Compliance: Free Choice Vouchers

• Household incomes at or below 400% of federal poverty level
• Premium payment is between 8 and 9.8% of household income
• Voucher amount is the amount the employer would have paid toward coverage in the plan where the employer pays the largest portion
• Employee can keep difference if exchange coverage is cheaper
• Employer can deduct voucher amount
Long Term Compliance Employer Mandate

• Law does not require employers to offer health coverage to their employees

• However, large employers will be subject to a penalty beginning in 2014 if they:
  – Do NOT offer coverage
  – Offer coverage that is NOT affordable, or
  – Offer coverage that DOES NOT meet the minimum essential standards
Long Term Compliance: Large Employer Mandate

• For purposes of the penalty, a *large employer* is an employer who has 50 or more full-time employees or full-time equivalents
  – Full-time employees: those that work 30 or more hours a week calculated on a monthly basis
  – Full-time equivalents are also counted in the determination of whether an employer is a large employer for purposes of the penalty
  – The penalty only applies with respect to full-time employees
Long Term Compliance: Employer Mandate – Penalties

• If full-time employees (and dependents) are not offered minimum essential coverage, penalty applies if at least one full-time employee receives federal assistance to purchase through an Exchange:
  – Penalty is equal to $2,000 multiplied by the total number of full-time employees not taking into account the first 30 employees.
Long Term Compliance: Employer Mandate—Penalties

- Penalty also applies if the health coverage offered is either:
  - unaffordable because the employee’s required contribution is more than 9.5% of employee’s household income, or
  - the plan pays for less than 60% of covered health care expenses

- Expect changes to this penalty since it is based on information that will not be available to the employer
Long Term Compliance: Employer Mandate–Penalties

- No penalty for employees receiving free choice vouchers paid by the employer
- Employers must annually report
  - Whether they offer health coverage to their full-time employees and dependents
  - The total number and names of full-time employees receiving health coverage
  - The length of any waiting period; and
  - Other information about the cost of the plan
Long Term Compliance: Employer Mandate—Penalties

• If employer coverage is not affordable the penalty is equal to:
  – At least, $3,000 multiplied by the number of full time employees receiving assistance, BUT
  – No more than $2,000 multiplied by the number of full time workers, but not taking into account the first 30 employees
Long Term Compliance: Minimum Essential Coverage

- Government sponsored programs – Medicare, Medicaid, CHIP, TRICARE, Veterans, Peace Corps
- Individual market plans
- Other coverage as determined by HHS
- Under 30 with hardship may use catastrophic plans to satisfy requirement
Long Term Compliance: Minimum Essential Coverage

• “Eligible employer sponsored plans:”
  – Governmental plans
  – Church plans
  – Grandfathered plans
  – Other group health plans offered in the small or large group market

• Does NOT include:
  – Excepted benefits
Action Steps

• Review population and current plan terms to determine how the plan will be impacted by Health Care Reform over the long term

• Coordinate with your consultants to review the costs associated with the changes as compared to the potential penalties of failing to comply with the employer mandate
Q & A Session
Submit a Question in the box at the lower left side of your screen

Alton C. Ward
Melanie J. Hancock
Kirsten L. Vignec
Closing & Announcements

• As we close today’s session, please be aware of additional opportunities for information:
  – Follow-up Panel Discussion to be held at our offices on Tuesday, August 17th
  – You will be receiving an invitation for that event in the near future
This concludes today’s Professional Development Webinar by Hill Ward Henderson

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