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Health Care Reform – What Does it Mean for Plan Sponsors?

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Topics to be Discussed Today

- ✦ Background
- ✦ Grandfathered Plans
- ✦ Insurance Reforms
- ✦ Minimum Essential Coverage
- ✦ Individual Responsibility
- ✦ Employer Responsibility
- ✦ Insurance Exchanges
- ✦ The “Cadillac Tax”
- ✦ Nondiscrimination Testing
- ✦ Section 125 Plan Issues
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- ✦ Retiree Reinsurance Program
- ✦ Medicare Part D Deduction
- ✦ Medicare Part D Coverage
- ✦ QUESTIONS?

Background

- ✦ December 24, 2009, the Senate passed the Patient Protection and Affordable Care Act (H.R. 3590) (the "Act")
- ✦ March 21, 2010, the House of Representatives passed the Patient Protection and Affordable Care Act (H.R. 3590)
- ✦ March 21, 2010, the House of Representatives also passed the Health Care and Education Affordability Reconciliation Act of 2010 (H.R. 4872) (the "Reconciliation Act")
- ✦ March 25, 2010, the Reconciliation Act was passed by the Senate and, as revised by the Senate, passed by the House
- ✦ March 23, 2010, the Act was signed by President Obama
- ✦ March 30, 2010, the Reconciliation Act was signed by President Obama

Grandfathered Plans

- ★ The Act provides that there will be no changes required with respect to a group health plan or health insurance in which an individual was enrolled on the date of enactment (i.e., March 23, 2010)
- ★ Such plans are “grandfathered” and will continue to be treated as grandfathered plans even if coverage is renewed after March 23, 2010
 - > Family members can be added to such plans
 - > New employees (and their family members) can be added to such plans

Grandfathered Plans

- ✦ The Act is silent as to what, if anything, will cause a grandfathered plan to lose grandfathered status
 - > Any change?
 - > Any material change?
 - > Only a benefits change?
 - > Can a plan expand (or restrict) eligibility?
- ✦ What if an employer with an insured plan wants to change insurance carriers?
- ✦ What if a self-funded plan only changes claims administrators but continues to provide the same substantive benefits?

Grandfathered Plans

- ★ Special Rule for Collectively Bargained Plans
 - > Certain provisions of the Act will not apply to health insurance coverage that is maintained pursuant to one or more collective bargaining agreements that were ratified before the date of enactment until the date the last collective bargaining agreement relating to the coverage terminates
 - > Unlike other grandfathered plans, it appears that collectively bargained plans are not grandfathered permanently

Health Insurance Reforms

- ◆ Extension of tax-favored dependent coverage to adult children to age 26, regardless of child's marital or student status (insured and self-funded)
 - > Applies to grandfathered plans
 - > First plan year after September 23, 2010 (January 1, 2011 for calendar year plans, further delay to January 1, 2014 for grandfathered plans except for certain adult children who are not eligible for employer-sponsored coverage)
- ◆ There is no obligation to make coverage available to the child of an adult child receiving coverage

Health Insurance Reforms

- ✦ No preexisting condition exclusions (insured and self-funded)
 - > Effective for children as of September 23, 2010
 - > Effective for adults for plan years beginning on or after January 1, 2014
 - > Applies to grandfathered plans
- ✦ Provides for the establishment of a process for reviewing unreasonable increases by health insurance issuers (insured only)
 - > Process will require issuers to justify to the Secretary of HHS and the applicable State, any unreasonable premium increase prior to the implementation of the increase
 - > Effective March 23, 2010
 - > Not applicable to grandfathered plans

Health Insurance Reforms

- ★ No lifetime or unreasonable annual limits on the dollar value of essential health benefits (limits may be imposed on non-essential health benefits) (insured and self-funded)
 - > No lifetime limits (effective for first plan year after September 23, 2010, January 1, 2011 for calendar year plans)
 - > Restricted annual limits (as defined by Secretary) on essential health benefits are permissible through December 31, 2013 only
 - > Applies to grandfathered plans

Health Insurance Reforms (Effective First Plan Year After September 23, 2010; January 1, 2011 for Calendar Year Plans)

- ✦ No rescission of health insurance coverage except for fraud or intentional misrepresentation of material fact (insured and self-funded)
 - > Applies to grandfathered plans
- ✦ Requirement to provide coverage for preventive health services (insured and self-funded)
 - > May not impose cost-sharing requirements
 - > Not applicable to grandfathered plans

Health Insurance Reforms (Effective First Plan Year After September 23, 2010; January 1, 2011 for Calendar Year Plans)

- ✦ Must implement effective appeals process for appeals of coverage determinations and claims (insured and self-funded)
- ✦ New requirements
 - > Must allow claimants to present evidence and testimony as part of appeal process
 - > Must continue coverage for claimants pending the outcome of the appeals process
 - > Must provide for external review process
 - Insured plans must comply with state's requirements
 - Self-insured plans must comply with standards set by Secretary of HHS
- ✦ Not applicable to grandfathered plans

Health Insurance Reforms (Effective First Plan Year After September 23, 2010; January 1, 2011 for Calendar Year Plans)

- ◆ Enrollees may select any available participating care provider or pediatrician for children (insured and self-funded)
 - > Not applicable to grandfathered plans
- ◆ No preauthorization requirement or increased cost-sharing for emergency services (network or out-of-network) (insured and self-funded)
 - > Not applicable to grandfathered plans
- ◆ No preauthorization or referral requirement for OB/GYN services (insured and self-funded)
 - > Not applicable to grandfathered plans

Health Insurance Reforms (Effective Plan Years Beginning On or After January 1, 2014)

- ✦ May not deny participation, discriminate against, or limit or impose additional conditions on coverage, to a qualified individual in an approved clinical trial (insured and self-funded)
 - > Not applicable to grandfathered plans

Health Insurance Reforms (Effective Plan Years Beginning On or After January 1, 2014)

- ✦ Plans may not discriminate on the basis of health status (insured and self-funded)
 - > Wellness program – reward may not exceed 30% of the cost of employee only coverage (may be adjusted by the Secretary of HHS, has discretion to increase to 50%)
 - > This provision of the Act is not applicable to grandfathered plans, but there are existing HIPAA portability rules that do apply
- ✦ Waiting period may not exceed 90 days (insured and self-funded)
 - > Applies to grandfathered plans

Health Insurance Reforms (Effective Plan Years Beginning On or After January 1, 2014)

- ◆ Premiums charged may vary only by the following (insured only)
 - > Individual or family coverage
 - > Rating area
 - > Age
 - > Tobacco use
- ◆ Not applicable to grandfathered plans

Health Insurance Reforms (Effective Plan Years Beginning On or After January 1, 2014)

- ★ Guaranteed availability of coverage – health insurance issuers must accept every employer and individual that applies for coverage (insured only)
 - > May restrict enrollment to open or special enrollment periods (must establish enrollment periods relating to COBRA qualifying events)
 - > Effective for plan years beginning on or after January 1, 2014
 - > Not applicable to grandfathered plans
- ★ Guaranteed renewability – health insurance issuers must renew or continue coverage at the option of the plan sponsor or the individual, as applicable (insured only)
 - > Not applicable to grandfathered plans

Health Insurance Reforms (Effective Plan Years Beginning On or After January 1, 2014)

- ✦ Health insurance issuers must ensure that coverage includes “essential health benefits” and complies with minimum cost-sharing requirements (insured only)
 - > Not applicable to grandfathered plans
 - > Note: Grandfathered plans are deemed to provide “minimum essential coverage”

Minimum Essential Coverage

- ✦ Effective on and after January 1, 2014, it will be important for individuals to maintain minimum essential coverage in order to avoid tax penalties
- ✦ Internal Revenue Code Section 5000A defines minimum essential coverage to include:
 - > Grandfathered plans
 - > Eligible employer-sponsored plans
 - Group health plans (self-insured)
 - Group health insurance
 - > Plans offered in the individual market

Minimum Essential Coverage

- > Government sponsored programs
 - Medicare
 - Medicaid
 - CHIP
 - TRICARE
 - Veterans health care program
 - Peace Corps volunteers health plan
- > Other health benefits coverage as determined by the Secretary of Health and Human Services and the Secretary of the Treasury
 - State health benefits risk pool

Minimum Essential Coverage

- ★ The Secretary of Health and Human services is to define what constitutes “essential health benefits”
- ★ Essential health benefits will include at least the following categories:
 - > Ambulatory patient services
 - > Emergency services
 - > Hospitalization
 - > Maternity and newborn care
 - > Mental health and substance use disorder services, including behavioral health treatment

Minimum Essential Coverage

- > Prescription drugs
- > Rehabilitative and habilitative services and devices
- > Laboratory services
- > Preventive and wellness services and chronic disease management
- > Pediatric services, including oral and vision care

Minimum Essential Coverage

- ✦ There will be annual limits on cost-sharing with respect to the “essential health benefits”
 - > Applies to deductibles, coinsurance, copayments, and other similar charges
 - > The total out-of-pocket expenses may not exceed the dollar amounts in effect under Internal Revenue Code Section 223(c)(2)(A)(ii) (HSA limits) beginning in 2014
 - > Dollar limits are subject to adjustment for 2015 and beyond
 - Note: For 2010, the limits are \$5,950 for self-only coverage and \$11,900 for family coverage
- ✦ New plans must cover preventive care without any cost-sharing

Minimum Essential Coverage

- ★ The Act provides for four levels of coverage that are designed to provide benefits that are actuarially equivalent to the stated percentage of the full actuarial value of the benefits provided under the plan as follows:
 - > Bronze level – 60%
 - > Silver level – 70%
 - > Gold level – 80%
 - > Platinum level – 90%
- ★ Based on essential health benefits provided to a standard population

Minimum Essential Coverage

- ✦ In addition, certain “young invincibles” may qualify as having minimum essential coverage if they are enrolled in a catastrophic plan and they:
 - > Have not attained age 30 before the beginning of the plan year; or
 - > Have a certification that they are exempt from the requirements of Internal Revenue Code Section 5000A because they either:
 - Do not have affordable coverage; or
 - Are eligible due to hardship

Individual Responsibility

- ✦ Effective on and after January 1, 2014, the Act generally requires all U.S. citizens and lawfully present residents and their dependents to have minimum essential coverage (as defined in Internal Revenue Code Section 5000A) or be subject to a penalty
- ✦ Exemptions for:
 - > Religious reasons
 - > Individuals not lawfully present in the U.S.
 - > Incarcerated individuals
- ✦ Premium credits and cost-sharing reductions will be available for low income individuals (100% - 400% of the federal poverty limit for their family size)

Individual Responsibility

- ✦ Effective beginning January 1, 2014, for each month that an individual does not have minimum essential coverage for him or her self and all dependents under age 18, a penalty will be assessed equal to the lesser of:
 - > The sum of the monthly penalty amounts; and
 - > The national average premium cost for bronze level coverage
- ✦ The monthly penalty amount is the greater of 1/12 of the applicable dollar amount (maximum 300% of the adult penalty), or the applicable percentage of household income, phased in as follows:
 - > \$95 in 2014 or 1% of household income
 - > \$325 in 2015 or 2% of household income
 - > \$695 in 2016 or 2.5% of household income
 - > Adjusted for inflation for years beginning after 2016
- ✦ The applicable dollar amount is one-half for those under age 18

Employer Responsibility – Timeline

- ✦ Effective (TBD), automatic enrollment in health plans
- ✦ Beginning for tax year 2011, report aggregate cost of employer-sponsored health coverage on Form W-2
- ✦ By March 23, 2012, employers must distribute a uniform summary of benefits and coverage
- ✦ By March 1, 2013, begin providing new notices to employees
- ✦ Effective beginning January 1, 2014, an applicable large employer must provide minimum essential coverage that is affordable or potentially be subject to assessments
- ✦ Effective beginning in 2014, various information must be reported to the government and covered individuals

Employer Responsibility – Automatic Enrollment

- ✦ Automatic enrollment applies to employers who:
 - > Have 200 or more full-time employees; and
 - > Offer at least one health plan
- ✦ Must auto-enroll new employees and continue enrollment of existing employees
- ✦ Employees must be provided notice of the automatic enrollment and have an opportunity to opt-out
- ✦ Effective date?
 - > No date is specified in the Act
 - > Automatic enrollment is required in accordance with regulations to be issued by the Secretary of Labor

Employer Responsibility – W-2 Reporting

- ✦ Beginning for tax year 2011, employers who provide health coverage must report the aggregate cost of employer-sponsored health coverage on Form W-2
 - > Provide by January 31, 2012
- ✦ Cost to be determined based on COBRA premium
- ✦ Regulations are to be issued on how to determine the COBRA premium
- ✦ Exclude salary reduction contributions to Health FSAs
- ✦ “Cadillac Plan” tax will be based on these values

Employer Responsibility – Summary of Benefits

- ✦ Not later than March 23, 2012, plan sponsors or plan administrators of self-insured group health plans must provide enrollees with a uniform summary of benefits and coverage
- ✦ The Secretary of Health and Human Services is to develop standards, including standard definitions, for such uniform summary of benefits and coverage by March 23, 2011
- ✦ Must be in uniform format, cannot exceed four pages, in not less than 12-point font, and meet other requirements for language and content
- ✦ Additionally, notice of future material modifications to the plan must be provided not later than 60 days prior to the effective date of the modification
- ✦ Above is in addition to the current ERISA Summary Plan Description requirements

Employer Responsibility – Notices

- ✦ Effective beginning March 1, 2013, employers are required to provide notice at the time of hire that informs employees:
 - > Of the existence of the Exchange and describes the services provided by the Exchange and how to contact the Exchange;
 - > That the employee may be eligible for a premium tax credit if the employer's share of the total allowed costs of benefits provided under the plan is less than 60%; and
 - > That if the employee purchases coverage through the Exchange they will lose the employer contribution (if any) to the employer's plan and that such contribution may be excludable from income

- ✦ Current employees must receive a notice that contains the above information not later than March 1, 2013

Employer Responsibility – “Play or Pay”

- ✦ Effective beginning January 1, 2014, an applicable large employer must provide minimum essential coverage that is affordable or potentially be subject to assessments
- ✦ An applicable large employer is one who employs an average of at least 50 employees on business days during the preceding calendar year
- ✦ All members of the controlled group will be aggregated for purposes of determining the size of an employer

Employer Responsibility – “Play or Pay”

- ★ Full-time employee means an employee who is employed on average at least 30 hours per week
 - > The Reconciliation Act provides that part-time employees will be included for purposes of determining the number of full-time employees employed by an employer
 - > This will be done by adding up the hours of all part-time employees and dividing them by 120
 - > Note: Seasonal employees may be excluded

Employer Responsibility – “Play or Pay”

- ✦ Assessments will apply to an applicable large employer for any month when the employer has one or more full-time employees to which a premium credit applies enrolled in a qualified health plan, if the employer either:
 - > Does not offer its full-time employees and their dependents minimum essential coverage; or
 - > Offers minimum essential coverage that is not “affordable” (i.e., the employee’s contribution for the coverage is more than 9.5% of the employee’s pay)

Employer Responsibility – Assessments

- ✦ The Reconciliation Act provides that:
 - > The monthly assessment for an applicable large employer who does not offer minimum essential coverage to its full-time employees is equal to the number of full-time employees minus 30 times 1/12 of \$2,000
 - > The monthly assessment for an applicable large employer who does not offer affordable minimum essential coverage to its full-time employees is equal to 1/12 of \$3,000 times the number of full-time employees who received premium credits
 - Subject to a maximum equal to the number of full-time employees minus 30 times 1/12 of \$2,000

Employer Responsibility – Free Choice Vouchers

- ✦ Employers who offer, and at least partially pay for, minimum essential coverage and who have employees with incomes of less than 400% of the poverty level or for whom the premium payments cost over 8% but less than 9.8% of their income, must offer these employees a “free choice voucher”
- ✦ Voucher amount equals the employer contribution under the employer’s plan
- ✦ Employees may then opt out of the employer’s plan and use the voucher as a credit towards the premium for coverage under an Exchange
- ✦ The employer pays the amount of the voucher to the Exchange
- ✦ If the amount of the voucher exceeds the premium for the Exchange coverage, the excess will be paid to the employee

Health Insurance Exchanges

- ◆ Effective not later than January 1, 2014, the Act requires each State to establish:
 - > An “American Health Benefit Exchange” (“Exchange”) to facilitate the purchase of qualified health plans
 - > A “Small Business Health Options Program” (“SHOP Exchange”) to assist small employers in enrolling their employees in qualified health plans

Health Insurance Exchanges

- ✦ Small business tax credit for up to 2 years is available to small employers that make coverage available to employees through a “qualified health plan”
 - > No more than 25 full-time equivalent employees and less than twice the specified average annual wage dollar limit
 - > Applies to the portion of the premiums a small business pays to cover its workers (up to 50% of the premiums paid)
 - > Applicable to amounts paid or incurred in taxable years after December 31, 2010
- ✦ Note: A separate tax credit is available to small employers now (up to 35% of the premiums a small business pays to cover its workers)

The “Cadillac Tax”

- ✦ 40% excise tax on excess benefit provided by high-cost group health plans provided to employees that exceed certain dollar thresholds
 - > For 2018 (1) self-only coverage \$10,200; (2) other than self-only coverage, \$27,500
 - > Thresholds are higher for covered individuals who are qualified retirees (between age 55 and Medicare-eligibility) or if the majority of employees are engaged in high risk professions
 - Law enforcement, fire protection activities, out-of-hospital emergency medical care, longshore work, construction, mining, agriculture – not including food processing, forestry, and fish industries

The “Cadillac Tax”

- > Transition rule for plans in the 17 states with the highest cost coverage
 - > Excludes excepted benefits (dental-only, vision-only, etc.)
 - > Who pays
 - If coverage is insured, the health insurance issuer
 - If any other employer-sponsored coverage, the person that administers the plan benefits (e.g., plan sponsor)
- ♦ Applicable to taxable years beginning after December 31, 2017

Nondiscrimination Testing

- ★ Discrimination rules that are similar to Internal Revenue Code Section 105(h) will now apply to insured plans
 - > Such plans may not discriminate in favor of highly compensated individuals
 - > Does not apply to grandfathered plans
 - > Effective first plan year after September 23, 2010 (January 1, 2011 for calendar year plans)

Section 125 Plan Issues

- ✦ New simple cafeteria plan for small businesses (average of 100 or fewer employees)
 - > If meet certain minimum contribution, eligibility and participation criteria, plan automatically passes discrimination testing
 - > Applicable to plan years after December 31, 2010
- ✦ Amends Internal Revenue Code Section 125(f) to clarify that a qualified health plan offered through an Exchange may not be offered by a Section 125 plan unless it is a group market product offered by an employer through an Exchange
 - > This means that an individual policy offered through an Exchange is not a “qualified benefit” for Section 125 purposes
 - > Applies to taxable years beginning after December 31, 2013

Other Health Plan Implications

- ✦ Effective January 1, 2011, over-the-counter drugs and medicines (except for insulin) may not be reimbursed from a Health Reimbursement Arrangement, Health FSA or an HSA unless the participant has a prescription
- ✦ Effective January 1, 2011, the penalty tax on distributions from HSAs and Archer MSAs increases from 10% to 20% when the distribution is not used for qualified medical expenses
- ✦ Effective January 1, 2013, salary reduction contributions to a Health FSA will be limited to a maximum of \$2,500

Retiree Reinsurance Program

- ✦ Effective beginning in June 2010, there will be an early retiree reinsurance program applicable to employer and union sponsored health plans
 - > Self-insured and fully-insured plans
- ✦ Applies to early retirees age 55 and older who are not active employees or eligible for Medicare
 - > And their spouses, surviving spouses and dependents
- ✦ Provides reimbursement equal to 80% of the claim costs between \$15,000 and \$90,000
 - > To be adjusted in subsequent years based on CPI

Retiree Reinsurance Program

- ★ Proceeds must be used to lower health costs for enrollees
 - > Premiums, co-payments, deductibles, etc.
- ★ Application is being developed by HHS to be available in June 2010
- ★ Program ends January 1, 2014 or when the \$5 billion of funding runs out

Medicare Part D Subsidy

- ✦ Employers who provide prescription drug benefits to retirees who are eligible for Medicare Part D are currently entitled to receive a tax-free 28% federal subsidy (subject to certain conditions)
- ✦ Employers can also claim a tax deduction for the cost of providing the prescription drugs
- ✦ Effective beginning in 2013, the Act eliminates the deduction for prescription drug expenses for which the employer receives a subsidy
- ✦ Creating an immediate impact on company financial statements (hearings are to be held)

Medicare Part D Doughnut Hole Fix

- ✦ Effective in 2010, Medicare Part D beneficiaries will receive a rebate of \$250 when they reach the doughnut hole
- ✦ Beginning in 2011, Medicare Part D beneficiaries who reach the doughnut hole will be eligible for a 50% discount on brand name drugs
- ✦ The Medicare Part D doughnut hole will ultimately be eliminated by 2020

Outlook

- ◆ Agencies (HHS, DOL and IRS) are hard at work preparing guidance and regulations to help implement the Act
 - > Expect guidance as the various provisions become applicable
- ◆ Several Attorneys General have filed suit challenging the constitutionality of the individual mandate
 - > No other provision has been challenged

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