

# Health Reform Teleconference Part VI

April 1, 2010

# Agenda

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- New coverage options and individual mandate
  - Employer fees
  - Group health plan mandates
  - Other provisions impacting plan design
  - Revenue provisions
  - Administrative requirements
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- Questions: [EB@milchev.com](mailto:EB@milchev.com)

# New Coverage Options

- States must establish Exchanges to offer private insurance choices by Jan. 1, 2014
  - Individuals who are offered employer-sponsored coverage may opt out and enroll in an Exchange
  - States may allow large employers (100+ employees) to purchase coverage through the Exchanges beginning Jan. 1, 2017
- Loans and grants are available to establish non-profit, member-run health insurance co-ops
- A public option was not included

# Individual Mandate

- Must obtain acceptable coverage beginning Jan. 1, 2014, or pay annual excise tax
  - Penalty is greater of \$95 in 2014 (phased up to \$695 in 2016) or 2.5% of income, up to cap of the national average bronze plan premium
  - Penalties are 50% for children up to a cap of \$2,085 per family
  - Amount are indexed to CPI
- Any employer-sponsored group health plan coverage will satisfy the individual mandate – no minimum coverage requirements

# Employer Fees

- No strict mandate to provide coverage, but free rider penalties beginning in 2014
  - If no coverage offered, and at least one full-time employee (30+ hours per week) receives a tax credit to buy insurance through an Exchange, penalty is \$2,000 X total number of full-time employees (after subtracting first 30 employees)
  - If coverage offered, but either the actuarial value is less than 60% or any employee's required premium is greater than 9.5% of income (thus entitling the employee with family income of <400% FPL to a tax credit), penalty is *lesser of*:
    - ❖ \$2,000 X total number of full-time employees, or
    - ❖ \$3,000 X number of employees receiving the tax credit
  - No exclusion for seasonal workers

# Employer Fees (cont'd)

- Free choice vouchers

- An employer that provides and contributes to health coverage for employees must provide free choice vouchers to each employee who:
  - ❖ Is required to contribute between 8% and 9.8% (9.5%?) of employee's family income toward the cost of coverage (indexed to rate of premium growth),
  - ❖ Employee's family income is <400% FPL, and
  - ❖ Employee does not enroll in a health plan sponsored by the employer
- Employees may use vouchers to purchase coverage through an Exchange (and may keep any extra)

# Employer Fees (cont'd)

- Free choice vouchers (cont'd)
  - Amount of the voucher is equal to the amount the employer would have provided toward such employee's coverage (individual vs. family based on the coverage the employee elects through the Exchange) with respect to the plan to which the employer pays the largest portion of the cost
  - Amounts are excluded from the employee's income and the employer receives a tax deduction
  - No free rider penalties are imposed for employees who receive vouchers
  - Appears to apply to full and part-time employees
  - Employers have many open questions about vouchers

# Employer Fees (cont'd)

- Comparative effectiveness research fee - employer must pay:
  - \$1 per plan participant for the first plan year ending after Sept. 30, 2012
  - \$2 per participant for the following year
  - Indexed to the cost of “national health expenditures” through 2019
  - Fee sunsets after 2019



# Group Health Plan Mandates

- Prohibits waiting periods greater than 90 days
  - Effective plan years beginning on or after Jan. 1, 2014
  - No grandfather
- Must cover adult children (unmarried or married) to age 26 (benefit is excluded from employee's income)
  - All plans must comply beginning in 2014
  - Prior to 2014, grandfather applies but must cover adult children who are not eligible for other employer-sponsored coverage

# Group Health Plan Mandates (cont'd)

- Prohibits lifetime limits on benefits
  - Effective plan years beginning after Sept. 23, 2010
  - No grandfather
- Restricts annual limits on benefits
  - Prohibits annual limits for all plans for plan years beginning on or after Jan. 1, 2014
  - Restrictions on annual limits (to be established by regulations) effective for earlier plan years
  - No grandfather

# Group Health Plan Mandates (cont'd)

- Limits cost-sharing to the HSA-qualified high deductible health plan out-of-pocket maximums
  - Effective plan years beginning on or after Jan. 1, 2014
  - Grandfather applies
- Imposes deductible limits of \$2,000 for individual coverage and \$4,000 for family coverage
  - May be increased by maximum health FSA contributions
  - Effective plan years beginning on or after Jan. 1, 2014
  - Grandfather applies

# Group Health Plan Mandates (cont'd)

- Prohibits plans from limiting coverage for preexisting conditions
  - Effective for all plans beginning Jan. 1, 2014
  - For children under age 19, effective for plan years beginning after Sept. 23, 2010
  - No grandfather
- Requires plans to cover preventive care services recommended by U.S. Preventive Service Task Force without any cost sharing (e.g., copays, deductibles)
  - Effective for plan years beginning after Sept. 23, 2010
  - Grandfather applies

# Group Health Plan Mandates (cont'd)

- Must cover clinical trials for life-threatening diseases (subject to the plan's normal restrictions on benefits and out-of-network providers)
  - Effective for plan years beginning after Sept. 23, 2010
  - Grandfather applies
- Must comply with new internal and external appeals standards to be established by regulations
  - Effective for plan years beginning after Sept. 23, 2010
  - Grandfather applies

# Group Health Plan Mandates (cont'd)

- Prohibits rescission of group health plan coverage without prior notice
  - Effective for plan years beginning after Sept. 23, 2010
  - No grandfather
- Grandfather for coverage mandates available for individuals enrolled in the plan on March 23, 2010, subsequently enrolled family members, and new hires
  - Collectively bargained plans are grandfathered until the date on which the last agreement relating to the grandfathered coverage terminates
  - Unclear what causes grandfather for other plans to end

# Other Provisions Impacting Plan Design

- Health FSA contributions are capped at \$2,500, indexed to CPI
  - Effective taxable years beginning after Dec. 31, 2012
- Prohibits pre-tax reimbursement of non-prescribed over-the-counter drugs from FSAs, HRAs, HSAs
  - Effective Jan. 1, 2011
- Codifies HIPAA wellness rules and increases 20% incentive cap to 30% with Secretary discretion to increase to 50%
  - Effective plan years beginning on or after Jan. 1, 2014

# Other Provisions Impacting Plan Design (cont'd)

- Temporary reinsurance program for employers providing coverage to retirees over age 55 who are not eligible for Medicare
  - Reimburses employers for 80% of claims between \$15,000 and \$90,000 (indexed for inflation)
  - Effective within 90 days of date of enactment
  - Ends on Jan. 1, 2014
- Eliminates the employer's deduction for the amount of the Medicare Part D retiree drug subsidy
  - Effective Jan. 1, 2013
  - Immediate FAS 106 accounting impact



# Other Provisions Impacting Plan Design (cont'd)

- Code Section 105(h) nondiscrimination rules that apply to self-funded group health plans will apply to insured plans as well
  - Most likely to impact executive health plans
  - Effective plan years beginning after Sept. 23, 2010
  - Grandfather applies
    - ❖ However, while the grandfather provisions are expected to be clarified in regulations, the language of the statute would not allow a newly-promoted executive to receive grandfathered status in an existing plan

# Revenue Provisions

- Excise tax on high cost plans
  - Beginning Jan. 1, 2018, 40% non-deductible excise tax imposed on insurer or TPA if the aggregate value of employer-sponsored health coverage exceeds a threshold amount:
    - ❖ Generally: \$10,200 (individual coverage) / \$27,500 (family coverage)
    - ❖ Retirees over age 55 and individuals in high-risk professions: \$11,850 (individual coverage) / \$30,950 (family coverage)
    - ❖ Adjustments to thresholds are available for plans that have higher-than-average costs due to age or gender of their workers

# Revenue Provisions (cont'd)

- Excise tax on high cost plans (cont'd)
  - Adjustments to thresholds
    - ❖ If health costs increase more than expected between now and 2018, thresholds will be automatically increased
    - ❖ Thresholds are indexed to CPI-U + 1% in 2019 and to CPI-U thereafter
    - ❖ No transitional adjustment will be made for high-cost states

# Revenue Provisions (cont'd)

- Excise tax on high cost plans (cont'd)
  - Coverage subject to excise tax
    - ❖ Includes employee/employer, pre-tax/after-tax contributions
    - ❖ Includes contributions to medical, health FSAs, HRAs, HSAs, and on-site clinics/ wellness plans that are ERISA plans
    - ❖ Does not include dental, vision, accident, disability, long-term care, and after-tax indemnity or specified disease coverage

# Revenue Provisions (cont'd)

- Excise tax on high cost plans (cont'd)
  - Cost of coverage
    - ❖ The value of the coverage is the COBRA premium
    - ❖ The value of coverage for pre-65 and post-65 retirees may be combined at the employer's discretion
    - ❖ Expect new Treasury guidance on how to calculate COBRA premiums

## Revenue Provisions (cont'd)

- Code section 162(m) executive compensation deduction cap reduced to \$500,000 for health insurance industry
  - Applies to *current* compensation paid during taxable years beginning after Dec. 31, 2012
  - Applies to *deferred* compensation for services performed in taxable years beginning after Dec. 31, 2009
- Annual health industry fees based on market share
  - Applies to health insurance premiums (not TPA fees)
  - Fees are \$8 billion in 2014, phased up to \$14.3 in 2018
- Increases excise tax for non-qualified HSA withdrawals from 10% to 20% for distributions after Dec. 31, 2010

# Revenue Provisions (cont'd)

- Medicare taxes

- Additional 0.9% Medicare tax for employees (not employers) on wages over \$200,000 (\$250,000 for joint filers) – total of 2.35%
- New 3.8% tax on unearned income (e.g., from interest, dividends, annuities, royalties, and rents) with respect to those with income over \$200,000 (\$250,000 for joint filers)
- Effective Jan. 1, 2013

# Administrative Requirements

- Automatic enrollment
  - Employers must automatically enroll all eligible individuals in employer-sponsored medical coverage
    - ❖ Employer must provide adequate notice and opportunity to opt out
    - ❖ Effective date unclear
  - Employers are expected to automatically enroll employees in, and facilitate payroll deductions for, new government-run voluntary long-term care program
    - ❖ Employers may choose not to participate
    - ❖ Program takes effect Jan. 1, 2011



# Administrative Requirements (cont'd)

- Reporting requirements
  - Must report value of employer-provided health insurance coverage on Form W-2
    - ❖ Effective Jan. 1, 2011
  - Must provide Form 1099 for all corporate service providers receiving more than \$600 per year for services or property
    - ❖ Currently limited to corporate service providers
    - ❖ Effective Jan. 1, 2012

# Administrative Requirements (cont'd)

- Reporting requirements (cont'd)
  - Individual mandate requires self-insured employers to report coverage information to IRS and to covered individuals
    - ❖ Effective Jan. 1, 2014
  - Excise tax on high cost plans requires employers to calculate and report amount subject to excise tax allocable to insurers/plan administrators (subject to underreporting penalty equal to tax not paid, plus interest)
    - ❖ Effective Jan. 1, 2018

# Administrative Requirements (cont'd)

- Notice and disclosure requirements
  - Must make transparency disclosures to HHS and the public for plan years beginning after Sept. 23, 2010
  - Must use government-developed uniform explanation of coverage documents by Sept. 2012
  - Must inform employees of the following (by March 31, 2013 or upon subsequent new hire):
    - ❖ Information about state Exchanges
    - ❖ If a plan's share of total allowed costs of benefits is less than 60%
    - ❖ Availability of a premium assistance tax credit
    - ❖ Availability of free choice vouchers

# Next Steps – Congressional and Regulatory

- Likely to be a technical corrections bill
- Agencies are required to issue a significant amount of guidance over the next several years
  - Are expected to answer many open questions for employer plan sponsors
  - Recent agency guidance for GINA and mental health parity has not been favorable for employers
  - Employers should consider actively participating in regulatory process
- Note about proposed DOL guidance defining what constitutes an ERISA group health plan

# Next Steps – Initial Compliance and Planning

- Now:
  - Account for changes to Medicare retiree drug subsidy
  - Take advantage of reinsurance program for early retiree costs
- For plan year beginning after Sept. 23, 2010:
  - Determine which plans qualify for the grandfather
  - Revise plan design for coverage mandates that are not grandfathered and amend plan documents
  - Amend plan documents to prohibit reimbursement of non-prescribed over-the-counter drugs

# Next Steps – Initial Compliance and Planning (cont'd)

- For plan year beginning after Sept. 23, 2010 (cont'd):
  - Revise internal and external appeals processes in accordance with guidance to be issued
  - Watch for guidance to prepare for:
    - ❖ Transparency disclosures
    - ❖ Automatic enrollment requirements
    - ❖ 2011 W-2 reporting
- Begin considering long-term strategy for plan sponsorship

# Questions?

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