Health Care Reform in the United States

Richard L. Menson

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Quebec, Canada

www.mcguirewoods.com
I. INTRODUCTION
A Complex and Confusing New Law


• Health Care and Education Reconciliation Act, P.L.111-152 enacted March 30, 2010 (HCERA), amends PPACA.

• The laws amend ERISA, the Internal Revenue Code, Public Health Service Act, and Fair Labor Standards Act.

• Regulatory guidance will come from DOL, IRS, and HHS.
Market Reforms: PPACA Title I Subtitles A and C

- Amends PHSA's HIPAA provisions to impose market reforms on group health plans and on health insurance issuers.
- Adds ERISA 715 which applies market reform provisions to ERISA group health plans "as if" included in Part 7 of ERISA Title I.
- Is there an exception from market reforms for plans with fewer than two participants who are current employees under ERISA 732(a)?
What Happens Right Away?

- A temporary $5 billion early retiree reinsurance program for $15k-$90k claims, including employees of state and local governments (June 21, 2010 to January 1, 2014, or until $5 billion fund runs out).
- Small business tax credit (up to 35% of premiums paid in 2010 by eligible small business employers and 25% of premiums paid by eligible tax-exempt employers).
- Federal rate review process established.
- HHS establishes temporary national risk pool until exchanges in place in 2014.
- HHS annually reviews "unreasonable increases in health insurance coverage premiums."
- Health plans in effect on March 23, 2010 are "grandfathered."
- Collectively bargained plans are not covered until effective date bargaining agreement terminates and then appear to be grandfathered.
II. OVERVIEW OF PPACA PROVISIONS
Grandfathered and Non-Grandfathered Plans

- **Grandfathered plans are all plans** (including health plans in effect on March 23, 2010):
  - Lifetime benefit limitations forbidden.
  - For plans that provide dependent coverage, preexisting condition exclusions for dependents under 19 are prohibited.
  - Rescission of coverage prohibited except for fraud or intentional misrepresentation.
  - "Restricted" annual limits on essential benefits are allowed only as determined by HHS.
  - Plans offering dependent coverage must continue to offer such coverage for dependents up to age 26, unless the adult dependent has access to other employer coverage.

- **Non-Grandfathered plans are all plans that are not grandfathered:**
  - Plans offering dependent coverage must continue to offer such coverage for dependents up to age 26, regardless of whether the adult dependent has access to other employer coverage.
• Non-Grandfathered Plans (cont)
  – Cost-sharing obligations for preventive services are prohibited.
  – Internal and external appeal processes must be established pursuant to regulations.
  – Coverage for emergency services at in-network cost-sharing level with no prior-authorizations mandated.
  – New health plan disclosure and transparency rules.
  – IRC 105(h) non-discrimination rules applied to insured plans.
Is My Plan Grandfathered?

• Plans in effect on March 23, 2010 are "grandfathered."

• Unclear how grandfathered plan status may be lost:
  – May add new employees and their dependents without losing grandfathered status.
  – Routine document updates, mergers, changes to deductibles and cost-sharing?
Dependent Coverage Extension

- Coverage of adult children to age 26:
  - Includes students and married adult children.
  - Excludes stand-alone dental and vision plans.
- Effective for plan years beginning on or after September 23, 2010.
  - Prior to 2014 plan year, "grandfathered" plans may exclude adult children who qualify for another employer's GHP.
- Effective immediately, a corresponding amendment to the Internal Revenue Code makes this coverage tax-deductible.
Lifetime and Annual Limits

- Lifetime limits on "essential health benefits" prohibited for plan years beginning on or after September 23, 2010.
  - "Essential health benefits" to be defined by HHS, but will include coverage for services such as emergency, hospitalization, maternity and newborn, pediatric, mental health and substance use disorders, prescription drugs, rehabilitative, and labs.

- Annual limits on "essential health benefits" prohibited for plan years beginning on or after January 1, 2014.

- Until 2014, plans may impose "restricted annual limits" on "essential health benefits."
  - "Restricted annual limits" to be defined by HHS, but must ensure that access to necessary services is made available with only a minimal impact on premiums.
Preexisting Conditions and Waiting Periods

• Effective for plan years beginning on or after January 1, 2014, plans may no longer impose any preexisting condition exclusions.
  – For dependents under age 19, effective for plan years beginning on or after September 23, 2010.
• Effective for plan years beginning on or after January 1, 2014, plans may not have waiting periods longer than 90 days.
Automatic Enrollment

- Requires large employers (200+ employees) to auto-enroll new employees in employer's GHP.
- Must provide notice and opportunity to opt-out.
- Effective date unclear – appears to be once the DOL issues regulations.
- Raises many potential problems.
FSAs, HSAs, and HRAs

- **Effective 2011:**
  - Over-the-counter medications not obtained with a prescription will no longer be reimbursable under flexible spending arrangements (FSAs), health savings accounts (HSAs), or health reimbursement arrangements (HRAs).
    - Insulin is the only exception to this rule.
  - The excise tax for the use of HSA money for reasons other than the reimbursement of qualified medical expenses will increase from 10% to 20%.

- **Effective 2013:** The annual limit on pretax salary contributions to FSAs will be $2,500 (indexed for inflation in future years).
Wellness Programs

• **Current law:** Wellness incentives that are linked to a health factor are limited to 20% of the cost of coverage.

• **Effective 2014:** Wellness incentives that are linked to a health factor will be limited to 30%.
  – This limit may be increased to 50%, if determined appropriate after study by the DOL, HHS, and IRS.
The CLASS Act

- CLASS = "Community Living Assistance Services and Supports" Program:
  - Federally-administered long term care insurance.
  - Voluntary for employees.
  - Must participate in program for at least 60 months before receiving benefits.
New Nondiscrimination Rules

- **Current law:** Nondiscrimination rules under Internal Revenue Code §105(h) apply only to self-insured medical plans.

- **Effective for plan years starting 6 months after enactment:** §105(h) rules will apply to fully-insured plans, too.
  - Grandfathered plans are exempt from this change.
III. EMPLOYER TAX ISSUES
• **Health Insurance Exchanges:**
  – New market for individuals and small groups to be established by states.
  – In 2017 states may allow larger groups to participate.
  – Massachusetts and Utah are current examples.

• **Employer "pay or play" provisions.**
  – Employers may be penalized for failing to offer adequate coverage.
Free Choice Vouchers

- **Effective 1/1/14:** Employers must provide qualified employees with a voucher whose value can be applied to purchase of a health plan through the exchange.
  - "Qualified Employees" are employees:
    - Who do not participate in the employer's health plan;
    - Whose required contribution for employer plan (if they did participate in the plan) exceeds 8%, but does not exceed 9.8% of household income; and
    - Whose total household income does not exceed 400% of the poverty line for the family.
Free Choice Vouchers

• Voucher is equal to the employer contribution to the employer health plan.
• Not includable in income to the extent it is used for the purchase of health plan coverage.
• If the value of the voucher exceeds the premium of the health plan chosen by the employee, the employee is paid in cash the excess value of the voucher, and the excess value is includible in income.
• Voucher recipients are disqualified from receiving any tax credits and cost sharing credits, and the employer is not assessed a shared responsibility payment on behalf of that employee.
Beginning in 2014 - Penalty for Employer Noncompliance

• Large employers (50 employees or more):
  – Must offer "minimum essential coverage" to all full-time employees.
  – "Minimum essential coverage" means that the plan's share of cost of benefits must not be less than 60%.

• Large employers will be subject to penalty if:
  – a full-time employee buys insurance through the exchange, and
  – a tax credit or cost reduction is paid to that employee.
What is the Penalty for Employer Noncompliance?

- The penalty for a large employer who does not offer minimum essential coverage is equal to:
  - $2,000 / 12 multiplied by the total number of full-time employees (minus the first 30 full-time employees)

- The penalty for a large employer who offers minimum essential coverage, but nevertheless has a full-time employee receiving subsidized coverage through an exchange, is equal to the lesser of:
  - (i) $3,000 / 12 multiplied by the number of full-time employees who receive subsidized coverage in an exchange, or
  - (ii) $2,000 / 12 multiplied by the total number of full-time employees (minus the first 30 full-time employees).

  - This penalty is eliminated for employees for whom a free choice voucher is offered.
Tax credits for small employers offering health coverage

• **Effective 1/1/2010:** Employers with 25 or less FTEs with full-time equivalent wages of less than $50,000 are eligible for a tax credit on employer contributions to purchase health insurance for employees.

• **Effective 1/1/2014:** Small employers who purchase coverage through the Insurance Exchange will be eligible for a tax credit for two years.
Tax credits for small employers offering health coverage

- FTEs determined by number of hours, excludes certain owners and seasonal workers, includes leased employees.
- Annual wages determined by taking payroll and dividing by FTEs.
- Employer contribution has to be at least 50% of premium cost per average FTE.
- Amount of credit
  - 2010-2013: 35% of employer contribution (25% for tax-exempts).
  - 2014: 50% of lesser of employer contributions or benchmark contribution for small employers (35% for tax-exempts).
  - Phase out for those employers with more than 10 FTEs or average wages more than $25,000.
Individual Penalties for Noncompliance

• For any month an individual does not maintain coverage, the penalty is equal to the greater of:
  – (1) 1% for 2014, 2% for 2015 and 2.5% for 2016 of household income over the threshold amount of income required for income tax return filing, or
  – (2) $95 for 2014; $325 for 2015; and $695 in 2016.
• Individual and spouse will be jointly liable.
• Some individuals are exempt:
  – Individuals whose required contribution exceeds 8% of household income.
  – Those who opt out for religious reasons.
  – Those residing outside of the U.S.
Individual Penalties for Noncompliance

• The shared responsibility penalty will be assessed and collected in the same manner as other taxes.

• However, IRS will not be permitted to:
  – Criminally prosecute.
  – Impose further penalties for nonpayment.
  – File a notice of lien with respect to taxpayer's property.
  – Levy on any property of a taxpayer with respect to any failure to pay the penalty.
Beginning in 2018

Excise Tax on "Cadillac Plans"

- 40% excise tax on excess of the value of employer-sponsored health insurance coverage for an employee over threshold amount.
  - $10,200 for individual coverage.
  - $27,500 for family coverage.
- Threshold amounts are higher for certain professions.
- Tax is imposed on insurers or on employers with self-insured plans.
New Annual Reporting Obligations

- **Effective for 2011 Form W-2:** Employers must report the value of the employee's health coverage on the employee's W-2.
- **Within 2 years of enactment:** HHS is directed to develop annual reporting standards for wellness programs and case management programs.
- **Effective 2014:** Employers must report:
  - Whether the employer offers "minimum essential coverage" to full-time employees and their dependents.
  - The names, addresses, and TINs of full-time employees covered under the plan.
  - The least expensive option in each enrollment category under the plan.
  - The employer's share of the total allowed costs of benefits provided under the plan.
  - The length of any waiting period under the plan.
Retiree Drug Benefits

• Medicare Part D beneficiaries who reach the "doughnut hole" in 2010 will receive a $250 rebate.

• Pharmaceutical manufacturers' 50% discount on brand-name drugs beginning in 2011 will be used to gradually close the doughnut hole with 75% discounts on brand-name and generic drugs by 2020.

• Elimination of Medicare Part D Retiree Drug Deduction effective for taxable years beginning after Dec. 31, 2012. Employers cannot deduct prescription drug expenses to the extent that they receive the employer subsidy intended to encourage the employer to maintain prescription drug coverage for retirees.
IV. IMPLEMENTATION

TIMELINE
Immediately Effective Provisions

• Tan Tax (10%)
• Medicare Drug Rebates ($250.00)
• Small Business Tax Credits (2010 tax year)
  – Max. 25 employees & average annual wage of $50,000
  – Credit up to 35% of employer’s insurance premium contribution to employer-sponsored health plans
  – Credit increases to 50% of premium in 2014
Effective in 3 Months

- Temporary High-risk Insurance Fund Receives $5 Billion
  - Extend benefits to individuals with pre-existing conditions
  - Extend benefits to individuals uninsured +6 months

- Temporary Reinsurance Program Receives $5 Billion
  - Extend benefits to retirees over age 55 and ineligible for Medicare
  - Operates as employer credit
  - Covers claims over $15,000 up to $90,000
Effective in 6 Months

- Ban Against Pre-existing Condition Limitations for Children
- Coverage for Adult Dependent Children to Age 26
  - Through 2013, grandfathered plans only required to cover children that are not eligible for coverage under another plan
- Health Plans Must Provide Free Preventative Care
  - No Co-pays or Deductibles
  - Immunizations
  - Cancer screenings for women
- Ban on Lifetime Limits on Individual Policy Holders
- Ban on Insurance Contract Rescission (absent fraud)
Effective for 2011

- Ineligible HSA Expense Penalty Tax Doubles to 20%
- Overcoming the Medicare “Doughnut Hole”
  - Drug makers provide 50% discount in brand drugs for seniors with gap in overage
  - Additional subsidies phased in through close of the coverage gap
- “CLASS” Program to Fund Long-term Care Expenses (+5 yrs. / $50 a day)
- Drug Makers Pay $2.5 Billion Annual Fee to Support Health Reform
- Form W-2 Reporting Must Include Aggregate Cost of Employer-Sponsored Health Benefits (2010 tax year)
- Insurance Rebates to Enrollees if <85% of Premiums Utilized for Care
Effective for 2011

- Community Health & Wellness Phase Launches
  - $11 billion funding boost for community health centers that provide indigent care
  - Funding available to community-based HC’s to fight chronic disease
  - Establishes Collaborative Care Network Program to coordinate and integrate care services
  - Enhanced collection and reporting of treatment and demographic data for analysis
  - Establishes Teaching Health Centers (ambulatory patient care centers)
  - Graduate Medical Education (GME) training positions expanded and redistributed (priority given to primary care & surgery)
  - 10% Medicare bonus payments to doctors and surgeons practicing in under-served areas
  - Education support
    - New training programs (e.g., “Ladder to Nursing” program)
    - Loan repayment and retention grants
    - Medical schools receive grants to establish programs to recruit students from underserved rural areas who want to return to practice in their hometowns
Effective for 2012-2013

• Threshold for Individual Deduction of Medical Expenses Increased to 10% of AGI (currently 7.5%)
• Medicare Taxes Increased by 0.9% on Earnings over $200k (individual) / $250k (family)
• New Medicare Tax of 3.8% on Unearned Income
• Drug Maker Annual Fee Increased to $3 Billion
• FSA Annual Contribution Limit Reduced to $2,500
• Small Business Tax Credits for Wellness & Prevention Programs (first appropriation for 2011 tax year)
Effective for 2014

- Employer Sanctions for Employers Not Providing Coverage
  - +50 Employees
  - At least 1 full time employee must qualify for federal health subsidy
- Medicaid Eligibility Expanded to Increase Income Eligibility to 133% of Federal Poverty Level
- State Health Insurance Exchanges Offer Marketplace for Uninsured Individuals and Small Businesses to Comparison Shop for Insurance
- Federal Subsidies Available to Offset the Cost of Buying Insurance (qualifying Americans and legal residents)
- Individual Mandates First Effective (greater of $95 individual / $285 family of 4 / 1% of household income)
- Insurance Companies Pay $2.5 Billion Annual Fee to Support Health Reform
Effective for 2015-2016

• For 2015, Individual Mandate Penalties Increased to Greater of:
  – $325.00 / Individual
  – $975.00 / Family of Four
  – 2% of Annual Household Income

• For 2016, Individual Mandate Penalties Increased to Greater of:
  – $695.00 / Individual
  – $2,085.00 / Family of Four
  – 2.5% of Annual Household Income

• Insurance Company Annual Fee Increases to $11.3 Billion
Effective for 2017-2018

• Insurance Company Annual Fee Increases to $13.9 Billion for 2017 and $14.3 Billion for 2018

• Drug Maker Annual Fee Increases to $3.5 Billion for 2017 and $4.32 Billion for 2018

• 40% Excise Tax on Plans Costing +$10,200 for Individual Coverage or $27,000 for Family Coverage
V. ENFORCEMENT
Enforcement?

- Inclusion of market reforms in ERISA may give participants a private right of action.
- ERISA §731(a)(2) may limit preemption of state laws applying these provisions to self-insured health plans.
- Inclusion of market reforms in Chapter 100 of the Internal Revenue Code may mean an excise tax of $100 per day for each violation of market reform rules.
- No requirement that IRS, HHS, and DOL coordinate guidance on these provisions.
VI. PLANNING ISSUES
Short Range Planning

• Keep alert for guidance from HHS, IRS, and DOL.
• Identify grandfathered plans and be alert to events that might jeopardize grandfather status (mergers, acquisitions, etc.).
• Check with your FSA/HRA/HSA provider for compliance with contribution limits and OTC drug restrictions.
• Analyze insured plans for IRC 105(h) nondiscrimination testing issues (and 409A issues) for non-grandfathered plans.
• Start thinking about auto-enrollment issues (cafeteria plan issues, opt-out issues, etc.).
• Think through needed amendments to health plans, cafeteria plan, etc.
• Talk to payroll staff and service providers regarding the W-2 reporting requirements to be sure your system can handle reports for 2011 tax year.
Long Range Planning for Your Plan(s)

- Keep alert for guidance from HHS, IRS, and DOL.
- Be aware of additional HI tax for wages over $200,000 after 2012.
- Given likely health care inflation, plan now to avoid 40% excise tax on Cadillac plans in 2018 by keeping costs down.
- Review your TPA/insurance agreements regarding who is ultimately responsible for paying or reimbursing for this tax.
- Think about plan design issues, such as having stand-alone dental/vision.