Health Care Reform: Health Plans Overview

AHT INSURANCE

Agenda

- Which plans must comply?
- Reforms currently in place
- Ongoing administrative compliance
- Healthcare marketplaces
- Employer reporting
- Fees and taxes
- Questions

Which Plans Must Comply?

Employer Responsibility

- Applicable large employers subject to "Pay or Play" rules
  - **Delayed for one year, until 2015 – these payments will not apply in 2014**
  - **Delayed for an additional year, until 2016, for applicable large employers with 50-99 full-time employees (including full-time equivalents)**
- Applies to employers with 50 or more full-time equivalent employees in prior calendar year
  - FT employee: employed an average of at least 30 hours of service per week
- Penalties may apply if the employer:
  - Fails to offer minimum essential coverage to all FT employees (and dependents) OR
  - Offers coverage that is not affordable or does not provide minimum value
- Penalties triggered if any FT employee gets subsidized coverage through Exchange

Plans Subject to Health Care Reform

- Health care reform's health plan rules generally apply to **group health plan** coverage
- Exceptions
  - Excepted benefits
  - Retiree-only plans
  - Group health plans covering fewer than 2 employees
- Excepted Benefits
  - Accident or disability income coverage
  - Separate dental and vision plans
  - Liability insurance
  - Some FSAs

Grandfathered Plans

- **Grandfathered plan:** group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010
- Certain health care reform provisions don't apply to grandfathered plans, even if coverage is later renewed
- A plan can lose grandfathered status by making too many changes to benefits or costs
  - Plans will have to analyze status and changes at each renewal

Which Rules Don't Apply to Grandfathered Plans?

- Patient protections
- Nondiscrimination rules for fully-insured plans
- Preventive care coverage
- New appeals process
- Quality of care reporting
- Insurance premium restrictions
- Guaranteed issue and renewal of coverage
- Nondiscrimination based on health status/in health care
- Comprehensive health insurance coverage
- Limits on cost-sharing
- Coverage for clinical trials

Employer Penalty Amounts

- Employers that fail to offer coverage to all FT employees:
  - $2,000 per full-time employee (excludes first 30 employees)
  - Transition relief for 2015: employers with 100 or more FT employees (including FTEs) can reduce their FT employee count by 80 when calculating the penalty
- Employers that offer coverage to substantially all FT employees (and dependents) **but not all FT employees** OR coverage is **unaffordable** or **not minimum value**:
  - $3,000 for each employee who receives subsidized coverage through an Exchange
  - Capped at $2,000 per FT employee (excluding first 30 FT employees, or 80 for 2015)

Safe Harbors

- Employer penalties: who is a full-time employee?
  - Ongoing employees
  - New full-time employees
  - New seasonal and variable hour employees
- Affordability safe harbors
  - Three optional safe harbors for determining affordability – W-2 wages, rate of pay and federal poverty line
- Waiting periods
  - Cannot exceed 90 days
  - No penalty for employees in waiting period
- Options for determining minimum value (MV)
  - MV calculator, design-based safe harbor checklist, actuary certification or metal level (small group plans)

Reforms Currently in Place

Provisions Effective before 2013

- Small employer tax credit
- Dependent coverage up to age 26
- No lifetime limits/restrictions on annual limits
- No rescissions
- No pre-existing condition exclusions for children
- No cost-sharing for preventive care services (non-GF plans)
- Appeals process changes (non-GF plans)
- No reimbursement for OTC medicine or drugs (without a prescription)
- Medical loss ratio rules
- Form W-2 reporting

Provisions Effective in 2013

- Uniform Summary of Benefits and Coverage (SBC) requirement
- No cost-sharing for preventive care services for women
- Increased Medicare tax
- Health FSA contribution limits
- Whistleblower protections
- Patient-Centered Outcomes Research Institute Fees (PCORI) Fees
- Notice of Exchange

Covered Health Services

- Well-women visits
- Gestational diabetes screening
- HPV DNA testing
- Sexually transmitted infection counseling
- HIV screening and counseling
- Breastfeeding support, supplies and counseling
- Domestic violence screening and counseling
- Contraceptives and contraceptive counseling (certain exceptions apply to religious employers)

Ongoing Administrative Compliance

Summary of Benefits and Coverage

- Simple & concise explanation of benefits and costs
  - Template provided
  - Can provide in paper or electronic form
- Applies to:
  - Issuers and health plans (plan sponsors)
  - GF and non-GF plans
  - No duplication required: if issuer provides to enrollees, plan doesn't have to
- Providing to participants and beneficiaries
  - 1st day of **1st open enrollment period** on/after Sept. 23, 2012
  - 1st day of **1st plan year** on/after Sept. 23, 2012 (for other enrollment)
  - Must provide at various points thereafter

SBC Content

- Uniform definitions of standard terms
- Description of plan's coverage
- Exceptions and limitations
- Cost-sharing provisions
- Renewability and continuation
- Coverage examples
- Required statements and contact information
- Internet address for obtaining the uniform glossary of terms

60-Day Notice Rule

- Effective once SBC rule is effective for a plan
- Material modifications **not in connection with renewal** must be described in a summary of material modifications (SMM) or an updated SBC
  - Must be provided at least **60 days BEFORE** modification becomes effective
- Material modification:
  - Enhancement of covered benefits or services
  - Material reduction in covered benefits or services
  - More stringent requirements for receipt of benefits

Waiting Period Limitations

- Waiting periods limited to 90 days beginning with 2014 plan year
  - First of the month following 90 days **not** permissible
  - Final rule issued Feb. 20, 2014 (may rely on proposed rule for 2014)
- Other eligibility conditions are permissible (unless designed to avoid compliance with 90-day limit)
  - Cumulative hours of service requirement cannot exceed 1200 hours and must be one-time only (not each year)
  - **Additional proposed rule issued Feb. 20, 2014: reasonable and bona fide employment-based orientation period permitted (proposed maximum length of one month)**
- Employers can use up to a 12-month measurement period to determine FT status for variable hour employees
  - Coverage must be effective by 13 months from start date (plus remaining days in the month)

Health FSA Limits

- Before health care reform
  - No limit on salary reductions
  - Many employers imposed limit
- Beginning with 2013 plan year, limit is **$2500/year**
  - Limit is indexed for inflation for later years
  - Per FSA limit
- Does not apply to dependent care FSAs

Wellness Program Changes

- Rules for wellness program rewards prior to 2014:
  - Reward must be no more than 20% of the cost of coverage
  - Program must be designed to promote health/prevent disease
  - Opportunity to qualify for those with health issues (and notice)
- **2014** health care reform changes:
  - Reward increased to 30% (up to 50% for programs to reduce/prevent tobacco use)
  - Small business grants to establish new wellness programs (on hold)
- Final wellness program rules issued in May 2013

Whistleblower Protections

- OSHA final rule clarifies protections for employees under ACA
- Employers may not retaliate against employees for:
  - Providing information or filing a complaint regarding ACA violations
  - Objecting to or refusing to participate in violations of the ACA
  - Receiving a premium credit or subsidy for coverage though an Exchange
- Employees can file complaints with OSHA if they experience retaliation
  - Discharge, demotion, discipline, etc.

Increased Medicare Tax

- Medicare tax rate increased for high-earners for **2013 tax year**
  - 0.9 percent increase (from 1.45 percent to 2.35 percent)
- High-earner threshold
  - Single: $200,000
  - Married : $250,000
- Individual liability for tax depends on filing status and household income
- Employer responsibilities
  - Withhold additional amounts from wages in excess of $200,000
  - No requirement to match additional tax
  - No requirement to notify employees

Notice of Exchange

- Employers subject to the FLSA must notify new and current employees of Exchange information
  - New employees **beginning Oct. 1, 2013** (within 2 weeks)
  - Current employees **no later than Oct. 1, 2013**
- Notice must include information about:
  - Existence of health benefit Exchange and services provided
  - Potential eligibility for subsidy under Exchange
  - Risk of losing employer contribution if employee buys coverage through an Exchange
- Model notice available (will need some customization)
- Notice can be provided by mail or electronically (if DOL requirements met)

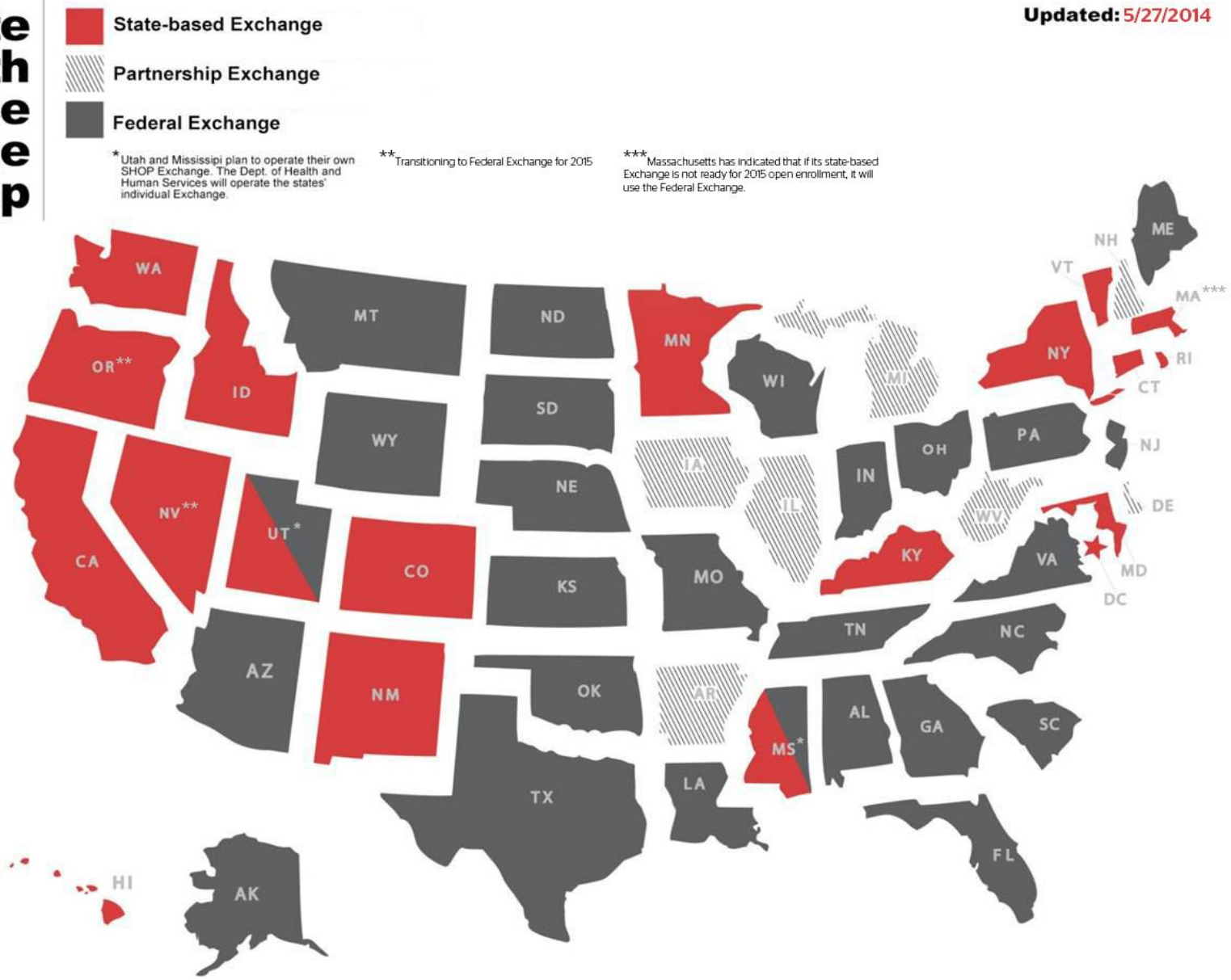
Healthcare Marketplaces (Exchanges)

Health Insurance Exchanges

- Health insurance Exchanges must be established in each state (by the state or the federal government)
- State action:
  - 17 (and D.C.) declared state-based Exchange
  - 7 planning Partnership Exchange
  - 26 default to federal Exchange
- Deadlines
  - Initial open enrollment: 10/1/13 – 3/31/14
  - Fully operational: 1/1/14
  - 2015 open enrollment: 11/15/14 – 2/15/15

State Health Insurance Exchange Map

Updated: 5/27/2014



Health Insurance Exchanges

- Individuals and small employers can purchase coverage through an Exchange
- Small Business Health Option Program (SHOP)
  - Small employers = up to 100 employees
  - Before 2016, states can define small employers as having up to 50 employees
- In 2017, states can allow employers of any size to purchase coverage through Exchange
- Individuals can be eligible for tax credits
  - Limits on income and government program eligibility
  - Employer plan is unaffordable or not of minimum value

Exchange Premium Assistance

- Employee eligibility will trigger employer penalties
- Employees who are **not offered employer coverage**
  - Not eligible for government programs (like Medicaid)
  - Meet income requirements (less than 400% of FPL)
- Employees who are **offered employer coverage**
  - Not enrolled in employer's plan
  - Not eligible for government programs (like Medicaid)
  - Meet income requirements (less than 400% of FPL)
  - **Employer's coverage is unaffordable (greater than 9.5% of income for single coverage, adjusted to 9.56% for 2015) or not of minimum value (covers less than 60% of cost of benefits)**

Employer Reporting

Employer Reporting

- Employers will have to report certain information about health coverage to the government and individuals
- Applies to:
  - "Applicable large employers" – generally, employers with at least 50 full-time equivalent employees
- Delayed for one year, until 2015
  - Treasury issued final regulations on March 5, 2014
  - No additional delay for applicable large employers with fewer than 100 FT employees

Information Required

- Employer identifying information
- Whether employer offers health coverage to FT employees and dependents
- Number of FT employees for each month
- Length of any waiting period
- Monthly premium for lowest-cost option in each enrollment category
- Employer's share of cost of benefits
- Names and contact info of employees and months covered by employer's health plan

How to Report

General Reporting Method

- File Form 1094-C (transmittal) and Form 1095-C (employee statement) or substitute form with same information
- Provide copy of Form 1095-C or substitute form with same information
- Will use indicator codes for reporting some information

Alternative Methods (optional)

- Details to be provided in forms and instructions
- Available for specific groups of employees

Medium-sized Employers

- Must still report for 2015
- Must certify that they meet requirements for delay

Electronic filing required for employers filing 250+ returns

Health Plan Identifier (HPID)

The HPID is a standard, unique health plan identifier that is primarily intended for use in standard transactions.

- Large group health plans ($5 million or more in receipts)must obtain number by November 5, 2014
- **Self-insured plans** generally qualify as Controlling Health Plans (CHP), and are required to obtain their own HPIDs.
- For insured health plans, the **health insurance issuer**, not the employer sponsoring the plan, is generally required to obtain the HPID.

Fees and Taxes

PCORI Fees

- Apply to plan years ending on or after **Oct. 1, 2012**
  - End with the 2018 plan year – do not apply for plan years ending on or after Oct. 1, 2019
  - Paid annually on Form 720 by July 31 each year
- Amount of fees
  - 2012 plan year: $1 x average number of covered lives
  - 2013 plan year: $2 x average number of covered lives
  - 2014 and beyond: increase based on National Health Expenditures
- Who pays?
  - Insurance carriers and self-funded plan sponsors
  - Special rule for HRAs

Reinsurance Fees

- Transitional reinsurance program to operate **2014-2016**
  - Fees imposed on health insurance issuers and self-funded plan sponsors of major medical plans (with some exceptions)
  - **March 11, 2014: Final rule includes exemption for self-funded, self-administered plans for 2015-2016 and fee changes**
- Fees based on annual national contribution rate
  - 2014: $5.25/month ($63/year) x average number of covered lives
  - 2015: **$3.67/month ($44/year)** x average number of covered lives
- Payment of fees
  - Nov. 15: issuers/sponsors submit annual enrollment count to HHS
  - Dec. 15 (or within 30 days): HHS to notify issuer/sponsor of amount due
  - **Payment due in two installments**: 1st payment due in January, 2nd payment due late in Q4
- **May 22, 2014: FAQ on collection process – will take place on www.pay.gov**

Future Compliance Deadlines

2018 – Cadillac Plan Tax

- 40 percent excise tax on high-cost health plans
- Based on value of employer-provided health coverage over certain limits
  - $10,200 for single coverage
  - $27,500 for family coverage
- To be paid by coverage providers
  - Fully insured plans = health insurer
  - HSA/Archer MSA = employer
  - Self-insured plans/FSAs = plan administrator
- More guidance expected

Nondiscrimination Rules Coming for Fully-Insured Plans

- Will apply to non-grandfathered plans
- Discriminating in favor of highly-compensated employees (HCEs) will be prohibited
  - Eligibility test
  - Benefits test
- HCEs
  - 5 highest paid officers
  - More than 10% shareholder
  - Highest paid 25% of all employees
- Effective date delayed for regulations

Automatic Enrollment Rules

- Will apply to large employers that offer health benefits
  - Applies to GF and non-GF plans
  - Large employer = more than 200 employees
- Must automatically enroll new employees and re-enroll current participants
- Adequate notice and opt-out option required
- DOL:
  - Regulations will not be ready to take effect by 2014
  - Employers not required to comply until regulations issued **and** applicable

Questions?