ATLANTA AUSTIN CHICAGO DALLAS HOUSTON LONDON

LLB&L

Locke Lord Bissell & Liddell LLP

A First Look at Health Care Reform

What Employers Need to Know

LOS ANGELES NEW ORLEANS NEW YORK SACRAMENTO SAN FRANCISCO WASHINGTON DC

ATLANTA AUSTIN CHICAGO DALLAS HOUSTON LONDON

LLB&L
Locke Lord Bissell & Liddell LLP

Health Care Reform
A First Look

Presented by:

Denise E. Hanna
Partner - Washington, DC

April 28, 2010

LOS ANGELES NEW ORLEANS NEW YORK SACRAMENTO SAN FRANCISCO WASHINGTON DC

Overview of Health Care Reform Law

- Health Care Reform Law
  - The Patient Protection and Affordable Care Act (Pub. L. No. 111-148) (the "Affordable Care Act") found at: http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf
  - The Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) (the "Reconciliation Act") found at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872enr.txt.pdf

Overview of Health Care Reform Law

- Presentation Summary
  - Increasing Access to Health Insurance
  - Health Insurance Market Reforms
  - Individual and Employer Requirements
  - Provider Reforms in Medicare and Medicaid
  - Wellness, Prevention and Health Improvement
  - Paying for Health Care Reform
  - What the Reform Acts Accomplish – According to CBO Estimates
  - The End of the Beginning; the Beginning of Forever

Overview of Health Care Reform Law

- Increasing Access to Health Insurance
  - Expand eligibility under public programs
    - Medicaid: cover all individuals with incomes up to $133% of FPL
    - CHIP: extend current eligibility until 2019 and funding until 2015
  - Provide federal subsidies to make it easier for the middle class to purchase health insurance
  - Make tax credits available to small businesses to ease the burden of offering private health insurance to their employees
  - Establish insurance pools for hard to insure individuals with pre-existing conditions
  - Cover children up to age 26

Overview of Health Care Reform Law

- Increasing Access to Health Insurance
  - Close Medicare Part D donut hole
    - For 2010, provide $250 rebate to Medicare beneficiaries who reach the donut hole during the year
    - From 2011 – 2020, phase down donut hole
      - For *brand drugs*, drug companies will provide 50% discount on drug cost and federal government will provide, over time, subsidy of 25% of drug cost
      - For *generic drugs*, federal government will provide, over time, subsidy of 75% of drug cost
  - Create temporary reinsurance for employers providing health insurance coverage to their retirees aged 55-64
  - Establish OPM-administered health insurance options and non-profit co-ops to compete with private health insurance

Overview of Health Care Reform Law

- Key Health Insurance Market Reform
  - Establish state-run exchanges through which health insurance policies may be offered to individuals and small employers in standard formats and in a more transparent manner
  - Eliminate pre-existing condition exclusions
  - Guarantee the issuance and renewal of insurance policies
  - Establish standard benefit plans, with minimum coverage requirements and maximum out-of-pocket spending by insureds
  - Prohibit health insurers from establishing lifetime coverage limits or annual coverage limits
  - Eliminate co-pays and deductibles for preventative health care services

Overview of Health Care Reform Law

- Key Health Insurance Market Reforms
  - Prohibit insurers from rescinding health care coverage, except for fraud or misrepresentation by the insured
  - Mandate federal disclosure and transparency requirements
  - Mandate independent appeals process with minimum federal standards
  - Require health insurers to meet minimum medical loss ratio (MLR) or rebate excess premium to insureds
    - Individual and small group products – 80% MLR
    - Large group products – 85% MLR
    - Report annually to HHS on percentage of spending on clinical services and quality improvement activities

Overview of Health Care Reform Law

- Individual and Employer Requirements
  - Individual mandate
    - Individuals must obtain minimum qualifying health coverage for themselves and their dependents
    - Failure results in an escalating tax penalty of up to $695 per individual, with a maximum of $2085 per family, by 2016
      - After 2016, the tax penalty will be adjusted according to COLA
    - Exemptions for financial hardship and religious objections
  - Responsibilities of employers with 50+ employees
    - Employers which offer health insurance coverage, but have at least one employee receiving federal premium subsidies, still are assessed a fee
    - Employers which do not offer health insurance coverage and have at least one employee receiving federal premium tax subsidies, pay a fee, likely to be much larger

Overview of Health Care Reform Law

- Individual and Employer Requirements
  - Employers with 200+ employees must automatically enroll all new employees into health insurance

Overview of Health Care Reform Law

- Provider Reforms in Medicare and Medicaid
  - Payment reforms
    - Bundle payments for hospital and physician services tied to a patient's episode of care to incent better care coordination
    - Pay for performance (P4P) models that pay hospitals and other health providers based on how they score on quality measures
    - Payment reductions for medical errors, hospital readmissions or conditions acquired in the hospital
    - Health care provider bonus payments tied to quality outcomes
  - Delivery system reforms
    - Accountable Care Organizations (ACOs): groups of health care providers and suppliers form virtual network to share joint decision-making about patient care and to share in the cost-savings

Overview of Health Care Reform Law

- Provider Reforms in Medicare and Medicaid
  - Delivery system reforms
    - Medical Homes: A primary care setting responsible for coordinating care for its patient population, with a focus on prevention and chronic care management
      - HHS may award grants to establish medical home models for Medicare beneficiaries
      - Under Medicaid, a state may establish a health home model to deliver integrated care to patients with two or more chronic conditions
  - Increasing reimbursement to Medicaid primary care providers to 100% of Medicare fee-for-service (FFS) payments
  - "Sunshine" provisions requiring physicians to annually disclose payments they receive from drug companies and medical device manufacturers

Overview of Health Care Reform Law

- Wellness, Prevention and Health Improvement
  - The Federal government has adopted a national strategy to foster disease prevention and health improvement and will use task forces, advisory councils and collaboratives to oversee health and health improvement initiatives
  - Standardized benefits must include preventative services, screenings at no out-of-pocket cost to the insured
  - Hundreds of millions of dollars of grant funds are available for community, government and private employer wellness and prevention programs
  - Employers will be permitted to increase financial incentives to their employees who participate in workplace wellness or prevention programs
    - Other than increasing financial rewards, GINA regulations are codified

Overview of Health Care Reform Law

- Wellness, Prevention and Health Improvement
  - Financial rewards are available for Medicare providers and Medicare Advantage plans that achieve quality goals
    - Restructuring of Medicare Advantage plan payments rewards plans that achieve both high quality ratings and low cost
      - Higher payment benchmarks, higher quality bonuses and greater rebates available to Medicare Advantage plans
    - Health care providers who achieve better patient outcomes will be paid more from Medicare

Overview of Health Care Reform Law

- Paying For Health Care Reform
  - Medicare savings
    - Cuts to Medicare FFS providers, including reductions to DSH
    - Restructuring payments to Medicare Advantage health plans
  - Fees paid by health industry participants based on their market share
    - Health insurers
    - Pharmaceutical companies
    - Medical device manufacturers
  - Savings from increased fraud and abuse enforcement against health care providers and suppliers
  - New taxes and reductions in current tax benefits
    - 40% excise tax paid by health insurers on health coverage that exceeds $10,200 for individuals and $27,500 for family of four

Overview of Health Care Reform Law

- Paying For Health Care Reform
  - New taxes and reductions in current tax benefits
    - Increase the Medicare payroll tax by 0.9% for high wage earners and impose new 3.8% tax on their unearned income
    - Increase threshold for itemized deduction for medical expense from 7.5% of AGI to 10%
    - Cap annual contributions to a flexible spending account (FSA) at $2500
    - Eliminate deductibility of federal subsidy paid to employers providing Medicare Part D prescription drug benefits to retirees
    - Impose 10% excise tax on amounts paid to tanning salons
    - Limit deductibility of health insurer's executive compensation to $500,000
    - Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying biofuel producer credit

Overview of Health Care Reform Law

- What the Reform Acts Accomplish – According to CBO Estimates:
  - By 2019, coverage of 32 million Americans by private health insurance or public health insurance programs
  - This federal expansion of health coverage would cost $938 billion over 10 years
  - Cost of coverage would be paid for by new taxes, additional tax revenues from reducing current tax benefits, health industry fees and Medicare and Medicaid savings
  - Revenue raised to pay for the expansion of health coverage should exceed its costs by $124 billion
  - The $124 billion excess would be used to reduce the federal deficit

Contact Information

Denise E. Hanna

Partner

Locke Lord Bissell & Liddell

701 8th Street, NW

Suite 700

Washington, DC 20001

(202) 220-6992

Dhanna@lockelord.com

ATLANTA AUSTIN CHICAGO DALLAS HOUSTON LONDON

LLB&L
Locke Lord Bissell & Liddell LLP

Health Care Reform
Impact On Employer-sponsored Health Plans

Presented by:

E. Philip Bush
Partner - Dallas

Jan R. Newsom
Senior Counsel - Dallas

April 28, 2010

LOS ANGELES NEW ORLEANS NEW YORK SACRAMENTO SAN FRANCISCO WASHINGTON DC

Health Care Reform
Impact On Employer-sponsored Health Plans

- Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act of 2010
- Benefit mandates, new recordkeeping and reporting obligations, complexity
- Likely will not be beneficial to the Employer community unless:
  - The health care system as influenced by the legislation reduces the rate of health costs increases, or
  - Health Care Reform leads to employers being out of the business of providing health care for their employees

Health Care Reform

Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Restrictions on Lifetime Limits
    - A plan may not apply lifetime dollar limits on "essential health benefits"
    - Essential health benefits: Required to be included in health plans state insurance "exchanges"
    - Secretary of Health and Human Services ("HHS") will define essential health benefit, but must include:
      - Ambulatory patient services
      - Emergency services
      - Hospitalization
      - Maternity and newborn care
      - Mental health and substance use disorder services
      - Prescription drugs
      - Rehabilitative services and devices
      - Laboratory services
      - Preventative and wellness services and chronic disease management
      - Pediatric services, including oral and vision care

Health Care Reform

Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Restrictions on Annual Limits
    - A plan may not apply any annual dollar limits on essential health benefits for plan years beginning on or after January 1, 2014
    - For plan years beginning prior to January 2014, some restricted annual limits may apply to essential health benefits, if not in violation of other federal or state laws
    - The Secretary of HHS is to issue regulatory guidance regarding restrictions on pre-2014 annual limits

Health Care Reform
Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Prohibition on Rescission of Coverage
    - A plan must not rescind coverage once a participant has become covered
    - Exceptions for fraud, intentional misrepresentation of material fact, “as prohibited by the terms of the plan”
    - Participant’s coverage under a plan may not be cancelled without prior notice

Health Care Reform

Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Preventative Services
    - A plan must provide coverage for certain preventative care
    - May not impose any cost-sharing requirements
    - Includes recommended immunizations
    - Statute refers to recommendations and guidelines for determining which preventative services are subject to prohibition on cost-sharing

Health Care Reform

Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Dependent Coverage for Older Children
    - Plans providing dependent coverage of children must continue coverage available for an adult child until age 26
    - Applies to married children
    - Not required to provide to a child of a covered child (a grandchild)

Health Care Reform

Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Uniform Explanation of Coverage
    - Secretary of HHS is required to develop standards for plans to summarize plan benefits and coverage
    - To be issued by March 23, 2011
    - Summary will be a short “highlights” description of the plan
    - Summary must not exceed four pages in length
    - Does not replace ERISA requirement for a summary plan description
    - Terminology must be understandable by the average plan participant

Health Care Reform
Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Uniform Explanation of Coverage (cont'd.)
    - The statute describes information that must be covered by summary:
      - A description of the coverage, including cost-sharing for "essential health benefits"
      - A description of any exceptions, reductions, or limitations on coverage
      - A description of any cost-sharing provisions, including deductible, coinsurance, and co-payment obligations
      - A description of any renewability and continuation of coverage provisions
      - A "coverage facts label" that includes examples to illustrate common benefit scenarios (e.g., pregnancy and serious or chronic medical conditions) and related cost-sharing

Health Care Reform

Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Uniform Explanation of Coverage (cont'd.)
    - The statute describes information that must be covered by summary (cont'd.):
      - A statement of whether the plan provides "minimum essential coverage" (standards which an employer plan must meet to avoid penalties under the employer mandate provisions)
      - A statement that the outline is a summary of the insurance policy or plan and that the policy or plan document itself should be consulted to determine the governing provisions
      - A contact number to call with additional questions, and a website address where a copy of the "group certificate of coverage" can be reviewed and obtained
    - Deadline to comply: March 23, 2012

Health Care Reform
Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Deadline for Summaries of Material Modification
    - Notice of any material modification be given to participants at least 60 days prior to the date the plan modification is to become effective
    - Provision is generally effective for plan years beginning on or after September 23, 2010
    - For plans in effect on March 23, 2010, SMM requirement is effective for plan years beginning on or after March 23, 2010

Health Care Reform

Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Standardized Definitions
    - Secretary of HHS is to issue regulations providing for standardized definitions of terms used in <u>insured</u> plans. The required four-page plan summary described above must include these definitions.
    - Standardized definitions to include:
      - Premium, deductible, co-insurance, co-payment, out-of-pocket limit
      - Preferred provider, non-preferred provider, out-of-network co-payments
      - UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, hospitalization, hospital outpatient care, emergency care, physician services, prescription drug coverage, durable medical equipment
      - Home health care, skilled nursing care, rehabilitation services, hospice services
      - Emergency medical transportation

Health Care Reform

Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Prohibition on Insured Plans Discriminating in Favor of Highly Compensated Individuals
    - Rules Currently Apply to Self-Insured plans
    - Plan (whether insured or self-insured) must not discriminate in favor of highly compensated individuals:
      - eligibility to participate
      - or benefits
    - $100 per day per participant penalty for violation
    - Highly Compensated Individual: (a) among the five highest paid officers, (b) shareholders owning more than 10 percent of the employer, and (c) the highest paid 25 percent of employees

Health Care Reform

Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - New Appeals Process Requirements
    - Do not displace the claims and appeals requirements of ERISA and related Department of Labor regulations
    - The new provisions require plans, including self-insured plans, to have an external review process
    - Guidance is to be issued by the Secretary of HHS
    - For insured plans the new rules largely defer to state external review requirements
    - Must allow a participant to review his or her file, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeals process

Health Care Reform

Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Choice of Health Care Professional
    - If a plan permits participant or beneficiary to designate a participating primary care provider, the plan must permit designation of any participating primary care provider available to accept that individual
  - Emergency Services
    - Plan must cover emergency services without requiring prior authorization and must provide coverage whether or not the health care provider is a participating provider
    - Plan must not impose limitations on coverage more restrictive than those applicable to participating providers
    - Applicable only to “emergency medical condition”

Health Care Reform
Impact On Employer-sponsored Health Plans

- Group Market Reforms
  - Pediatric Care
    - If a plan provides for the designation of a participating primary care provider for a dependent child the plan must permit the designation of a participating physician who specializes in pediatrics as the child's primary care provider
    - Does not require a plan to waive any coverage exclusions under the terms of the plan relating to coverage of pediatric care
  - Obstetrical and Gynecological Care
    - A plan that provides coverage for obstetric or gynecology care and requires the designation of a participating primary care provider may not require authorization or referral in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating provider specializing in obstetrics or gynecology

Health Care Reform

Impact On Employer-sponsored Health Plans

- Preserving and Expanding Coverage
  - No “Dumping” of Participants
    - Secretary of HHS to establish temporary high risk health insurance pool for persons with pre-existing conditions who have not had creditable coverage for at least six months
    - Pool to be established by June 21, 2010
    - Will cease operation on January 1, 2014
    - Secretary of HHS to establish criteria for determining whether an insurer or an employment-based health plan has discouraged an individual from remaining covered based on health status (e.g., financial incentives to disenroll)
    - Effective March 23, 2010

Health Care Reform
Impact On Employer-sponsored Health Plans

- Preserving and Expanding Coverage
  - Reinsurance for Early Retirees
    - Temporary reinsurance program to reimburse employment-based plans for portion of cost of providing health coverage to early retirees and their dependents
    - To be implemented by June 21, 2010
    - Early Retiree: age 55 or older, not eligible for Medicare, and not actively employed by an employer maintaining a health plan
    - Reimbursement is equal to 80 percent of costs per year for an early retiree or dependent exceeding $15,000
    - Expenses exceeding $90,000 will not be eligible for reimbursement
    - Reimbursement must be used to lower costs for the plan, such as reducing contributions, co-payments, deductibles, co-insurance, or other out-of-pocket cost for participants

Health Care Reform

Impact On Employer-sponsored Health Plans

- Health Insurance Market Reforms
  - Restrictions on Pre-existing Condition Limitations
    - Effective for plan years beginning on or after January 1, 2014, a plan may not impose any pre-existing condition exclusion
  - Fair Health Insurance Premiums (Small Group Market)
    - Premiums charged by insurers in the small group market may vary with respect to a particular plan or coverage only by (1) whether it is individual or family coverage, (2) the rating area, under state standards, (3) age, except that the rate may not vary by more than a factor of 3 to 1 for adults, and (4) tobacco use, except the rate may not vary by a factor of more than 1.5 to 1

Health Care Reform
Impact On Employer-sponsored Health Plans

- Health Insurance Market Reforms
  - Guaranteed Availability of Coverage
    - Insurers offering coverage in a group market in a state must accept every employer in that state that applies for coverage. The insurer may restrict enrollment to open or special enrollment periods. Must have special enrollment periods for COBRA qualifying events.
  - Guaranteed Renewability of Coverage
    - Insurers offering coverage in the group market must renew or continue in force coverage at the option of the plan sponsor

Effective for policies issued on or after January 1, 2014.

Health Care Reform
Impact On Employer-sponsored Health Plans

- Health Insurance Market Reforms
  - Wellness Programs
    - Permissible : Premium discount, rebate or reward for participation in a wellness program is not based on satisfying a standard related to a health status factor, and program is available to all similarly situated individuals
    - Permissible: Premium discount, rebate or reward for participation in a wellness program is based on satisfying a standard related to a health status factor, and:
      - Discount, rebate or reward does not exceed 30 percent of the cost of employee-only coverage under the plan
      - Wellness program is reasonably designed to promote health and prevent disease
      - The plan gives eligible individuals the opportunity to qualify for the reward at least once each year
      - The full reward is available to all similarly situated individuals
      - Plan discloses in all plan materials regarding the wellness program the availability of a reasonable alternative standard

Health Care Reform

Impact On Employer-sponsored Health Plans

- Health Insurance Market Reforms
  - Prohibition Against Provider Discrimination
    - A plan must not discriminate with respect to participation under the plan (or with respect to coverage) against any health care provider acting within the scope of the provider's license or Certification under applicable state law
    - Designed to prohibit discrimination against types of providers, such as chiropractors, osteopathic doctors, etc.
    - A plan may vary reimbursement rates based on "quality or performance measures"

Health Care Reform
Impact On Employer-sponsored Health Plans

- Health Insurance Market Reforms
  - Anti-Retaliation Provision
    - The Fair Labor Standards Act has been amended to prohibit an employer from discharging, or in any manner discriminating against, any employee because the employee has received a premium tax credit or cost-sharing subsidy under the legislation’s provisions for helping individuals afford coverage

Health Care Reform

Impact On Employer-sponsored Health Plans

- Health Insurance Market Reforms
  - Small Group Market: Essential Health Benefit Requirements
    - An insurer that offers coverage in the small group market must include in that coverage the “essential health benefits package” required for plans offered through the state insurance exchange

Health Care Reform

Impact On Employer-sponsored Health Plans

- Health Insurance Market Reforms
  - Maximum Waiting Periods
    - A plan must not apply a waiting period that exceeds 90 days

Health Care Reform
Impact On Employer-sponsored Health Plans

- Grandfathered Plans
  - A plan in existence on March 23, 2010, may for many of its participants avoid the rules we have described above
  - Exceptions:
    - Disclosure rules (simplified explanation, Summary of Material Modification requirement),
    - Waiting period rules,
    - The restrictions on lifetime and annual limits,
    - The rules on rescission of coverage,
    - The pre-existing condition prohibition, and
    - The rules on covering adult children (up to age 26) as dependents

Health Care Reform

Impact On Employer-sponsored Health Plans

- Employer Mandates
  - Excise tax on Large Employers
    - Large employers: employing an average of at least 50 full-time employees during the preceding calendar year
    - Nondeductible excise tax imposed if:
      - Fails to offer its full-time employees (and their dependents) "minimum essential coverage" and one or more employees has been certified as having enrolled in a qualified health plan and entitled to a premium tax credit or cost-sharing reduction. The "applicable payment amount" is $166.67 per employee in excess of 30 for each month of such failure.
      - Offers its full-time employees (and their dependents) minimum essential coverage, but one or more full-time employees has been certified to the employer as having enrolled in a qualified health plan and is entitled to a premium tax credit or cost-sharing reduction. The "applicable payment amount" is $250.00 times the number of employees entitled to a premium tax credit or cost-sharing reduction each month.
    - To be certain to avoid a penalty an employer must offer "affordable" health coverage to all its full-time employees (and their dependents), and the plan must be structured so participants do not pay more than 40 percent of covered claims costs

Health Care Reform

Impact On Employer-sponsored Health Plans

- Employer Mandates
  - Automatic Enrollment for Large Employers
    - An employer with more than 200 full-time employees that offers one or more health benefit plans must automatically enroll new full-time employees in a plan (subject to any permissible waiting period) and continue the enrollment of current employees
    - Employees must be provided with adequate notice of this automatic enrollment and be given opportunity to opt out of coverage

Health Care Reform

Impact On Employer-sponsored Health Plans

- Employer Mandates
  - Employee Notice
    - Effective March 1, 2013, employers must provide each employee a notice disclosing:
      - (1) the insurance exchange, including a description of the services and how the employee may contact the exchange to request assistance;
      - (2) if the employer's share of the cost of benefits is less than 60 percent of total costs, that the employee may be eligible for a premium tax credit or cost-sharing reduction if health coverage is purchased through the exchange; and
      - (3) if the employee purchases health coverage through the exchange, that any employer contribution under any employer health plan will be lost, and that the employer's contributions may be excludible from income.

Health Care Reform

Impact On Employer-sponsored Health Plans

- Employer Mandates
  - Reporting of Employer Health Insurance Coverage by Large Employers (50+ Employees)
    - Commencing December 31, 2013, large employers must provide information about any health coverage they offer to the Internal Revenue Service
    - A large employer must include a certification as to whether it offers to its full-time employees (and their dependents) minimum essential coverage under an eligible employer-sponsored plan
    - If the employer does offer such coverage, it must describe:
      - The length of any waiting period
      - The monthly premium for the lowest cost option, and the employer's share of such cost
      - The number of its full-time employees for each month, and provide specified information about each full-time employee covered under its health plan(s)
    - The Employer must provide a statement to its employees covered under the plan(s) indicating the information it was required to report to the IRS. This statement is to be provided the employees by January 31st of the following year.

Health Care Reform
Impact On Employer-sponsored Health Plans

- Employer Mandates
  - Employer Reporting Cost of Health Coverage on W-2
    - For years beginning after December 31, 2010, an employer must report on an employee's W-2 the aggregate cost of the employee's health insurance coverage sponsored by the employer
    - Does not include the amount of any salary reduction contribution to a flexible spending arrangement

Health Care Reform
Impact On Employer-sponsored Health Plans

- Employer Mandates
  - Cost Sharing
    - Insurers will be limited in the annual cost-sharing they may impose under a group health plan
    - The law is ambiguous as to whether self-insured plans are subject to these same constraints
    - For plan years beginning in 2014, a plan must not impose cost-sharing in excess of the maximum out-of pocket amount in effect for high deductible health plans for 2014*
    - “Cost-sharing” includes (1) deductibles, coinsurance, copayments, or similar charges, and (2) any other expenditure required by a participant for essential health benefits

*E.g., Limits for 2010 are $5,950 for self-only coverage and $11,900 for family coverage

Health Care Reform

Impact On Employer-sponsored Health Plans

- Employer Mandates
  - Free Choice Voucher Requirements
    - Effective January 1, 2014, employers offering minimum essential health coverage must provide qualified employees with a voucher which can be used to purchase health coverage through an exchange
    - "Qualified employees" are employees (a) whose required contribution under the employer's plan exceeds 8%* but not more than 9.5%* of the employee's household income, and (b) whose total household income is less than 400% percent of the poverty line. The employee must not participate in the employer's health plan.
    - The voucher value must equal the employer's contribution to the employer's health plan. If there is more than one (1) health plan, the voucher value must be the amount paid by the employer under the plan involving the largest percentage of employer cost. The value of the voucher would include any family subsidy by the employer if the employee purchases family coverage in the exchange.

*Indexed for years after 2014

Health Care Reform
Impact On Employer-sponsored Health Plans

- Other Provisions
  - Multiple Employer Welfare Arrangements (“MEWAs”)
    - False Statements - A new criminal provision has been added prohibiting false statements or false representations of fact, in connection with the marketing or sale of a MEWA concerning:
      - the financial condition of the MEWA
      - the benefits provided by the MEWA
      - the regulatory status of the MEWA under federal or state law
      - the regulatory status of the MEWA regarding exemption from state regulatory authority under ERISA
    - Cease and Desist Orders - The Secretary of Labor may issue a cease and desist order if the Secretary determines that the MEWA is fraudulent, is a danger to the public safety or welfare, or may cause significant, imminent, and irreparable public injury
    - MEWA Registration - MEWAs must now register with the Secretary of Labor prior to operating in a state

Health Care Reform

Impact On Employer-sponsored Health Plans

- Other Provisions
  - "Cadillac" Plan Tax
    - An excise tax on insurers, if the aggregate value of employer-sponsored health insurance coverage exceeds a threshold amount
    - The tax is equal to 40 percent of the aggregate value that exceeds the threshold amount
    - For 2018, the threshold amount is $10,200 for individual coverage and $27,500 for family coverage, multiplied by a "health cost adjustment percentage" and increased by the "age and gender adjusted excess premium amount"
    - The "health cost adjustment percentage" is designed to increase the threshold amount if the growth in health care costs by 2018 exceeds the projected growth
    - The "age and gender adjusted excess premium amount" is equal to the excess, if any, of (1) the premium cost of standard coverage under the federal employees health benefits system based on the age and gender characteristics of all employees of the individual's employer, over (2) the premium cost, based on procedures prescribed by the Secretary of HHS, for that coverage based on the age and gender characteristics of the national workforce

Health Care Reform

Impact On Employer-sponsored Health Plans

- Other Provisions
  - "Cadillac" Plan Tax (cont'd.)
    - The excise tax is imposed pro rata on the issuers of the insurance
    - If self-insured group health plan, a Health FSA or an HRA, the excise tax is imposed on the plan administrator
    - The threshold amounts are increased for individuals age of 55 or older who are not Medicare eligible and are receiving employer-sponsored retiree health coverage and for employees in high-risk professions
    - Effective for taxable years beginning after December 31, 2017

Health Care Reform

Impact On Employer-sponsored Health Plans

- Other Provisions
  - Tax Credit for Small Businesses
    - Eligibility is limited to employers with no more than 25 full-time equivalent employees (FTEs) whose annual full-time equivalent wages average no more than $50,000
    - The full amount of the credit is available only to employers with 10 or fewer FTEs with average annual full-time equivalent wages from the employer of less than $25,000
    - An eligible small employer must contribute on behalf of each employee who enrolls in qualifying health insurance
    - The employer contribution must be a uniform percentage (not less than 50%) of the premium cost of the plan
    - The credit is initially available for 2010, 2011, 2012, and 2013

Health Care Reform

Impact On Employer-sponsored Health Plans

- Other Provisions
  - Tax Credit for Small Businesses (cont'd.)
    - Beginning in 2014, the credit is only available for purchases through a state exchange and is only available for a maximum coverage period of two consecutive taxable years
    - The amount of the credit is generally equal to the "applicable tax credit percentage" (35 percent for the years 2010-13, or 50 percent thereafter) of the employer's contribution to the health insurance premium for each covered employee
    - Only non-elective contributions by the employer are taken into account
    - The credit is reduced (1) for employers whose employees' average wage is between $25,000 and $50,000, and (2) for employers with more than 10 FTEs but not more than 25 FTEs
    - The amount on which the credit is based is reduced if the amount of premiums paid by the employer exceeds the "benchmark premium"
    - The "benchmark premium" is the average total premium cost in the small group market for employer-sponsored coverage in the employer's state

Health Care Reform

Impact On Employer-sponsored Health Plans

- Other Provisions
  - Elimination of Deduction for Retiree Prescription Drug Subsidy
    - The deduction for retiree prescription drug plan subsidies has been eliminated, effective for taxable years beginning after December 31, 2012
  - Tax Code Provisions for Dependent Children
    - Extension of the general exclusion for the cost of coverage under an employer-provided health plan to any child of an employee who has not attained age 27
    - Effective as of March 23, 2010

Health Care Reform

Impact On Employer-sponsored Health Plans

- Cafeteria Plans, HSAs, and HRAs
  - Offering Exchange-Participating Qualified Health Plans
    - After December 31, 2013, qualified health plans offered through an exchange are not "qualified benefits" permitted to be offered through a cafeteria plan
      - Exception for a small employer offering enrollment in a qualified health plan through such an exchange
      - Beginning in 2017, this is extended to large employers, if state offers qualified health plan through such an exchange in the large group market

Health Care Reform
Impact On Employer-sponsored Health Plans

- Cafeteria Plans, HSAs, and HRAs
  - Medicine Under HSAs, FSAs, and HRAs
    - Must prescribed drug or insulin to qualify for reimbursement as a medical expense
    - For HSAs, this is effective for reimbursements after December 31, 2010
    - For health plans, FSAs, and HRAs this is effective for expenses incurred in taxable years beginning after December 31, 2010
  - Increase in Tax on HSA Distributions
    - The tax on distributions from HSAs and Archer MSAs that are not for qualified medical expenses is increased from 10 percent to 20 percent, effective for distributions made after December 31, 2010

Health Care Reform
Impact On Employer-sponsored Health Plans

- Cafeteria Plans, HSAs, and HRAs
  - Health FSAs Limited to $2,500
    - Benefits payable under a health flexible spending account under a cafeteria plan will be limited to $2,500* per employee for any taxable year. This is effective for taxable years beginning after December 31, 2012.

*Adjusted for inflation after Dec. 31, 2013

Health Care Reform
Impact On Employer-sponsored Health Plans

- Cafeteria Plans, HSAs, and HRAs
  - Simple Cafeteria Plans for Small Businesses
    - Small businesses will be allowed to establish a "simple cafeteria plan," effective for years beginning after December 31, 2010
    - A small employer (100 or fewer employees) is eligible for a safe harbor from the nondiscrimination requirements for cafeteria plans
    - The plan must meet minimum eligibility and participation requirements, as well as minimum contribution requirements

Health Care Reform
Impact On Employer-sponsored Health Plans

- COBRA Coverage Subsidies
  - Not directly part of health reform laws but provides 65% subsidy for COBRA continuation costs
  - Initially part of financial recovery efforts (ARRA)
  - Extension in December, 2009 to allow 15 months of coverage instead of 9 months
  - Additional changes in March, 2010 to include workers who had hours reduced, lost coverage and then were laid off
  - Extension in April for employees losing jobs through May, 2010

Health Care Reform
Impact On Employer-sponsored Health Plans

- Challenges to New Laws
  - Lawsuits filed by 19 states on constitutionality of health reform provisions

    Initial hearing in Florida Federal District Court April 14th
  - Challenges by individual groups
  - Refusal to participate in reform programs
    - Georgia – High Risk Pool

Overview of Health Care Reform Law

- The End of the Beginning; The Beginning of Forever
  - Good news! Health reform debate is far from over
    - Washington DC advocacy and lobbying will continue as interested parties try to shape implementation of health reform or change reform measures believed to have deleterious impact
  - The Acts both <u>require</u> and <u>permit</u> Federal agencies to adopt regulations to implement reform measures
    - Some regulations are due as early as June of this year
    - Other regulations will be adopted over the next several years
    - The regulatory process will likely continue for years, if not decades, to come

Overview of Health Care Reform Law

- The End of the Beginning; The Beginning of Forever
  - Opportunity for public engagement in the regulatory process necessary to implement health reform
    - Proposed notice of rulemaking allows interested persons the opportunity to comment before agency adoption of a final rule
    - Issuance of interim final rule is effective immediately, subject to change if agency is persuaded by public comments received after the fact
  - Congress will play a role in the regulatory process
    - Congress may convene oversight hearings on matters subject to administrative rule-making
    - Members of Congress may meet with federal agency officials involved in developing regulations or send letters to these officials expressing their opinions and beliefs

Overview of Health Care Reform Law

- The End of the Beginning; The Beginning of Forever
    - Members of Congress also may file public comments to proposed rules
  - Further action in Congress
    - Efforts to repeal all or some substantial portion of the Acts
    - Efforts to authorize federal government to review health insurers' premiums and block "unreasonable" rate increases
    - Efforts down the road to authorize a true government-run public health insurance plan
    - Technical corrections to clean up the Affordable Care Act, in particular
    - Efforts to change measures that are not effective until some future date

Contact Information

E. Philip Bush
Partner
Locke Lord Bissell & Liddell
2200 Ross Avenue
Suite 2200
Dallas, Texas 75201
(214) 740-8542
pbush@lockelord.com

Jan R. Newsom
Senior Counsel
Locke Lord Bissell & Liddell
2200 Ross Avenue
Suite 2200
Dallas, Texas 75201
(214) 740-8542
jnewsom@lockelord.com

Questions & Answers

If you have questions, please email us at

healthreform@lockelord.com