BAKER DONELSON
BEARMAN, CALDWELL & BERKOWITZ, PC

The Supreme Court Has Ruled: What Now For Employer-Sponsored Health Plans?

July 19, 2012
Birmingham, Alabama

Presented by:

Andrea Bailey Powers
205.244.3809
apowers@bakerdonelson.com

EXPAND YOUR EXPECTATIONS℠

The Affordable Care Act (ACA)

- The bottom line on the U.S. Supreme Court's decision on the health care reform law is that all of the health care reform provisions that apply to group health plans and insurers that sell coverage to group health plans have been left standing and employers must make sure that their health plans comply.
- Some employers may have deferred their compliance efforts pending the outcome of the constitutional challenges to health care reform and some may have been overwhelmed by the number of requirements and the amount of work required to ensure compliance. Now is the time for all employers to review the requirements that are already in effect as well as those that will take effect in the next few months.

THE BOTTOM LINE: Delaying Compliance Efforts is Not an Option

Grandfathered Plans

- There is a false impression that health plans can take advantage of the grandfathering provisions of the ACA in order to delay or avoid compliance requirements. But grandfathered plans are not excepted from complying with all of the law—only specific provisions—and remain subject to many other provisions.
- A plan can lose grandfathered status in several ways. Any employer relying on the grandfathered plan exceptions should make sure that grandfathered status has not been lost inadvertently. Examples of changes that can cause loss of grandfathered status include:
  - Elimination of Particular Benefit
  - Increase in Coinsurance
  - Increase in Deductible or Out-of-Pocket Maximum
  - Increase in Copayment
  - Decrease in Employer Contribution
- Employers are subject to special compliance requirements for grandfathered plans, including:
  - provision of special notices to plan participants,
  - maintenance of records dating back to March 23, 2010 documenting the plan terms, and
  - making plan records available for examination.

ACA Requirements That Are Currently Effective

- Reporting of aggregate cost of health coverage on W-2s for calendar year 2012.
- For insured plans, proper handling of any medical loss ratio rebates for 2011 (to be distributed by insurers by August 1, 2012).
- Coverage of employees' adult children up to age 26 (for plans that allow coverage of dependents) (limited exception for employed children in grandfathered plans until January 1, 2014).
- Prohibition on preexisting condition exclusions for children under 19.
- First-dollar coverage of preventive care services (grandfathered plans excepted).
- Patient protection provisions (e.g., choice of primary care provider, coverage of out-of-network emergency services) (grandfathered plans excepted).

ACA Requirements That Are Currently Effective

- Prohibition on health FSA reimbursements for over-the-counter drugs and medicines without a prescription, except insulin.
- Prohibition on lifetime limits and restrictions on annual limits for essential health benefits (grandfathered plans excepted from some restrictions).
- Enhanced requirements for claims and appeals, including the addition of external review, the treatment of eligibility decisions as subject to claims and appeals and external review in many instances, and inclusion of notices of availability of non-English language services and documents depending on the county to which the claim or appeal information is sent (grandfathered plans excepted).

2012 To Do List

Seven items with effective dates between July 1, 2012 and January 31, 2013

1. Minimum Loss Ratio (MLR) for Insured Health Products

Effective: plan/policy year ending on or after December 31, 2011 with first reporting to policy holders or subscribers in July 2012

Provisions: Insurance companies must not have a loss ratio lower than 85% (expenses and profits more than 15% of the premium) in the large group market (50 plus employees) and 80% in the individual and small group market. Special rules apply for mini-med, expatriate plans, and student health plans in 2013. Self-insured, stop-loss, dental and vision plans are all exempt from MLR. The first required reporting to policyholders or subscribers is due July 2012.

Financial Impact: Plans with insured health products may receive money back (rebates) from insurance companies not meeting the MLR. While we have seen some re-categorizations of clinical costs from non-claim expenses to claims, loss ratios lower than 85% are not uncommon. We recommend that administrators and/or consultants request a reporting from their insurer.

2012 To Do List

Seven items with effective dates between July 1, 2012 and January 31, 2013

2. Preventive Care for Women

Effective: Later of the plan/policy year beginning on or after August 1, 2012 or date "Grandfathered Status" is lost

Provisions: Plans must cover: i) well-woman visits – includes preventive services that are age and risk factor appropriate, ii) screening for gestational diabetes, iii) human papillomavirus (HPV) testing, iv) counseling for sexually transmitted infections (STIs), v) counseling and screening for HIV, vi) contraceptive methods, sterilization, and counseling using FDA approved methods, vii) breastfeeding support, supplies, and counseling, and viii) screening and counseling for interpersonal and domestic violence.

Financial Impact: Although preventive care is often cost effective – meaning it saves money especially in the long-term for low turnover groups – it is hard to prove that this is the case for all of the above services. This is the first federally mandated requirement for Plans to cover ***all*** FDA-approved methods for a covered benefit regardless of best practices. Net costs will vary depending on a plan's current covered benefits, female population, and health care management practices.

2012 To Do List

Seven items with effective dates between July 1, 2012 and January 31, 2013

3. Summary of Benefits and Coverage (SBC)

Effective: On or after September 23, 2012

Provisions: Group Health Plans and health insurance issuers must provide an SBC to enrollees, applicants, and policyholders at specified times, free of charge, or face a possible monetary penalty of up to $1,000 per person involved. Chart of provisions provided on next slide

Financial Impact: The cost is administrative and will vary by the complexity of the plan and current plan communication materials.

Summary of Benefits and Coverage (SBC)

Type of Communication *	Effective Date - On or after 9/23/2012
Open Enrollment period with an open enrollment communication mailing	1st day of the Open Enrollment
Open Enrollment period without an open enrollment communication mailing, e.g., auto-enrollment	30 days prior to the earlier of the beginning of the plan or policy year
No Open Enrollment period, i.e., no benefit plan options and cannot opt out	See effective date for other communications
Upon request	Seven (7) business days after the request
New Hire Packet	Earlier of beginning of plan or policy year
COBRA Packet	90 days after COBRA enrollment following the earlier of the beginning of plan or policy year
Summary of Material Modification or Summary of Plan Description	Not required; may include and if so, then must comply with standard location in the packets
Group Health Insurance Application	Seven (7) business days after the earlier of application or issuance date
Group Health Insurance Renewal	Upon distribution of renewal material
Automatic Renewal of Group Health Insurance	30 days prior to policy year
Changes to Group Health Insurance	First day of coverage change

2012 To Do List

Seven items with effective dates between July 1, 2012 and January 31, 2013

4. Flexible Spending Accounts Limited

Effective: Plan/policy year beginning on or after January 1, 2013

Provisions: Maximum salary reduction amount is $2,500.

Financial Impact: Employers will have reduced FICA savings, reduced forfeitures, and increased communication costs which will be slightly offset by reduced claims processing. Individuals who would have contributed more than $2,500 will have an additional tax burden.

5. W-2 Reporting of Employer-Sponsored Health Coverage

Effective: January 31, 2013

Provisions: The value of the health benefits (net of employee contributions) must be reported on the employee's 2012 W-2 Form due by January 31, 2013.

Financial Impact: Administrative cost of calculating the value and producing the new W-2 forms.

2012 To Do List

Seven items with effective dates between July 1, 2012 and January 31, 2013

6. Added Medicare Tax

Effective: January 1, 2013

Provisions: Employers must withhold an additional 0.9% Medicare tax for employees with adjusted gross income over $200,000 ($250,000 for joint filers), increasing the total Medicare tax to 3.8%. These thresholds are not indexed. In addition, these same high earnings individuals will see their investment income taxed an additional 3.8%.

Financial Impact: Administrative costs plus possibly all or part of the 0.9% extra Medicare tax since either the employer or the individual may be picking up the burden via a wage adjustment.

7. Tax on Retiree Drug Subsidies (RDS) and Gradual Closing of the "Donut Hole" for Medicare Rx coverage

Effective: Tax Years beginning after December 31, 2012

Provisions: Plans that are taxable entities will be taxed on the amount that they receive from the RDS program beginning in 2013. However, Plans can achieve an even greater savings than provided by RDS by using a Medicare Part D product since the infamous "donut hole" will continue to shrink through 2020 via pharmaceutical industry discounts and increasing federal subsidies.

Timeline of ACA Changes for 2013-2018

Effective Date	Key Changes:	
3/1/13	Reporting	Notice to employees about Exchanges including (for families under 400% of FPL, currently $92,200 for a family of four) that they have access to subsidies if their employer does not offer affordable health care - 60% benefit ratio for less than 9.5% of the household income
7/31/13	Tax	Patient-Centered Outcome Research fees of $1 per covered person are due for 2012 plan/policy years ending before October 1, 2013. The fee increases to $2 for the 2013 plan year and is then indexed by the Per Capita National Health Expenditure each year through 2019. After the 2019 plan year, no fees are required. Fees apply to both insured and self-insured plans with Plans that have both components paying twice. Stop-loss, stand alone dental/vision, HSAs, and most FSAs are exempt. HRAs and retiree-only Plans must pay the fees.
1/1/14	Exchanges	Exchanges available for individuals and for employers with less than 50 employees (states may choose to allow participation by employers up to 100 employees)

PYB means Plan Year Beginning on or after. FTE means Full-time Employees

* Grandfathered plans are exempt from this requirement.

** Large Plan Sponsor (LPS) is defined as having 50 or more FTEs on average during the Plan Year. An FTE works 30 or more hours a week.

Timeline of ACA Changes for 2013-2018

Effective Date	Key Changes:	
PYB 1/1/14	Benefits	Wellness Incentive Cap increased from 20% to 30% of cost of health care
PYB 1/1/14	Benefits	Removes Annual Maximum on Essential Health Benefits (phased in) [HHS has until 1/1/2014 to issue regulations on what can be covered under the annual limits.]
PYB 1/1/14	Benefits	Prohibits Pre-existing Limitation for all enrollees
PYB 1/1/14*	Benefits	Applies Maximum Caps on Cost-Sharing (e.g., Ded.: $2,000/$4,000 single/family indexed starting in 2015; OOP Max: $6,050/$12,100 indexed from 2012)
PYB 1/1/14	Eligibility	Requires Auto-Enrollment for employers of 200 or more employees and allows for opt-outs
PYB 1/1/14	Eligibility	Requires New Employee Waiting Period not to exceed 90 days

PYB means Plan Year Beginning on or after. FTE means Full-time Employees
* Grandfathered plans are exempt from this requirement.
** Large Plan Sponsor (LPS) is defined as having 50 or more FTEs on average during the Plan Year. An FTE works 30 or more hours a week.

Timeline of ACA Changes for 2013-2018

Effective Date	Key Changes:	
PYB 1/1/14*	Eligibility	Prohibits excluding from coverage because of Health Status
PYB 1/1/14*	Eligibility	Prohibits excluding from coverage because of Clinical Trial participation
PYB 1/1/14*	Eligibility	Fully insured plans must provide Guaranteed Availability and Renewability
PYB 1/1/14*	Premiums	Fully insured plans have rating restrictions on age of 3 to 1; on tobacco use of 1.5 to 1
PYB 1/1/14	Tax LPS**	If No Coverage and 1 FTE qualifies, then pay No Coverage Tax which is (#FTE - 30) x $2,000 [No Coverage FTE qualifies if their Household Income (HHI) is at least equal to 100%/133% FPL (depending on that State's Medicaid limit) and is below 400% of the Federal Poverty Level (FPL) AND goes to an Exchange.]
PYB 1/1/14	Tax LPS**	If Limited Coverage and 1 FTE qualifies, then Plan Sponsor must pay Assisted Coverage Tax (assisted #FTE x $3,000), but not greater than No Coverage tax. Limited Covered FTE qualifies for either a Tax Credit if HHI ≥100%/133% FPL and < 400% FPL AND goes to an Exchange AND A or B. A) Benefit Ratio on Essential Benefits < 60%; or B) FTE contribution > 9.5% HHI

PYB means Plan Year Beginning on or after. FTE means Full-time Employees
* Grandfathered plans are exempt from this requirement.
** Large Plan Sponsor (LPS) is defined as having 50 or more FTEs on average during the Plan Year. An FTE works 30 or more hours a week.

Timeline of ACA Changes for 2013-2018

Effective Date	Key Changes:	
PYB 1/1/14	Subsidy	Certain small employers may be eligible for subsidies of up to 50% of premium for up to 2 years if coverage is purchased from exchanges
1/31/15	Reporting	Special IRS Report required by Plan Sponsor on Minimum Essential Coverage
1/31/15	Reporting	Special IRS Report from Large Plan Sponsor3 to IRS and FTE
1/1/16	Exchanges	Exchanges available for employers with up to 100 employees in all states
1/1/17	Exchanges	States may expand exchanges for employers of more than 100 employees
PYB 1/1/18	Tax	Excise Tax on cost of more than $10,200 single / $27,500 family; industry and retiree adjusted

PYB means Plan Year Beginning on or after. FTE means Full-time Employees
* Grandfathered plans are exempt from this requirement.
** Large Plan Sponsor (LPS) is defined as having 50 or more FTEs on average during the Plan Year. An FTE works 30 or more hours a week.

QUESTIONS?