Alliance Learning Circles ™

EXECUTIVE SUMMARY

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

AUGUST 18, 2010

Employers struggling to anticipate the evolving regulations of the Patient Protection and Affordable Care Act (PPACA) gained insights during The Alliance's Learning Circle event on August 18 in Madison.

To examine a specific area of discussion, click the links below:

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Health Care Reform Hits Home

John Barlament, a partner practicing exclusively in employee benefits law at Michael Best & Friedrich, LLP, Milwaukee, WIs., presented at *The Patient Protection and Affordable Care Act – Balancing the Big Picture with Immediate Implications*.

Staying in compliance with PPACA — which is being implemented with staggered deadlines even though regulations are still being written — represents a challenge for employers, according to Barlament.

"There's a lot of little tricky rules when you start digging into the weeds of this," Barlament noted when describing one of the Act's many provisions. Employers' intense interest in how these rules will be weeded out was clear in their participation in lively question-and-answer sessions.

The unknowns of health care reform abound, so employers must remain alert as the Department of Health Services (HHS) develops regulations. While the exact impact of many changes is yet to be determined, it is certain that health care reform is going to hit home for employers who offer health coverage to employees and dependents.

Will Employers 'Pay or Play?'

Congress is banking on employers continuing to provide health coverage to their employees, Barlament said. They may do this by continuing to offer their existing health plans; joining state-based "exchanges" that will offer standardized benefit plans to individuals and small businesses, with large employers eligible to join in 2017; purchasing benefits from multi-state plans; or joining state-approved insurance cooperatives.

Beginning Jan. 1, 2014, employers who had an average of 50 full-time employees in the preceding year must offer "minimum essential coverage" or pay a fine of $2,000 per employee. Offering coverage that fails to meet a multi-step definition of "minimum essential coverage" triggers a fine of $3,000 per

Will Employers 'Pay or Play?', cont.

employee.

Uncertainties abound, since HHS is yet to define "minimum essential coverage" and other rules are still in development. But it is possible that some organizations will weigh the cost of providing health care against the $2,000 per-employee penalty and decide it is cheaper to eliminate coverage, despite other considerations, such as taxes and employee recruitment and retention.

Employees who lose their health coverage may demand higher wages to make up for it and companies may find that health benefits are essential to attract talented employees.

Yet several employer representatives said their companies might seriously consider eliminating coverage and giving funds directly to employees instead. Vital issues include costs, federal regulations and employee demands.

"Any of these things could tip it one way or another," one employer representative said.

The Voucher Option

Beginning in 2014, employees who have to pay too much for coverage under an employer's plan can demand a "free choice voucher" at the employer's expense. The voucher can be used to purchase coverage from an insurance exchange.

Employees are eligible for these vouchers if they meet three conditions based on their existing employer-based plan:

- » The required employee contribution is between 8 and 9.5 percent of household income;
- » The employee does not make more than 400 percent of the federal poverty level, or roughly $88,000 annually for a family of four;
- » The employee does not enroll in the employer's plan.

Voucher eligibility is based on any existing plans in which the employer pays the largest portion of the plan cost, regardless of whether an individual employee is actually eligible for that plan. The voucher is based on self-only coverage unless the employee elects family coverage. If the exchange's coverage costs less than the voucher, the excess amount is returned to the employee, who can then be taxed for it. It is unknown how the exchange and the employer will communicate about costs, issues, and tax notifications.

New Benefits

The PPACA requires insurance plans to offer new benefits and eliminate plan restrictions. A number of these changes apply to all companies, even those with grandfathered status. Significant changes include:

- » No lifetime limits on amount of coverage*
    - • Can exclude all benefits for a specified condition
    - • Can place lifetime limits on benefits that are not "essential health benefits" which are currently

New Benefits, cont.

defined in statutes. Employers are allowed to adopt a "resonable interpretation" of this definition until the term is further defined by regulations

- Must send special notice to employees who previously lost coverage due to lifestime limits and now regain eligibility for benefits that are not subject to such limits

» No annual limits on amount of coverage*

- For plan years from September 23, 2010 to 2013, some restricted annual limits are allowed on "essential health benefits" on a schedule of $750,000 until September 23, 2011; $1.25 million from September 23, 2011 to September 23, 2010; and $2 million from September 23, 2012 but before January 1, 2014.
- Can exclude all benefits for a specified condition
- Can place lifetime limits on benefits that are not "essential health benefits: which are currently defined in statutes. Employers are allowed to adopt a "reasonable interpretation" of this definition.
- HHS can grant waivers if complying would significantly decrease access to benefits or increase premiums

» No preexisting condition exclusions for enrolees under age 19, effective for new or renewed plans immediately*

- Applies regardless of age as of 2014

» No recission of coverage*

- Exceptions made in cases of fraud or misrepresentation of fact, such as failure to notify plan of divorce

» Restrictions on over-the-counter reimbursements*

- No over-the-counter drug expenses are reimbursed without a prescription, with the exception of insulin, effective Jan. 1, 2011

» Preventive care coverage on a "first dollar" basis for evidence-based preventive care, such as well-child are and some immunizations

» Designation of primary care provider

- Must allow participant to select any provider available to accept them
- Can restrict to providers within network

» Pediatrician may be selected as primary care provider for a child

» Coverage of emergency services must be provided without prior authorization, even if services must be provided without prior authorization, even if services are provided "out of network"

» OB/GYN coverage must be covered without authorization or referral

Additional details about benefit changes and related notices to employees are offered in Barlament's slide presentation.

* *Applies to all places including those with "grandfathered" status.*

The Massachusetts Example

The Massachusetts approach to health reform developed by former Gov. Mitt Romney and introduced in 2006 may offer some insights into how the Affordable Care Act may impact the national marketplace.

In Massachusetts, 8 percent of individuals currently choose to pay the penalty rather than purchase insurance. This reflects national critics' concerns that individuals will pay the penalty until they need insurance to address a specific problem; purchase the insurance to help fix the problem; and then drop the insurance as soon as they are well.

"If it happens in Massachusetts, why wouldn't it happen elsewhere," Barlament said.

Health Plan Adds Taxes

The Affordable Care Act provides revenue to help pay for health reform. These taxes include:

- » A Comparative Effectiveness Fee of $1 per participant for the first plan year ending after Sept. 30, 2012, which increases to $2 in subsequent years and is subject to inflation adjustments in 2014.
- » A Reinsurance Fee charged to third-party administrators (TPAs) and insurers beginning in 2014 and continuing for three years.
- » An insurer fee of $8 billion assessed to insurers based on market share. Self-funded plans are specifically exempted from this fee, but fully insured, employer-based plans are not.

In addition, insurers who offer "rich plans" after Jan. 1, 2018 can face a "Cadillac" tax, which will likely be passed along to employers. Barlament said this tax was designed to force people in high-cost, high-value plans to use the appropriate level of care, such as a family doctor instead of an emergency room for minor ailments. The tax is assessed at a rate of 40 percent of the "excess benefit," based on plans worth $10,200 for single coverage and $27,500 for family coverage. Those amounts increase to $11,850 and $30,950 respectively for individuals in high-risk professions.

Several other provisions are designed to increase revenues and appear to be effective Jan. 1, 2013.

- » Medicare Tax: An additional Medicare tax of 0.9 percent is charged to employees on wages of over $200,000 for an individual or $250,000 for joint filers, for a total tax of 2.35 percent.
- » Unearned income: A new 3.8 percent tax is assessed on "unearned income" from sources such as interest, dividends, rents, royalties and annuities if the individual's income is over $200,000 or $250,000 for join filers.
- » Medicare Part D Subsidy: If the employer received the 28 percent subsidy for retiree drug expenses, the employer's allowable deduction must be reduced by the amount of the subsidy.
- » Health Savings Accounts (HSAs): The excise tax on nonqualified HSA withdrawals increases from 10 percent to 20 percent.

Tax Credits Offered

Barlament noted that many employees might be eligible for federal assistance in the form of tax credits to help purchase health insurance coverage. Individuals are eligible for premium assistance credits if their income is between 100 percent and 400 percent of the federal poverty level.

Small employers with up to 25 full-time employees per year and an average annual wage at or below $50,000 can be eligible for a credit of roughly 35 percent of employer contributions if the employer contributes at least half the premium cost. The subsidy decreases to 25 percent for tax-exempt employers.

Is Repeal Likely?

"Don't hold your breath," Barlament advised employers hoping the Affordable Care Act will be repealed. A number of political and business groups have called for repeal or significant revisions, but Barlament said there is nothing on the "near horizon." Lawsuits filed to block the case are unlikely to succeed because the commerce clause of the U.S. Constitution gives Congress authority to act on this legislation.

"Those plan changes will have to be made; maybe they'll be reversed in a couple of years," Barlament predicted.

The PPACA aims at expanding coverage. Barlament said Congress is likely to reexamine health reform in coming years to address the additional issues of cost and quality.

Exempt Plans

The PPACA is likely to apply to most existing insurance plans that provide major medical coverage, regardless of whether they are offered by employers or non-federal governmental entities. Some "mini med" plans with low levels of coverage and stand-alone health reimbursement accounts (HRAs) may be exempt from annual rules on coverage limits.

Other plans that are likely exempt from most PPACA changes include:

- Retiree-only plans, as long as they are not blended with plans for active employees.
- Stand-alone dental or vision plans, as long as the employee is required to make some form of monetary contribution to its cost.
- Health FSAs, except for changes that specifically address them.
- HSAs, except for changes that specifically address them.
- Fixed indemnity plans, such as plans that offer a specific amount of payment to hospitalized individuals on a per-day basis.
- Some supplemental benefits, such as "Medigap" policies.

In addition, plans with "grandfathered" status are exempt from some requirements.

Extending Young Adult Coverage

Beginning with the first plan year on or after Sept. 23, 2010, all insurance plans must offer coverage to all children of plan participants until they reach age 26. This coverage must be extended to all children of employees, regardless of their residency, student status, financial dependence, marital status, or employment. This coverage extends only to the child and not to their dependents.

There is a limited modification for grandfathered plans, which are not required to cover a child who is eligible to enroll in "eligible employer-sponsored health coverage" for plan years before 2014.

Barlament advised employers to notify all adult children of the opportunity to enroll in their plans. The PPACA requires that children be given written notice of the opportunity to enroll by the first day of the first plan year after Sept. 23, 2010, and must then have 30 days to enroll. Coverage must be effective no later than the first day of the plan year and can also be retroactive if necessary, although it is unclear if the salary reduction associated with the coverage can be retroactive.

Employers should be prepared to respond to dependents who request coverage even though the employee has not selected family coverage and wants to avoid covering dependents. Employers cannot deny benefits to these young adults, although regulations are still being developed to cover these situations.

Wisconsin employers who offer fully-insured plans must extend coverage to age 27 under state law, which has tax implications for the employee. Rules require that the employer adjust the employee's W-2 to reflect the benefit to the dependent.

Employers cannot charge more for older dependents, but they can charge employees for coverage on a "per covered person" standard. A number of companies at The Alliance event predicted dependent coverage would cause health plan costs to rise significantly in coming years.

Cost Increases and Preventative Care

Beginning in September 2010, insurance plans are required to pay the full cost of recommended preventive care. It is unclear whether employer-based health clinics offered at or near workplaces will satisfy the preventive care requirement, although employers say on-site clinics offer considerable cost savings.

Barlament said the regulations do not address how preventive care must be offered but allow health plans to use "reasonable medical management" to limit costs. Another unknown is whether employer-based plans will be required to cover the "facility fee" often tacked on to bills for visits to physician clinics.

Health plan costs are likely to increase 1 to 1.5 percent in the coming year if the plan previously offered preventive care and 4 percent if preventive care was not covered. Roughly half the employers in the room currently offer preventive care.

Overall, health reform changes are expected to account for health plan cost increases of approximately 6 to 7 percent. Significant factors include the removal of maximum coverage limits and the addition of coverage for adult dependents. The impact of other changes, particularly the removal of lifetime dollar limits on coverage, is difficult to weigh, given the possibility of increased claims as well as increased

Cost Increases and Preventative Care, cont.

costs for stop-loss insurance among self-funded plans.

"This is the biggest open issue for employers right now," Barlament noted.

Notices, "Nightmare" Rules and Non-Compliance Penalties

The PPACA is expected to prompt tight rules related to sending notices to employees and dependents about issues such as dependent coverage and auto enrollment. In some cases, these rules may be effective even if they are issued after the provision is already in effect. While employers may apply for relief in some situations, they also must be scrupulous about correctly handling notices and fulfilling regulatory requirements.

Another example of the difficulties created by the PPACA are the rules requiring coverage of out-of-network emergency room care, which include complex calculations for determining how much to pay. The rules require coverage of any type of out-of-network care, even if it occurs within the local area.

"It is backward, it is a nightmare and it's going to be a bit of a challenge," Barlament said.

Auto enrollment rules for employers of 200 or more full-time employees that offer a health benefit plan appear to take effect on March 23, 2010, but there are no regulations available at this time. That means employers should be able to stay with their "status quo" procedures until new regulations are issued.

Barlament also warned that penalties for non-compliance are likely to be significant. The PPACA places failures to comply under the Health Insurance Portability and Accountability Act (HIPAA), which set the penalty at $100 per day per individual. In some cases, penalties for failing to provide specific plan documents can be even higher. While providing insurance coverage is tax deductible for employers, penalties are not deductible.

Grandfathered Status

Plans with "grandfathered status" can avoid numerous PPACA requirements both now and after 2014, but the rules are stringent. For example, existing plans can lose their grandfathered status if they fail to state that the plan is grandfathered in enrollment materials, enter into a new insurance policy, or decrease the dollar value of an annual limit.

The grandfathered status of each benefit package or plan option is determined separately, so Barlament encouraged employers to document each benefit package as of March 23, 2010. Incorrectly assuming that a plan has grandfathered status can trigger penalties of $100 per person per day in each impacted category.

"Laminate your plan document, and I mean that almost literally," Barlament said.

Most plans will eventually lose their grandfathered status due to changes over time. Barlament encouraged employers to think strategically about the amount of work required to maintain grandfathered status and the relative cost of the grandfathered plan compared to a new plan that changes to adapt to new conditions.

Administrative Changes

The PPACA significantly changes administrative requirements for self-funded and fully-insured health plans. Major changes include:

» New appeals procedures are established.*

- Participants have the right to review their files, present testimony in appeals and continue to receive coverage during the appeal process.
- The appeals process must ensure independence and impartiality of decision-makers.
- External reveiw of sppeal by the state is required; the HHS will determine if state sppeals review meets federal requirement, with any appeal procedure that is non-compliant subject to federal external review.
- Strict rules govern notices of appeal outcome and other elements.

» Nondiscrimination rules are applied to full-insured plans.*

- Claims and notices must be offered in a "culturally and linguistically appropriate manner."

» Transparency disclosure rules are established.*

» Wellness plans may not require disclosure of presence or storage of lawful firearms or ammunition.

» Strict rules are established for the "summary of benefits" document.

- Document must be no longer than four pages and provide long list of required content.
- It must be provided in addition to summary plan document.
- Penalties are set at $1,000 for each "willful failure" to comply.

» Rules are created for reporting the "aggregate cost" of employer-based coverage on W-2 tax forms.

» Offering incentives designed to "dump individuals" into state high risk poll is forbidden.

**Grandfathered plans are exempted*

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