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The Road to 2014: ACA Considerations for Group Health Plans

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The Road to 2014

- ACA considerations for employers
  - https://www.morganlewis.com/index.cfm/publicationID/8CD8F0A9-4F6B-4170-A73A-3451008094D6/fuseaction/publication.detail
- ACA considerations for group health plans
  - Do I have to pay any new taxes?
  - How do I have to change my plan's design?
  - How will my operations and administration change?
- ACA considerations for individuals
  - March 21, 12-1 p.m. ET

The Road to 2014

- The Road to 2014 is still under construction, and will be for years to come (not to mention patches and possible road widening in future years)
  - But, we have a good idea where the road is going, and how to get to 2014
  - Expect some detours along the way—and perhaps even some dead ends
- We'll all have to make some educated guesses along the way
  - Don't expect too many more significant regulations
  - Expect to hear, along the way, "Off Route: Recalculating" on occasion!

The Road to 2014

- Today's objective:
  - Determine if your group health plan is prepared for 2014
    - *New Taxes and Fees*
    - *Plan Design*
    - *Operation and Administration*
  - Focus on large self-insured plans
    - *Rules can be more extensive for Exchange plans or insured arrangements*

ACA Plan Mandates

All Plans

Plan Mandates

- Age 26 dependent coverage
- No lifetime limits and restricted annual limits
- No rescissions
- No preexisting condition exclusions (under age 19)
- No reimbursement from FSAs/HSAs/HRAs for OTC drugs

2011

2012

- Uniform explanation of coverage (SBCs)
- 60 day advance notice of material modifications
- W-2 reporting of value of health coverage

2013

- $2,500 cap on employee contributions to FSAs
- PCORI fee - $2 per member
- Notice of exchange/premium assistance (delayed)

2014

- Waiting periods limited to 90 days
- No preexisting condition exclusions
- No annual limits
- Employer reporting coverage to IRS
- Reinsurance fee - $63 per member

TBD

- Automatic Enrollment
- Non-discrimination requirements for insured plans (2014?)

Non-Grandfathered Plans

Additional Plan Mandates

- No cost sharing for preventive care
- Choice of primary care physician in-network
- Direct OB/GYN services without referral
- Internal and external claims review procedures
- Emergency services without pre-authorization at in-network rates

- Limits on cost sharing/deductibles
- Coverage required for clinical trials

Do I Have To Pay Any New Taxes?

- Patient Centered Outcomes Research Institute Fee (PCORI)
  - $2 times average number of covered lives
  - IRS Form 720—first due 7.31.2013
- Reinsurance Fee
  - Anticipated to be ~$63 times average covered lives
- Play or Pay Shared Responsibility tax
  - Discussed in-depth in first webinar http://www.morganlewis.com/podcasts

Do I Have To Pay Any New Taxes?

- Excise Tax on Non-Compliant Plans
  - Non-deductible excise tax on plans that do not meet plan mandates
  - $100 per day "with respect to each individual to whom such failure relates" – may not apply:
    - *if it was not known (and, in exercising reasonable diligence, would not have been known) that there was a compliance failure or*
    - *if it was due to reasonable cause (rather than willful neglect) and was corrected within 30 days*

Do I Have To Pay Any New Taxes?

- Minimum excise tax for a compliance failure discovered after a notice of examination generally is $2,500; increased to $15,000 if violations are “more than de minimis”
- Maximum excise tax for “unintentional failures” is the lesser of 10% of the amount paid during the preceding tax year by the employer for all group health plans, or $500,000
- For multiemployer plans, the excise tax is imposed on the plan
- Self-reported on Form 8928

Do I Have To Pay Any New Taxes?

- Excise tax on high value coverage ("Cadillac Tax")
  - In 2018, excise tax is 40% of the amount of the premium that exceeds
    - *$10,200 for individual coverage*
    - *$27,500 for family coverage*
  - Premiums include employer and employee contributions
  - Non-deductible
  - Paid by Plan Administrator or Insurer, but . . .

How Have I Changed My Plan's Design?

- All Plans
  - Adult child dependent coverage
  - No lifetime or annual limits on EHB (subject to phase-in)
  - No rescissions of coverage
  - No preexisting condition exclusions (under age 19)
  - No reimbursement for OTCs by HRA/FSA/HSA
  - $2,500 limit on health FSAs
- Non-Grandfathered Plans Only
  - No cost sharing for preventive care (check for updates annually)
  - Choice of primary care physician in-network (if applicable)
  - Direct OB/GYN services without referral
  - Internal and external claims review procedures
  - Emergency services without preauthorization at in-network rates

How Do I Have To Change My Plan's Design?

- All Plans
  - Eligibility waiting period based solely on the lapse of time may be no more than 90 days
    - *Other conditions generally permissible unless designed to avoid 90-day restriction*
    - *Special seasonal and part-time rules*
  - No preexisting condition exclusion regardless of age

How Do I Have To Change My Plan's Design?

- Plan sponsors may offer a wellness incentive of up to 30% of the self-only COBRA rate (50% for tobacco cessation incentives)
  - *Note new reasonable alternative requirement*
  - *Hearings and final regs still to come*
    - May lead to additional restrictions

How Do I Have To Change My Plan's Design?

- No annual limits on EHB (phase-in expires)
  - *Mainly impacts annual or lifetime limits*
  - *The end of mini-med plans and waivers*
  - *Impacts HRAs—particularly stand-alone HRAs*
    - May need to redesign, or eliminate, stand-alone HRAs
- Loss of ability to exclude adult dependents with other employer coverage
  - *Offer coverage to children of employees*
    - Try in 2014, must by 2015

How Do I Have To Change My Plan's Design?

- Non-Grandfathered Plans Only
  - Limits on Cost-Sharing
    - *Must meet OOP limits across all benefits*
    - *Deductible limits only for Exchange or insured small group plans*
  - Plans must provide coverage for clinical trials
    - *Cannot deny, limit, or impose additional conditions*
    - *May not discriminate against any qualified individual who participates in a clinical trial*

How Do I Have To Change My Plan's Design?

- Mandatory automatic enrollment
  - Employers with 200 or more employees must automatically enroll newly hired or newly eligible FTEs into a default health plan providing "affordable" coverage
  - Opportunity to opt-out
- Non-discrimination rules for insured plans
  - Delayed for now, but will bring an end to discriminatory insured benefits unless a plan only covered retirees or retains its grandfather status

How Will My Operation and Administration Change?

- Create and provide SBC at required events, including annual enrollment
  - 60-day advance notice of material modification
- W-2 reporting of value of health coverage
  - Rules will be stable for 2013
- Notice of Exchange/premium assistance
  - Delayed
  - Plan sponsors must notify employees of state health insurance exchanges, whether an employer's plan meets minimum coverage requirements, and how to access information regarding premium subsidies that may be available for Exchange-based coverage

How Will My Operation and Administration Change?

- Employer must report coverage in 2015
  - Terms & conditions of health care coverage provided to full-time employees (for 2014)
    - *Duration of waiting period*
    - *Monthly premium for lowest cost option & employer's premium share*
    - *List of employees (address, TIN, months covered)*
  - Copy to participant
    - *January of following year*

How Will My Operation and Administration Change?

- Proof of employee opt out of employer coverage
  - Good idea, based on experience with MA
- Interface with Exchange/Government?
  - Offer customized on-demand worksheet for Exchange use?
- Are union plans good enough and cheap enough?
  - Whose problem is it if they are not?
- OOP max – who tracks OOP across multiple benefits?
  - Try in 2014, required in 2015

Questions?

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