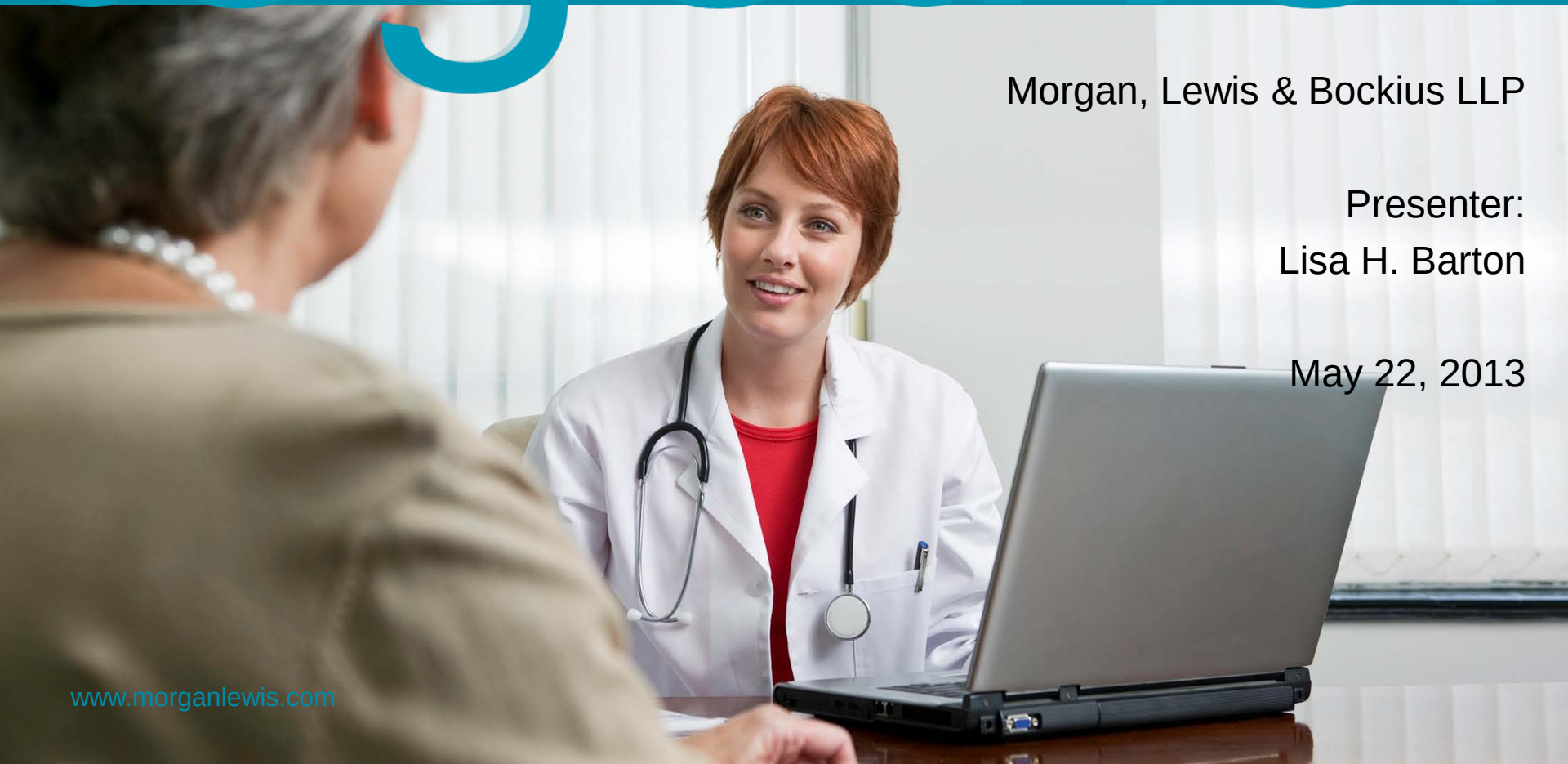
Morgan Lewis

The Road To 2014: ACA Issues For Employers And Group Health Plans



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The Road To 2014

- ACA issues for employers
  - Who is subject to the employer mandate?
  - Which employees must be offered health coverage?
  - What type of health coverage helps an employer avoid shared responsibility payments?
- ACA issues for group health plans
  - New taxes and fees
  - New plan mandates
  - Changes to plan administration

Recent Developments

- New proposed IRS regulations relating to “minimum value” for purposes of HSAs, HRAs, wellness incentives, etc.
- Notice to employees of coverage options in ACA exchanges and updated COBRA model election notice
- FAQs clarifying ACA Out-of-Pocket mandates
- Proposed rules relating to health plan waiting period limits
- FAQs clarifying certain ACA required preventative services

When Does The Employer Mandate Apply?

- Typically effective 1.1.2014, but there are limited delayed effective date rules for non-calendar year plans
  - Delayed until start of the 2014 plan year for any employee eligible for coverage on 12.27.2012
  - Delayed until start of 2014 plan year for all employees (whether previously eligible or not) if:
    - *Employer offered plan to at least one-third of all employees at most recent open enrollment; or*
    - *Plan covered at least one-quarter of all employees on any day between 10.31.2012 and 12.27.2012*

Who Is Subject To The Employer Mandate?

- Applies to all types of employers
  - Private, government, nonprofit, church, etc.
  - No exception or delay for collectively bargained plans
    - *Throws a huge monkey wrench into current collective bargaining agreements*
      - Does CBA allow employer to change benefits due to changes in law?
      - Risk of unfair labor practice charge if employer unilaterally changes benefits, even if plan is more generous
      - Talk to your labor counsel soon

Who Is Subject To The Employer Mandate?

- Only “large” employers
  - On average, at least 50 full-time employees on business days during the previous calendar year
    - *Six consecutive-month transition rule for 2013*
  - Determine if “large” by adding together
    - *FT employees*
      - 30 hours per week (or 130 hours per month)
    - *FT employee equivalents*
      - Total hours for all part-time (PT) employees divided by 120
    - *From all controlled group employers*

Shared Responsibility Payments

No Coverage Penalty	Inadequate Coverage Penalty
Applies if employer does not offer Minimum Essential Coverage to 95% of its FT employees	Applies if employer offers coverage to its FT employees, but the coverage is not Affordable and/or does not provide Minimum Value
AND One FT employee enrolls in an Exchange and receives a subsidy	
Employer must pay penalty of: $2,000 for all FT employees (less 30) (including those receiving coverage)	Employer must pay penalty of: $3,000 for each FT employee receiving a subsidy (capped at the maximum No Coverage Penalty)

No Coverage Penalty

- Offer
  - At least 95% of all FT employees (and their children beginning in 2015)
    - *FT employee = 30+ hours per week (130+ hours per month)*
  - Qualifying coverage . . .
    - *"Minimum Essential Coverage" (basically any ER-sponsored plan)*
- Or pay No Coverage Penalty
  - $2,000 times all FT employees (minus 30)

No Coverage Penalty

- Only applies if one FT employee enrolls in an Exchange and receives a subsidy
  - *No subsidy available if:*
    - Eligible for Medicaid (100%-133% of federal poverty level)
    - Household income more than 400% of federal poverty level
- Calculated on all FT employees of each controlled group member separately
  - *30-employee reduction apportioned across controlled group members*
  - *Considerations for controlled group members only providing "services" to other controlled group members*

Inadequate Coverage Penalty

- Offer
  - To all FT employees (and their children beginning in 2015)
    - *FT employee = 30+ hours per week (130+ hours per month)*
  - Qualifying coverage . . .
    - *Employer group health plan coverage that provides "Minimum Value" and is "Affordable"*

Inadequate Coverage Penalty

- Or pay Inadequate Coverage Penalty
  - $3,000 for each FT employee who receives a subsidy for Exchange coverage (capped at maximum No Coverage Penalty)
  - No subsidy available if:
    - *Eligible for Medicaid (100%-133% of federal poverty level)*
    - *Household income more than 400% of federal poverty level*
  - Applied separately to each controlled group member

Inadequate Coverage Penalty

- Example: Employer Z offers health coverage, but it does not provide Minimum Value because it pays less than 60% of the total allowed costs for benefits under the plan. Of its 1,000 full-time employees, 200 enroll in an Exchange and receive a premium tax credit for the entire year. For each employee that receives a tax credit, Employer Z will owe $3,000 for a total penalty of $600,000 (200 times $3,000) for the year (or $50,000 per month).

Who Is A Full-Time Employee?

- Average 30 hours of service/week
  - For non-hourly employees, can use 8 hours/day or 40 hours/week equivalents as long as hours are not under-counted
  - 130 hours/month can be used
- Different from large employer determination
  - PT employees are not considered
- Determined on a controlled group basis
  - Hours employee works for different members of group are added together

What Is Minimum Essential Coverage?

- Necessary to avoid the No Coverage Penalty and Inadequate Coverage Penalty
- Coverage constitutes Minimum Essential Coverage if it is coverage under an “eligible employer-sponsored plan”
  - Satisfies 2014 ACA plan mandates
  - Self-insured or fully-insured
  - Single employer or multiemployer plan
  - Excepted benefits (dental, vision, fixed indemnity) do not qualify

What Is Minimum Value?

- Necessary to avoid Inadequate Coverage Penalty
- Generally plan must cover at least 60% of total allowed costs in four core categories of benefits:
  - physician and midlevel practitioner care
  - hospital and emergency room services
  - pharmacy benefits
  - laboratory and imaging services
- Determined by design-based safe harbor, HHS calculator, or actuarial certification

Clarifications Regarding Calculating Minimum Value

- On May 3, 2013, the IRS released proposed regulations relating to how HSAs, HRAs and wellness plans are treated for purposes of calculating minimum value
  - Proposed regulations provide
    - *For HSAs, all amounts contributed by an employer for the current plan year are taken into account in determining the plan's share of costs for MV and are treated as amounts available for first dollar coverage*
    - *For HRAs, all amounts count in the same manner as HSAs, provided that amounts may be used only for cost-sharing and not to pay insurance premiums*

Clarifications Regarding Calculating Minimum Value

- *For wellness incentives, MV is generally determined without regard to reduced cost-sharing available due to wellness incentives*
  - Exception for programs designed to prevent or reduce tobacco use as MV may be calculated assuming that every eligible individual satisfies the terms of the program relating to prevention or reduction of tobacco use

Clarifications Regarding Calculating Minimum Value

- Example: Employer X offers a wellness program as part of its health plan that reduces premiums by $300 for employees who do not use tobacco products or who complete a smoking cessation course. Premiums are reduced by $200 if an employee completes cholesterol screening within the first six months of a plan year. Employee B does not use tobacco and the cost of his premiums is $3,700. Employee C uses tobacco and the cost of her premiums is $4,000.

Clarifications Regarding Calculating Minimum Value

- Only incentives relating to tobacco use are counted toward the premium amount used to determine the plan's affordability.
  - *Under the rule, employee C is treated as having earned the $300 incentive for attending a smoking cessation course (even though employee C did not do so).*
  - *The employee's required contribution to premium for determining affordability for both Employees B and C is $3,700.*
    - The $200 incentive for completing cholesterol screening is disregarded.

When Is Coverage Affordable?

- Necessary to avoid Inadequate Coverage Penalty
- Premium for cheapest employee-only coverage must be less than 9.5% of household income
  - No cap on premiums for dependent coverage
- Three safe harbors:
  - W-2 Wages: Premium cannot exceed 9.5% of the employee's wages from the employer as reported on Form W-2 for that year

When Is Coverage Affordable?

- Rate of Pay: Premium cannot exceed 9.5% of the employee's hourly rate of pay multiplied by 130 hours (or monthly salary) at the beginning of the coverage period
  - *Ignores pay for hours in excess of 130*
- Federal Poverty Line: Premium cannot exceed 9.5% of an amount equal to the federal poverty level for the year divided by 12
  - *May rely on the most recently published FPL as of the first day of the plan year*
  - *FPL published on 1.24.13 is $11,490/12 x 9.5% = $90.96*

How Will Penalties Be Paid?

- If one or more employees receive subsidized coverage on an Exchange, the IRS will send a notice to the employer
- Employer will have opportunity to respond
- If shared responsibility payments are owed, they will be assessed and paid separately from employer's income tax return

Lingering Concerns

- Nondiscrimination rules
  - Particularly worrisome if employer has different health coverage, or varying approaches across its controlled group
- ERISA section 510 claims
- Employee classification (independent contractor issues)
- Cadillac Tax
  - Some coverage may be too rich for 2018

New Taxes And Fees On Health Plans

- 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 number of covered lives

New Taxes And Fees On Health Plans

- 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*

New Taxes and Fees On Health Plans

- 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

New Taxes And Fees On Health Plans

- 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 . . .

New Plan Mandates

- 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

New Plan Mandates

- 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

New Plan Mandates

- No annual limits on EHB (phase-in expires)
  - *Mainly impacts annual or lifetime limits*
  - *The end of mini-med plans and waivers*
  - *Stand-alone HRAs no longer permitted for active employees*
- Coverage of adult children to age 26
  - *Ability to exclude those with other employer coverage ends*
  - *Must offer coverage to children of employees to avoid shared responsibility penalty*
    - Try in 2014, must by 2015

New Plan Mandates

- Non-Grandfathered Plans Only
  - Limits on Cost-Sharing
    - *Must meet out-of-pocket 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*

New Plan Mandates

- Mandatory automatic enrollment
  - Employers with 200 or more employees must automatically enroll newly hired or newly eligible FT employees 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 covers retirees or retains its grandfather status

Changes to Plan Administration

- Create and provide SBC at required events, including annual enrollment
  - 60-days advanced notice of material modification
- W-2 reporting of value of health coverage
  - Rules will be stable for 2013
- Notice of Exchange/premium assistance
  - Due to be distributed by October 1, 2013
  - Plan sponsors must notify employees of existence of 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

Changes to Plan Administration

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

Changes to Plan Administration

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

ACA Plan Mandates Timeline

All Plans

Plan Mandates

2011

- 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

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

2014

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

Questions?

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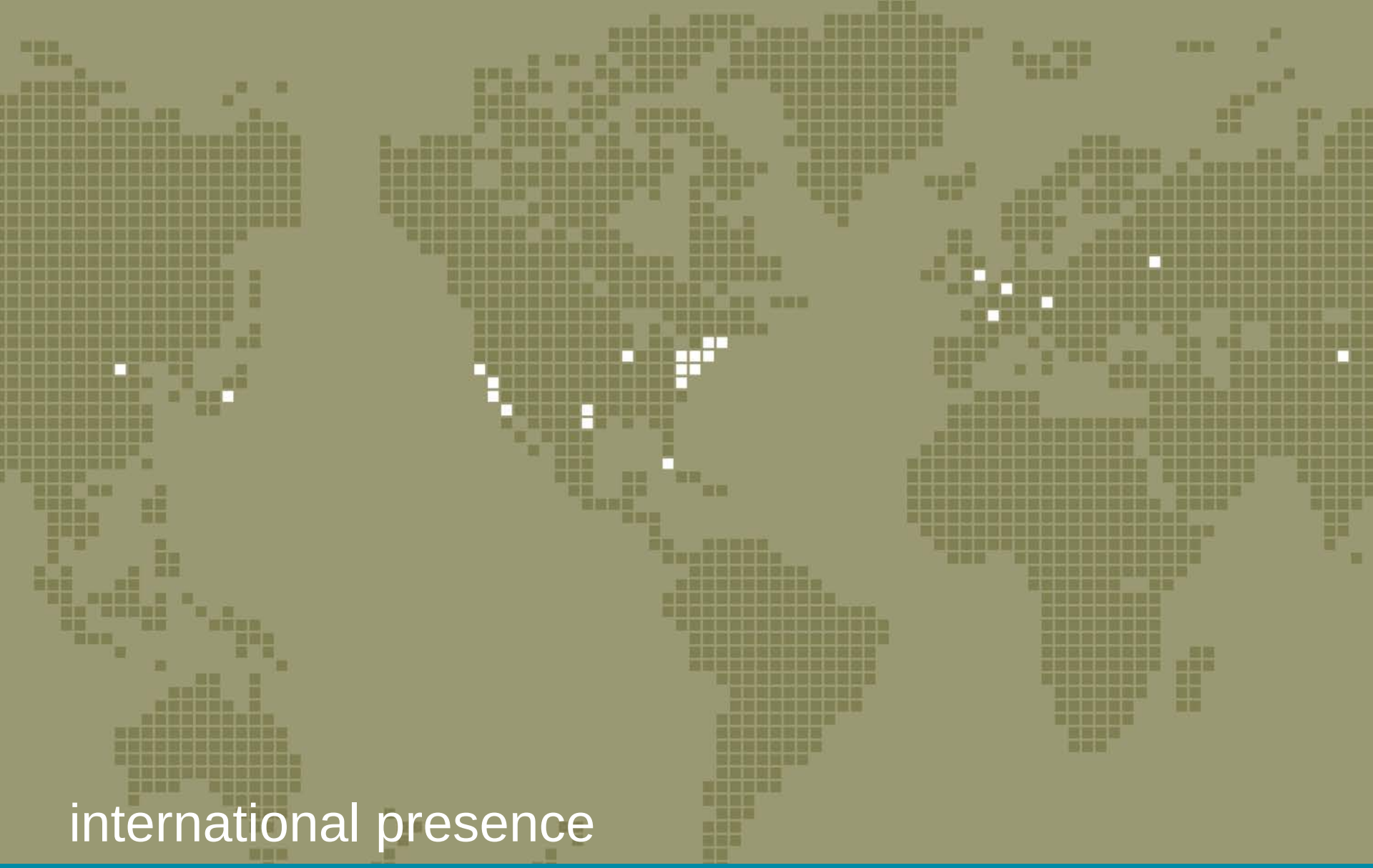

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