2012 Legislative and Regulatory Update: Health Care in a Post-PPACA World . . . Or, Back to the Future

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Since We Last Met

- The First Wave of Affordable Care Act (ACA) Reforms In Place
  - What issues are still in play?
  - Is the law Constitutional?
    - Supreme Court heard case last month, decision in June
    - Day one – arguments under Anti-Injunction Act
    - Day two – arguments related to Interstate Commerce Clause
    - Day three – Medicaid expansion and severability issues

Which Way Will the Justices Lean?

- Justice Kennedy . . .
  - "And here the government is saying that the Federal Government has a duty to tell the individual citizen that it must act, and that is different from what we have in previous cases, **and that changes the relationship of the Federal Government to the individual in a very fundamental way**."

Which Way Will the Justices Lean

- Justice Scalia:
  - "We're not stupid. They're going to buy insurance later. They're young and need the money now."
  - Health care is like a health club membership . . . If you don't exercise, cost of health care goes up, so government can force you to join a health club
- Justice Alito
  - Health insurance is like burial insurance and do we mandate that coverage?

Since We Last Met

- HHS Activity With Respect to HIPAA and HITECH
  - Final regulations under HITECH at OMB and due out ANY DAY
  - HHS audit initiative announced
  - Huge HIPAA breach assessment against health plan for stolen laptops
  - New Interim Final regulations provide standard for ACH EFT

The Administration's Budget Proposal

- No direct impact on Flex, FSAs, HRAs, HSAs, but …
  - Proposal to cap health (and other) exclusions and deductions for high income taxpayers at 28%
    - Makes Flex and other pre-tax benefits less attractive to high income individuals. How would that work?
    - To determine your tax increase (subject to AMT and other complications) take the amount of your current pre-tax expenditure for health care as reflected on W-2 (including salary reduction and employer paid HC) and multiply by 8% if in 36% bracket or 11% if in 39% bracket.
    - Example: The Hickman family HC bill (high deductible coverage at $15,000 per year) times 11% equals an additional $1650 in taxes.

Will We See Such Changes?

- Congress Unanimously rejected budget but
  - Number one tax subsidy is health care (qualified plans, IRAs, pensions, combined are second)
    - Consistent with JCT expenditure analysis
  - Existing Cadillac tax provisions would be a wear-away
  - All Major tax Reform Proposals Target Health Care Tax Subsidies
    - Simpson Bowles – Zero Plan eliminates 106 exclusion
    - Bipartisan
      - Wyden/Coats – Eliminates Section 125 but not 106
      - Domininci/Rivlan – Caps 106, then eliminates over 10 years, eliminates HSAs over 10 years
    - Ryan – Proposal before 111th Congress eliminates 106, but retains HSAs

PPACA and Its Impact on Employer Provided Health Coverage

What We Will Cover

- Health Care Reform: A High Level Recap and Update
  - Where are we now
  - Where are we going
- What does it all mean ?
  - Will employers play or pay?
  - Focus on Self Funded
  - Focus on FSAs
  - Focus on HRAs
    - New Challenges Under ACA and Otherwise
  - Focus on HSAs

The New Health Care Coverage Landscape—General Overview

- Health Care Reforms
  - 2 waves of mandates for Group Health Plans
    - FPY on/after 9/23/2010
    - FPY on/after 1/1/2014
- Health Care Exchange in 2014
  - New Regs regarding minimum essential coverage
- Individual Mandate in 2014
  - Supreme Court hearing in March, decision by June
  - What if it's unconstitutional?
- Employer "pay or play" mandate in 2014
  - Agencies Requested Input
- Tax Provisions

The New Health Care Coverage Landscape—Changes in Effect Prior to 2014

- Implementation Timeline
  - Changes effective in 2010
    - Change in "dependent" definition for purposes of health plan tax exclusions ("child" through age 26)
      - » Coverage and Plan changes
    - Small employer tax credit
      - » In 2014 restricted to exchange coverage
  - Immediate Health Care Reform (First PY beginning on or after 9/23/10)—Wave #1 of Health Reforms
  - Changes effective January 1, 2011
    - Limits on OTC benefits
    - SIMPLE Cafeteria Plan Rules for Small employers
  - W-2 reporting for coverage cost delayed until 2012 (first report in 2013)
    - Special exceptions for most FSAs, small employers, and HRAs
  - Changes effective January 1, 2013
    - Loss of Medicare Part D retiree subsidy deduction
    - $2500 cap on FSA salary reductions

The New Health Care Coverage Landscape—Changes in Effect On and After 2014

- Changes Effective in 2014
  - Individual mandate
  - Employer play or pay requirement
  - Employer Coverage Reporting
    - Required to Report Minimum Essential Coverage and premium Costs in 2014
    - Applies to insurers and self funded plans
  - Exchanges
- Changes generally effective first plan year on/after January 1, 2014—
  - Wave #2 of Health Reforms
  - Employer Quality of Care Coverage Reporting
    - Will require information on health care outcome, safety, and wellness
    - Regulations due by March 23rd
    - Must Make available to enrollees and on internet
- Changes Effective in 2018
  - "Cadillac Plan" excise tax

Health Reforms---What is a group health plan?

- Reforms added to the HIPAA portability subparts of ERISA and the IRC
- This means that:
  - Liability for failing to comply w/reforms is same as violating HIPAA portability under ERISA/Code
    - Specific performance under ERISA
    - $100/day penalty under IRC and HIPAA
    - Mandatory Self-Reporting and excise tax for violations (Form 8928)
  - The reforms do not apply to:
    - Excepted Benefits (such as stand alone and non-integrated dental, vision, Health FSA)
    - Stand alone retiree plans
    - Delayed effective date for certain requirements for grandfathered plans

  Note: Other aspects of PPACA such as tax changes do apply.

Grandfathered Plans Overview

- Grandfathered plans are permanently exempt from the following reforms:
  - Preventive services
  - Limits on cost sharing
  - Reporting requirements
  - Appeals process
  - Selection of doctors and referral requirements
  - Coverage of clinical trials
  - No discrimination against providers

Grandfathered Plans

- Grandfathered plans *are* subject to the following requirements:
  - Uniform explanation of coverage (Summary of Coverage)
  - Cost reporting and rebates
  - Notification of availability of the exchange and subsidies
  - Prohibition on lifetime/annual limits (FPY 6 months after enactment)
  - Limitation on preexisting condition exclusions (FPY 6 months after enactment for children under 18 and 2014 for adults)
  - Prohibition on rescissions (FPY 6 months after enactment)
  - Limitation on waiting periods (FPY 2014)
  - Coverage of adult children; (FPY 6 months after enactment however, for years before 2014, the coverage requirement applies only if the adult child is not eligible to enroll in another eligible employer plan)

Grandfathered Plans

- Interim Final Regulations issued 6/14/2010
    - FAQ Guidance Parts I, II, IV and new guidance issued April 1, 2011 (Q/A Part VI)
- A plan is a grandfathered plan with respect to individuals who were enrolled on March 23, 2010. The plan does not stop being a grandfathered plan because individuals enrolled on that date cease to be covered, provided that the plan has continuously covered someone since March 23, 2010.
    - Family members may be added
    - "New employees" (newly eligible and newly hired) may be added
    - Two anti abuse rules
        - Merger and acquisition
        - Employer initiated transfer to another option/plan
- Regulations apply separately to each benefit package option offered under a plan
    - A single ERISA plan may have multiple benefit options

Grandfathered Health Plans

- What changes cause loss of grandfather status?
  - Bucket #1: Elimination of all or substantially all benefits to diagnose or treat particular condition (no recent guidance)
  - Bucket #2: Any increase in percentage cost-sharing
    - FAQs Part VI provide that reclassifying brand-name drug to new cost-sharing tier when generic alternative becomes available does not cause loss of grandfather status

Grandfathered Health Plans

- What changes cause loss of grandfather status?
  - Bucket #3: Increase in fixed-amount cost-sharing of more than $5 or 15% above medical inflation
    - FAQ Part II clarifies that this applies even to co-payments that are for a single category of service
    - FAQ Part VI provides that certain changes to implement a value-based insurance design do not cause loss of grandfather status

Grandfathered Health Plans

- What changes cause loss of grandfather status?
  - Bucket #4: Decrease in employer contribution rate of more than 5 percentage points below rate on 3/23/10
    - Applies to rate for any tier of similarly situated individuals
    - FAQ Part II clarifies that if tiers are restructured (e.g., single/family to single, plus one, family), then each new tier must be evaluated against corresponding prior tier
    - FAQ Part VI provides that if employer's contribution rate changes as a result of increases in costs but not increases in the formula, it is not considered a decrease for this purpose
      - Example: Retiree formula that is fixed dollar multiplied by years of service subject to flat dollar cap

Grandfathered Health Plans

- What changes cause loss of grandfather status?
  - Bucket #5: Certain changes to annual limits (no recent guidance)
    - Lowering an annual limit in place on 3/23/10
    - For a plan with no limits on 3/23/10, adding an annual or lifetime limit
    - For a plan with a lifetime (but no annual) limit on 3/23/10, imposing an annual limit that is lower than the lifetime limit
    - Still unclear how newly added treatment specific limits would be measured under these rules

Prohibition on Lifetime and Annual Limits (ALL)

- Interim final regulations
  - Essential benefits defined by statute -- HHS leaves determination of essential benefits to states
  - Minimum allowable annual restrictions
    - $750k PY before 9/23/2011
    - $1.25M PY before 9/23/2012
    - $2M PY before 9/23/2014
- Implementation Issues related to Scope of prohibition
  - Financial limits only
    - While day or treatment limits generally "ok" be wary of impact on GF status and combination of financial cap and per day/treatment limit
  - Prohibition is on any EHB (not just aggregate caps)
  - What benefits are "essential" (Chiro, Fertility treatment, Transplants)?
    - Agency guidance provides that states will make determination
    - Issues for multi-state self funded plans
  - Scope of special enrollment rights for newly eligible
  - Impact on HRAs
  - Limited Time Waiver program for "mini-med" plans now closed

Prohibition on Rescissions (ALL)

- No rescission of coverage is permitted except in cases of fraud or intentional misrepresentation
  - Interim final regulations define rescission as any retroactive termination of coverage other than for non-payment of premium
  - Permissible rescission (e.g., for fraud, intentional misrepresentation) requires at least 30 days notice.
  - Termination for nonpayment of premiums not a rescission
- Implementation issues
  - How to handle ineligible participant/dependent terminations
    - Some good informal FAQ guidance for COBRA events
    - What about immediately eligible dependents
  - How to handle administrative errors

New Claim Appeals Process (NGF)

- Changes for ERISA plans
  - Definition of "adverse benefit determination"
    - Now includes rescission determinations
  - Urgent Care Timeframe
    - Amended regulations retain 72 hour period
  - Appeals Procedure
    - Access to documents
    - Right to present "testimony"
  - Conflicts of Interest
  - Denial Notice Content
    - Certain additional content applicable FPY on/after July 1, 2011
    - Amended regulations clarify that treatment/diagnosis codes need not be provided in claims and appeal determinations unless requested
    - CLA requirement clarified based on county-wide statistics
  - Strict Adherence
    - Modified consistent with court decisions (deminimis, good faith, for cause exceptions)
  - External review
    - Modified so that only applies to rescissions and decisions requiring medical judgment

External Review: FYA 9/23/10

- External review applies for both GHPs and insurers
  - State or federal external review process must be followed
- No grace period for external review rules
- (for plans subject to federal external review) Only issues that involve medical judgment or rescission are subject to external review
  - Medical necessity, experimental/investigational, medical appropriateness, etc.
  - Other adverse benefit determinations not subject to external review

Dependent Coverage Mandate

- Required coverage for children until age 26
  - Plans that cover children must make coverage available for employees' children until age 26
    - Marital status of the child is not relevant (but a child's children/spouse need not be covered)
    - Eligibility is definable only by the child's relationship with the employee (residency, financial dependence, student status, or employment cannot be used—because of age correlation)
  - Terms and conditions of coverage cannot vary based on age ("uniformity requirement")
    - Example: Premium surcharge for over age 18 not OK
  - Effective for plan years beginning on or after 9/23/10
    - Until 2014, grandfathered plans need not cover child with other employer coverage available (not through parent)

Dependent Coverage Mandate

- Under related tax rule, coverage is nontaxable until December 31st in year that child turns 26
  - Tax rule defines "child" using Code § 152(f)(1) definition—
    - Son or daughter (generally biological)
    - Legally adopted son or daughter (or one placed for adoption)
    - Stepson or stepdaughter
    - Eligible foster child
  - The new rules do not affect state tax treatment of coverage provided to employees' children
    - All states (including WI) now conform to federal tax treatment

Dependent Coverage Mandate

- Other practical issues in complying with mandate
  - Grandfathered plans can limit, but is it worth it?
    - Only available until 2014
    - May be cumbersome to track other coverage
    - Transient coverage could increase special enrollments
  - Mandate is not applicable to "excepted benefits"
    - But employers may prefer to apply uniform eligibility and extend dependent coverage under other plans (e.g., health FSA, stand-alone dental)
      - Tax rule will make most coverage nontaxable
  - Mandate and tax rule applies to HDHPs, but not HSAs
    - Expenses of nondependent children are not reimbursable by HSA because HSA rules not yet amended
    - But nondependent child could have his or her own HSA

Additional FYA 9/23/2010 Mandates

- (ALL) No pre-existing condition exclusions on enrollees under age 19
  - Could apply to young employees, spouse or dependent children
  - Implementation issues
    - Determine if any pre-ex in plan may apply to children
- (NGF) First dollar coverage (i.e., no cost-sharing) must be provided for certain evidence-based preventive care (including well-child care) and certain immunizations
  - Regulations allow for network and medical management restrictions
  - Implementation issues
    - Conform wellness/preventive care to list and ensure no cost sharing applies
    - Issues with regard to contraceptives
      - » Insurer/TPA may be required to provide benefit
    - How to communicate list of covered expenses to participants
    - Difficulty with interplay between essential benefits (no annual/lifetime cap) and preventive care caps.

Additional FYA 9/23/2010 Mandates

- (ALL) Prepare and distribute a new "Summary of Coverage"
  - Distributed at enrollment, no more than 4 pages, and 12pt font
  - Notice of material changes in Summary required 60 days prior to effective date
  - Final regulation issued February 2012
  - Required to be distributed for annual enrollments beginning September 23rd 2012
- (NGF) Fully insured plans sponsored by employers will generally be required to satisfy the same Section 105(h) discrimination requirements that apply to self-funded plans
  - Impact on executive comp arrangements designed to avoid 409A
  - Likely no small employer exception
  - Guidance provides for delay until FPY after regulations
  - Applicable to premium reimbursement plans (not subject to 105(h)?
  - Penalty is $100 per day excise tax (self reported) for affected participant

Additional FYA 9/23/2010 Mandates

- (NGF) Special rules regarding health care providers:
  - Plan enrollees are allowed to select their primary care provider, or pediatrician, from any available participating providers;
  - Precludes prior authorization or increased cost-sharing for emergency services, whether in-network or out-of-network
    - Interim final regulations require payment at greater of network rate, out of network rate, or Medicare rate; and
  - Precludes plans from requiring authorization or referral by the plan for obstetrical or gynecological care
  - Interim final regulations impose notice requirements

Effective in 2011

- No reimbursement of OTC medicines or drugs (except insulin) by health FSA, HRA, or HSA without prescription
  - Related to expenses incurred in calendar year 2011; not based on "plan year"
  - Notice 2011-5 Provided Guidance on health debit cards
    - Impact on participation rates and administration costs?
    - Recent study by CHPA re: OTC cost efficiency

CER Fees Effective in 2012

- Comparative Effectiveness Research CER Fees payable for plan years ending after 9/30/2012
  - For Calendar year plan, payable for 2012 PY
  - (IRS Notice 2011-35 request for comments)
- For the first year for which the fee is effective, it is $1 multiplied by the ***average number of covered lives***. The rate of the fee increases to $2 for the next year and is indexed thereafter.

- Issues for HRAs, EAPs, non-exempt FSAs

W-2 Reporting for 2012 Coverage

- Employers must report aggregate value of employer-sponsored coverage on Form W-2 (reports due 2013 for 2012 coverage)
  - Includes COBRA rate of all health coverage subject to Cadillac tax
  - Are payroll systems in place to capture amounts
  - Retirees not already required to receive W2 not subject to this requirement
  - Transitional rule exception for employers with fewer than 250 W-2s

W2 Guidance

- IRS guidance on this issue so far:
  - IRS Notice 2011-28
    - Effective for 2012 Forms W-2, Qs & As providing guidance on requirement.
  - IRS Notice 2012-9
    - Amends and Restates Notice 2011-28, adding additional guidance and clarification.
    - Among other things, clarifies reporting for HRAs (Q33), health FSAs (Q-19), vision and dental (Q-20), wellness and EAP (Q-32).
    - (Q-37-38) Cancer, Hospital Indemnity and Other Supplemental Health coverage must report cafeteria plan salary reductions and employer contributions
      - » Accident coverage, disability coverage, dental and vision coverage not required to report value of coverage

Effective in 2013

- Health FSA salary reductions limited to $2,500 each year
    - The cap is indexed to the CPI starting in 2014
    - Interpretation issues
        - Calendar year mandate
        - Plan year approach
    - Does this open door to elimination of use/lose rule?
- Deduction previously permitted for amounts allocable to the Medicare Part D subsidy for prescription drug plans is eliminated
    - FAS 106 impact and impact on balance sheets

Reforms Effective Plan Years On/After 2014

- (ALL) No preexisting condition exclusions or limitations are permitted
- (ALL) Prohibition on excessive waiting periods—i.e. no waiting period in excess of 90 days
- (NGF) Fair Health Insurance Premiums (applicable only to health insurers)
  - Limitations on premium setting (e.g. limitations on premium setting based on age, tobacco use)
  - Indirect impact on self insured plans?

Reforms Effective Plan Years On/After 2014

- (NGF) No discrimination based on health status is permitted
  - Essentially, the same rules that currently exist under HIPAA
  - The bill raises maximum incentive amount for wellness programs that provide the incentive based on achieving a health standard from 20 to 30 percent of the COBRA cost of coverage
    - Also gives the Secretaries of Labor, HHS, and the Treasury leeway to increase the percentage to 50 percent
- (NGF) Cost limitations
  - Out-of-pocket expenses do not exceed the amount applicable to coverage related to health savings accounts (HSAs)
  - Deductibles do not exceed $2,000 for single coverage and $4,000 for family coverage (as indexed)
    - Unclear whether deductible requirement may only apply to fully insured plans in small group market
    - Query: Can you ever have a "bronze plan" once this requirement applies?

Reforms Effective Plan Years On/After 2014

- (NGF) Fully insured plans in small group market must provide essential benefits
    - Not applicable to fully insured plans in large group market and self insured plans
    - Self insured plans NOT required to provide essential benefits
- (NGF) Group and individual plans are required to cover routine costs
  of participation in certain clinical trials by qualified individuals
- (NGF) No nondiscrimination against providers who act within the scope of their license
    - Not an any willing provider statute

Health Insurance Exchange

- PPACA provides funds to states to establish a health insurance exchange through which individuals may purchase health insurance beginning in 2014
- Exchange-related provisions in PPACA impact employers in the following ways:
    - Beginning in 2017, states may allow all employers of any size to offer coverage through the exchange
        - Prior to 2017, only small employers - employers with 100 employees or less (except in states that limit small employers to employers with 50 or fewer employees)—may participate
    - Employers who offer coverage through the exchange may permit employees to pay for such coverage with pre-tax dollars through the employer's cafeteria plan

Employer Responsibility

- Effective January 1, 2014 - play or pay mandate #1:
  - Employers with 50 or more full-time "applicable" employees are subject to the following penalties related to coverage that they offer or fail to offer to full-time employees:
    - Applicable employers who fail to offer full-time employees health coverage must pay a penalty with respect to each full-time employee in any month in which any full-time employee receives a federal subsidy for the exchange
      - » The penalty is determined on a monthly basis and is the product of the total number of full-time employees of the employer (over 30) for that month and 1/12 of $2000 (up from $750)
      - » For example, a business with 51 employees that does not offer coverage is subject to tax equal to 21 times the applicable payment amount

Employer Responsibility

- Effective January 1, 2014 - play or pay mandate #1 (cont'd):
  - Part-time employees are taken into account solely for the purpose of determining if an employer has at least 50 employees
    - The number of full-time employees otherwise determined is increased by dividing the aggregate number of hours of service of employees who are not full-time employees by 120
  - Employers who are "applicable large employers" solely because of seasonal employees who are otherwise full-time employees and that work less than 120 days during the year are NOT considered "applicable large employers"

Employer Responsibility

- Effective January 1, 2014 - play or pay mandate #2:
  - Even when coverage is extended, applicable employers who offer coverage for any month to a full-time employee who is certified as having enrolled in the exchange and received a tax subsidy is subject to a penalty equal to the product of the total number of such employees who have received a tax subsidy and 1/12 of $3000 (capped at 1/12 of $2000 times the total number of full-time employees during such month)
    - » Note: employees offered employer coverage are not eligible for a credit unless their required premium exceeds 9.5% of household income or the plan's share of allowed costs is less than 60%.

Weighing the Pay or Play Decision

- If coverage is dropped
  - Nondeductible excise tax of $2000 per FTE (real cost higher deduction)
  - Pressure to increase taxable wages to pay for exchange coverage
  - Uncertainty as to whether coverage is purchased
  - Exchange risk of higher cost
    - Adverse selection
    - Mandated benefits
- If coverage continues
  - Cost of continuing coverage
    - Costs are deductible
    - Subsidy is variable
  - Potential competitive advantage of offering better/lower cost coverage
  - More freedom over coverage options
  - Potential risk pool advantage

Auto-enrollment for employers with more than 200 employees

- Effective date?
  - Provision has no separate effective date,
  - But recent q/a guidance indicates likely NOT effective until some time after 2014
- What plans does it apply to?
  - Excepted benefits ? Likely not.
- How does it apply with regard to cafeteria plan rules

Cadillac Plan Tax

- Beginning in 2018, PPACA (as modified by the Reconciliation Bill) imposes a 40 percent excise tax on:
  - "Coverage providers:" for the sum of months in which the aggregate value of employer sponsored health coverage for the employee exceeds:
    - 1/12 of $10,200 for single coverage and $27,500 for family coverage
      - The higher family threshold applies to both single and family coverage offered under a multiemployer plan
      - These amounts are to be adjusted automatically if health costs increase by more than anticipated before 2018
      - The thresholds are increased by CPI + 1 in 2019, and by CPI thereafter
      - An employer may make an adjustment to reduce the cost of plans when calculating the tax if the employer's age and gender demographics are not representative of a national average
      - The PPACA transition rule for high cost states does not apply
    - The annual limit for retirees between ages 55 and 64, individuals engaged in certain high-risk professions (e.g., law enforcement professionals, EMTs, longshoremen, construction workers, and miners), and those employed to install electrical or telecommunication lines is increased to $11,850 for individual coverage and $30,950 for family coverage

Cadillac Plan Tax

- Determined by the employer and assessed against "coverage providers"
  - "Coverage providers" are defined to include the following:
    - In the case of fully insured plans, the health insurer
    - In the case of HSA or medical savings account (MSA) contributions, the employer making the contributions
    - In the case of a self-insured plan or flexible spending account (FSA), the person that administers the plan (e.g., the TPA)
  - In many cases, employer-sponsored coverage will include both fully insured and self-insured contributions (it may also include HSA contributions)
    - The coverage provider's applicable share of the tax will bear the same ratio to the total excess benefit as the cost of the coverage provider's coverage to the total value of employer-sponsored coverage

Cadillac Plan Tax

- The coverage subject to the excise tax rule includes:
  - The applicable premium (determined in accordance with COBRA rules) for all accident and health coverage provided by the employer, even if paid for with after-tax dollars by the employee (except vision only insurance, dental insurance, accident and disability insurance, long-term care insurance, and after-tax funded hospital indemnity and/or specified disease coverage)
  - Both non-elective and salary reduction contributions to a health FSA
  - Employer contributions (presumably including salary reductions) to an HSA

Other New Taxes

- Several new taxes are imposed, including:
  - Indoor tanning procedures effective for services performed on or after July 1, 2010)
  - New sector tax on health insurers (but not self-insured plans or TPAs) beginning in 2014
  - 0.9 percent increase in Medicare taxes for those earning more than $200,000 for single individuals and $250,000 for joint filers (effective beginning in 2013)
    - Such individuals would also be subject to a 3.8% tax on their net investment income (to the extent that total income exceeds the thresholds)
    - This new tax would be effective starting in 2013
  - CER fee: A fee equal to $2 ($1 in 2013) multiplied by average number of covered lives imposed. Applies to both fully insured and self insured plans.

What Does it All Mean?

- What does it all mean for employer-sponsored health coverage?
  - Self-funding before PPACA
  - Self-funding after PPACA
- What does it all mean for Individual account based plans?
  - Focus on FSAs
  - Focus on HRAs
    - New Challenges Under ACA and Otherwise
  - Focus on HSAs

Self-Funding Before Health Care Reform

- Advantages
  - Maximum flexibility with respect to plan design without regard to state mandates
    - Uniform schedule of benefits across many states
  - Premium taxes generally not assessed against self-funded portion
  - For “Good risk” employers self funded plans are not subject to risk pooling
    - Small group insured market (state regulation impacting guarantee issue and rates)
    - Medium/large group insured market (carrier risk pooling)

Self-Funding Before Health Care Reform

- State Efforts to Avoid Adverse Selection for Small Group Risk Pool
  - Some states prohibit issuance of stop loss coverage below certain thresholds
    - Number of covered employees
      - » NY, DE, NC
    - Minimum attachment point
      - » MD, NV, NH, VT

Self-Funding Before Health Care Reform

- Disadvantages
  - Claims Risk
    - Potential Mitigation Through Stop-loss Coverage
  - Additional Infrastructure Requirements for Employer
    - Document Maintenance: Plan Documents and SPDs
    - Addressing employee questions
    - Potential outsourcing to TPAs

Self-Funding Before Health Care Reform

- Disadvantages
  - Compliance-Related Risks/Obligations
    - HIPAA Privacy
      - » Privacy officer
      - » Privacy and Security policies
      - » Recordkeeping requirements and Breach Notification
    - ERISA
      - » Plan document/SPD Maintenance
      - » Claim fiduciary role
      - » Potential additional complexity fro Form 5500
    - COBRA and HIPAA Certificates
    - Tax Nondiscrimination testing under IRC Section 105(h)

PPACA Scorecard: Insured vs Self Funding

- Factors to review and consider . . .
  - Traditional self-funding advantages
    - Avoid state law mandates, premium taxes, etc
    - Nondiscrimination testing will apply to insured and self-funded
  - Essential Benefit requirement
    - Applies only to small insured plans requires insured plans to INCREASE coverage (and cost)
  - Sector tax on insurers
    - Only applies with regard to insured coverage resulting in increased costs
  - MLR requirement
    - Impacts profitability of insured coverage
  - Limitations on "Unreasonable" premium increases for insurers

PPACA Scorecard: Insured vs. Self Funding

- Factors to review and consider . . .
  - Adverse Selection Risk for Exchange
    - Employers will self fund until high risk (e.g., high claims employee) and then unload risk onto exchange and fully insured coverage, and then resume self funding once risk subsides
  - Impact of risk pooling/smoothing
    - Insurers generally required to pool exchange and non-exchange risks thereby spreading increased risk of exchange to non-exchange plans
  - Impact of Cadillac tax and group-centric wellness activities
    - Employers with healthy workforces and/or aggressive wellness plans will seek to internalize "health/wellness" gains by self funding rather than pooling risk in insured plans

PPACA Scorecard: Impact of PPACA on FSAs

- Generally excepted from PPACA as an excepted benefit
- Permitted (not required) to cover children up to 26
    - Changes to plan documents, SPDs, etc.
- In 2011 OTC medicines and drugs require an Rx
    - Additional manual administration, but IIAS automation allowed by IRS in Notice 2011-5
- Simple Cafeteria Plan Provisions
    - When applicable, possibly provides pre-tax coverage option for some small employers
        - Company comprised of only key employees or HCEs (for DCAP test)

PPACA Scorecard: Impact of PPACA on FSAs

- In 2013 FSA salary reductions cannot exceed $2500
  - Administration issues for non-calendar year plans
  - May open the door for elimination of use/lose rule
    - Impact on grace period?
    - Impact on elections?

PPACA Scorecard: Impact of PPACA on FSAs

- Impact of 2014 Marketplace changes
  - Some of "gap" that FSAs typically fill will be taken up by more robust mandated coverages but many employers will convert to self funded to avoid such mandates, which could preserve greater room for FSAs;
  - As costs to comply with PPACA continue to increase (in particular the increase in delivery costs due to the health insurance reforms), employers may shift more traditional health coverage responsibility (coinsurance/deductibles) to employees, which may also preserve role of FSAs
  - Employers who drop coverage in 2014 due to market factors such as pay or play penalty/existence of exchange may desire to "stay in game" with FSA
- FSA benefits will be counted for Cadillac Tax
  - Likely a "crowding out" impact beginning in 2018

PPACA Scorecard: HRAs

- In 2011 OTC medicines and drugs require an Rx
- Limited term W-2 reporting exception; no SBC exception
- Some HRAs are exempt from most of PPACA
    - Limited scope vision, dental, and retiree only coverage
- Non-exempt HRAs will be especially impacted (square peg, round hole) by
    - Annual cap prohibition
        - Qualification for regulatory FSA exemption (5 times rule)
        - Qualification for "mini-med" waiver until 2014 for plans in existence 9/21/2013
    - Claims requirements and external review
    - SBC requirements
- Limits on deductible and OOP will constrict plan design in 2014
- Subject to Cadillac Tax in 2018

PPACA Scorecard: HRAs

- Will market changes (elimination of underwriting/exchange) open door for defined contribution health plans?
  - Retiree medical only plans
    - PPACA mandates are n/a
    - Limits on insurer underwriting (3/1 age based variance) make this an attractive pre-65 option
  - Active employee plans have outstanding issues
    - Will stand-alone HRA violate prohibition on annual caps
    - Will employer get credit for play/pay purposes as minimum essential coverage
    - Can employee receive both employer reimbursement and exchange subsidy?
      - » Nondiscrimination issues for employer arrangements unavailable to lower paid employees

PPACA Scorecard: HSAs

- Subject to separate W-2 reporting,
- In 2011 OTC medicines and drugs require an Rx
- Excise tax for non-health care distributions increased to 20%
- New "mismatch" between dependent for HDHP eligibility purposes and tax free distribution purposes
- Some concern with regard to viability of HDHP coverage under actuarial valuation requirements
    - Agency bulletin provides for crediting of portion of annual value of employer funded HRA/HSA toward actuarial value of underlying coverage
- Limits on deductible and OOP for employer group coverage (but not health insurance issuers) will constrict plan design in 2014
- Salary reductions and employer contributions likely subject to Cadillac tax

HITECH Amendments to HIPAA Privacy & Security Rules

Amended HIPAA Privacy and Security Rules

- HIPAA Amendments are in The Health Information Technology for Economic and Clinical Health Act (HITECH) provisions of The American Recovery & Reinvestment Act of 2009 (ARRA).
- Effective Date: February 17, 2010, except as otherwise noted.
  - HITECH Breach requirements effective September 23, 2009 (enforcement moratorium until approximately February 23, 2010)
  - Proposed HITECH Regulations provide for transition period until 180 days after effective date of final regulations for compliance and until 12 months after effective date to get business associate agreements updated.

Overview of Amendments to HIPAA Privacy and Security Rules

- Expanded Obligations of Business Associates (BAs)
  - Security
  - Privacy
- Affirmative Notification of Breach Requirements
- Guidance on "Minimum Necessary" Standard
- Prohibition on Sale of PHI
- Restrictions on Marketing
  - Potential impact on some revenue sharing arrangements
- Application to Personal Health Records (PHR) Vendors
  - FTC Enforcement
- Increased Enforcement and Penalties, including application to BAs

Expanded Obligations of Business Associates (BAs)

- Pre-HITECH Rule:
  - BAs were not directly subject to the HIPAA Privacy and Security Rules. Rather, their duties arose out of their BA Agreements.
- Revise BAAs to incorporate expanded Privacy and Security Rule obligations.
- Civil and criminal penalties now apply directly to BAs.

Expanded Obligations of BAs (con't)

- Expanded Security Rule Obligations:
  - Security Rule obligations that govern Administrative, Physical and Technical Safeguards, and require Security Policies and Procedures, now apply directly to BAs.
  - BAs are also directly subject to additional HITECH requirements, which must be incorporated into BA Agreements.

Expanded Requirements for BAs

- *Most* security requirements to apply directly to BAs
  - Pre- HITECH—security requirements not directly imposed on BAs
    - BA only contractually obligated to CE to safeguard ePHI
  - Post- HITECH—effective Feb. 17, 2010, most HIPAA security requirements apply directly to BAs
    - Establish administrative safeguards to protect ePHI
    - Implement physical safeguards to limit physical access to ePHI
    - Implement technical safeguards for electronic information systems that control access to ePHI
    - Implement reasonable and appropriate policies and procedures and maintain proper documentation

Expanded Requirements for BAs

- Changes to business associate contracts
  - CEs (including GHPs) should review their BA contracts and be prepared to make needed modifications
    - Proposed regulations allow for transition period for updating contracts until 12 months after effective date of final rules
  - BAs (TPAs and other service providers) should take a proactive approach to identifying their status as a BA and entering into BA contracts with CEs, when required
    - Review existing safeguards and policies and procedures to determine what gaps exist relative to enhanced obligations
      - » Some BAs may be more prepared than others but all need to have formal compliance program going forward
      - » Note: Requirements would seem to apply even if BA and CE fail to execute a written BA contract (perhaps, unknowingly)