

ERISA Issues Under the ACA (and Beyond)

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Overview of Today's Discussion

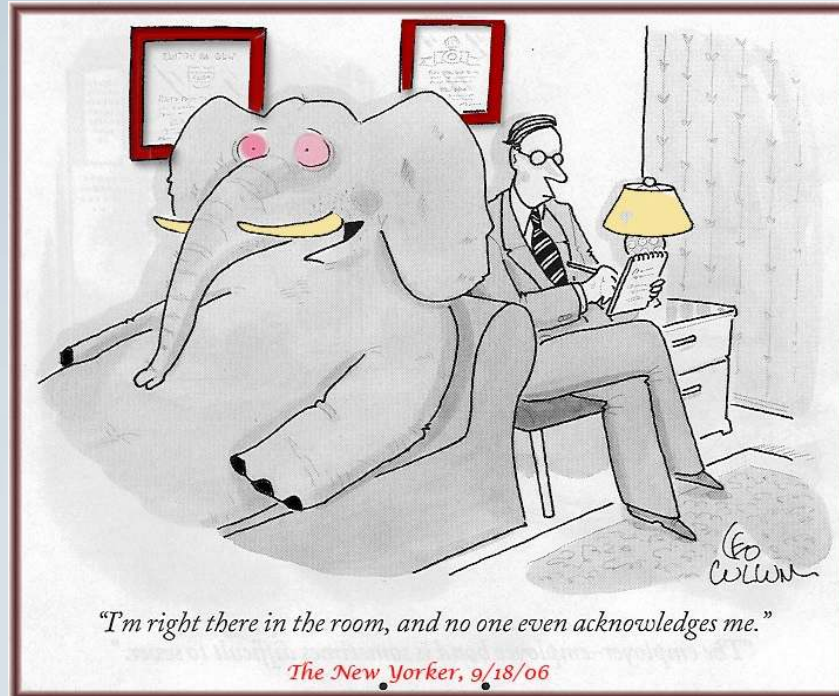
- Focus on implications of health reform to issuers in their roles as underwriters of, and ASOs to, group plan coverage
- Where we are now in terms of ACA implementation
 - Anticipated SCOTUS decision
 - Implications of decision to ERISA plans under alternative scenarios
- ERISA issues beyond the ACA

Where Are We Now with ACA and ERISA Plans?

- Most insurance reforms implemented
 - But wait... a few more to come...
- Rate review ongoing
- SBCs
 - On your mark, get set...
- MLR rebates
 - Sub-regulatory rulemaking ongoing, much remains unclear
 - First round of rebates due out VERY soon
 - ERISA implications

SCOTUS Decision

- “Damned if they do, damned if they don’t”
 - Compliance challenges loom for ERISA plan sponsors, ASOs, and small and large group issuers regardless of SCOTUS decision



SCOTUS Decision

- If ACA is overturned in whole or in part –
 - What can be retained voluntarily?
 - Post-decision administrative and legislative landscape remains hard to predict
 - But expect regulators to seek to preserve or reissue certain regulations under existing non-ACA authority
 - Many ACA provisions likely could be preserved at the election of the employer plan sponsor or group issuer
 - For example: age 26 dependent coverage, enhanced preventive care, no lifetime limits, increased annual limits
 - » Consider tax consequences regarding retaining age 26 coverage
 - Employer and employee expectations
 - Market factors/competitive analysis with respect to insured ERISA group products

SCOTUS Decision

- If ACA is overturned in whole or in part –
 - What can be retained voluntarily?
 - Interesting state law issues are likely to arise regarding insured group coverage
 - Could be required to maintain certain of the insurance reforms, such as:
 - » Age 26 dependent coverage
 - » Enhanced preventive care
 - » No lifetime limits
 - » Caps on annual limits
 - » Expanded claims and appeals
 - » Limitations on the use of pre-existing condition exclusions
 - Whether this is the case, could turn on nature of state law as self-executing
 - Thus, need to review all applicable state laws

SCOTUS Decision

- If ACA is overturned in whole or in part –
 - What can be undone or voided... and how?
 - Likely will depend on state law issue and whether regulators seek to use existing rulemaking authority to preserve or reissue certain ACA-specific provisions
 - *E.g.*, expanded claims and appeals rules for group coverage
 - Regarding the “how”
 - What are your contractual obligations as issuer or ASO?
 - » To what extent do you need to act or do you need the plan sponsor to act to return to pre-ACA status quo?
 - Does it trigger ERISA notice requirements
 - » *E.g.*, summaries of material modifications (SMMs)
 - What about claims incurred?
 - » Consideration should be given to whether a previously incurred claim must be reviewed under pre-SCOTUS decision plan terms

SCOTUS Decision

- If ACA is overturned in whole or in part –
 - Do I still get paid? And what if I owe money?
 - Implications to federal funds and commercial contracts regarding ERISA plans
 - Such as the \$5 billion of ERRP monies that have been received or are expected by employers
 - Limited precedent
 - Commentators have indicated that past precedent suggests you get to keep whatever money you have received from the government or under the commercial contract for services rendered
 - » But have little to no rights to expected payments
 - » Litigation should be expected regarding commercial contracts
 - ERISA implications
 - Did you receive plan assets in anticipation of future services to the plan? What if you retain the assets but aren't required to provide the services, could this give rise to fiduciary/PT liability?

SCOTUS Decision

- If ACA is upheld as constitutional
 - Congrats... it's like a pie-eating contest
 - More of the same from the perspective of compliance
 - If you took the foot off the accelerator, need to get back up to speed
 - 2014 is around the corner (with state exchanges, mandates, likely nondiscrimination testing)
 - But anticipate post-11/6 legislative activity



Summary of Benefits and Coverage

- Technical content and form issues
 - How to describe the plan coverage terms in the SBC format
 - Especially with medical savings account plans that may not be excepted (such as stand-alone HRAs)
 - Inconsistency between instructions and sample form
 - Limited space, *e.g.*, for names of plan and plan sponsor
 - Can deviate from requirements
 - How to address carve-outs such as mental health, Rx
 - Questions arising regarding reliability of SBC calculator outputs
- Notice requirements
 - J&S liability on issuers under general rules
 - Asymmetry/incomplete information for issuers
 - Sub-regulatory notice safe harbor for issuers
 - Expanded e-delivery rule for group coverage where the SBC is delivered “in connection with” online enrollment
 - What if online enrollment is merely optional?

Form W-2 Reporting

- Effective date: optional for 2011, mandatory for 2012
 - Transitional rule for small employers
 - Employers filing fewer than 250 Forms W-2 for the preceding calendar year are not subject to the reporting requirement
 - Does not apply across the employer's controlled group
 - Exception for mid-year requests for Forms W-2
- Requires Form W-2 reporting of “aggregate cost” of all “applicable employer-sponsored coverage”
 - Generally use COBRA rates to determine “aggregate cost” and COBRA definition of “group health plan”
 - Applies to coverage paid with pre-tax and post-tax dollars
 - Applies to nonspouse/nondependent coverage
- Applies only to those employees otherwise due a Form W-2

What Plans Are Subject to Reporting?

- Applies generally to all “applicable employer-sponsored coverage”

IN



- ✓ Group health plans, including:
 - Major medical
 - “Mini-med”
 - On-site medical clinics
 - Medicare supplemental
 - Medicare Advantage
 - Employer flex credits into an IRC § 125 health flexible spending arrangement (HFSA)
- ✓ Likely “in” (at least a portion thereof):
 - EAPs *
 - Wellness programs *

* Consider whether “incidental” medical or bundled with major medical

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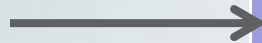


- ✓ “Non-integrated” dental and vision
- ✓ Long-term care
- ✓ Amounts salary reduced into HFSA
- ✓ Health Savings Accounts (HSAs)
- ✓ Health Reimbursement Arrangements (HRAs)
- ✓ Accident, disability and AD&D
- ✓ Workers’ compensation and similar coverage
- ✓ Automobile medical payment
- ✓ Government-provided military coverage
- ✓ Employer contributions to multiemployer plans
- ✓ If HIPAA-excepted and paid on after-tax basis:
 - Hospital or fixed indemnity insurance
 - Specified disease or illness insurance
- ✓ Coverage provided by governments primarily for military and their families

What Plans Are Subject to Reporting? (Cont'd)

- Special rule for “split” programs
 - Where medical benefits are “incidental” to non-medical benefits, no reporting required
 - But, what is “incidental”? More than “de minimis”?
 - Where non-medical benefits are “incidental” to medical benefits, the non-medical portion may be reported
 - Implications beyond the Form W-2 reporting requirement?
 - Example: LTD with medical benefit rider

Incidental?



What Plans Are Subject to Reporting? (Cont'd)

- Considerations for EAPs, wellness and on-site medical:
 - Coverage is only required to be reported to the extent it is applicable employer-sponsored coverage, i.e., a group health plan
 - Note: The Notice provides little meaningful assistance in determining what is applicable employer-sponsored coverage
 - If “split” program and some component thereof provides group health plan coverage, is it “incidental” and can it be disregarded?
 - If not incidental, is separate reporting required?
 - If a separate premium is not charged to COBRA beneficiaries for coverage under EAPs, wellness programs, or on-site medical clinics, then not subject to new reporting requirement
 - If a separate premium is charged, then must separately report
 - Note: The Notice does not address where COBRA coverage is not provided for EAPs, wellness programs, or on-site medical clinics; negative implication is that they are subject to COBRA

Nondiscrimination Testing

- Existing IRC section 105(h) rules for self-funded plans remain in play
 - Regulators appear to be struggling to find statutory authority to make significant changes to outdated regulations
- New rules for insured group health plans as added to PHSA section 2716 by the ACA
 - Currently inapplicable by administrative grace
 - But all good things must come to an end
 - Depending on nature of rules, could have significant implications on insured products
 - Executive-only health
 - Differential premium subsidies
 - Limiting access to Bronze+ coverage to only some

MLR Rebates

- Sub-regulatory rulemaking ongoing, much remains unclear
 - Tax allocation
 - Treatment of intra-company and third party reinsurance
- First round of rebates due out VERY soon
- ERISA implications
 - DOL indicates rebate may be plan assets, depending on governing plan documents
 - Are there opportunities to modify small and large group contracts and plan documents to make clear that some or all of the rebate is not a plan asset?
 - Likely to raise thorny employer relations issues – especially given current notice requirements
 - Potential fiduciary and/or PT liability for the manner in which they calculate their MLR rebates?
- State and federal audits likely
- Penalties?

Exchanges and Employer Shared Responsibilities

- Exchanges
 - Issue of minimum participation requirements post-2013
- Employer shared responsibilities
 - Minimum value calculations
 - Recent IRS Notice indicates minimum value will be based on composite of self-funded ERISA group health plans
 - Implications for incentives to self-fund
 - Stop-loss and self-insurance clearly under review by state and federal regulators
 - Three mechanisms to determine minimum value
 - Calculator, checklist and actuarial valuation
 - Many questions remain
 - » How to account for non-standard plan benefits
 - » Whether the checklists or calculators will prescribe specific benefits
 - Employers are likely to look to issuers as ASOs for assistance in determining minimum value

Exchanges and Employer Shared Responsibilities

- Employer shared responsibilities (con't)
 - Notice requirements
 - IRC section 6055 – Applies to issuers and plan sponsors that provide minimum essential coverage
 - What is its purpose?
 - » To communicate whether a given individual is covered by minimum essential coverage
 - Who gets it?
 - » Employee participants get a statement
 - » IRS gets a return
 - When is it sent?
 - » Annual filing beginning in 2015 (may be in connection with issuance of Form W-2)
 - Who has the obligation to deliver it?
 - » If self-funded, then employer plan sponsor
 - » If insured, Notice 2012-32 contemplates that the issuer would be responsible

Exchanges and Employer Shared Responsibilities

- Employer shared responsibilities (con't)
 - Notice requirements
 - IRC section 6056 – Applies to employers subject to employer mandate
 - What is its purpose?
 - » To allow the IRS to determine whether an employer is subject to penalty under IRC section 4980H and whether an individual is eligible for an IRC section 36B premium tax credit.
 - Who gets it?
 - » Employee participants get a statement
 - » IRS gets a return
 - When is the statement sent?
 - » No later than January 31st of each subsequent year
 - Who has the obligation to deliver it?
 - » Employer in all respects

Fees and Assessments

- Three fees: PCORI, reinsurance assessment, and annual health insurer fee
- All raise very interesting federal tax and ERISA issues
 - PCORI
 - Per capita fee applies to health insurers and sponsors of self-insured group health plans (IRC sections 4375 and 4376)
 - Generally excepts following insurance: HIPAA-excepted plans, certain expatriate plans, stop-loss or indemnity reinsurance
 - Generally excepts following self-insurance: HIPAA-excepted coverage, EAPs, disease management and wellness if no “significant” medical benefits
 - Assessed for plan years ending after 9/30/12; not assessed for plan years ending after 9/30/19
 - Responsibility for payment
 - If a group health plan is insured, the health insurer is responsible for calculating and paying the fee.
 - If the plan is self-insured, the plan sponsor is responsible.
 - Double counting exception
 - Only for purposes of self-funded plans, can aggregate plans that share same plan year
 - What about insurance?
 - Planning opportunities?

Fees and Assessments

- Reinsurance Assessment

- Requires all health insurance issuers, and third party administrators on behalf of self-insured group health plans, to make contributions to support the transitional reinsurance program.
 - Does not apply to HIPAA-excepted benefits
 - Applies to EAPs, wellness, and onsite medical if group health plan
- Contributions are collected quarterly beginning 1/14
 - If insured, collected by states (or HHS if states don't collect)
 - If self-insured, collected by HHS
- Aggregate contributions to be collected for and/or by all states (although states may collect more) are: \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016
 - An additional aggregate amount equal to \$2 billion in 2014, \$2 billion in 2015 and \$1 billion in 2016 will be collected for general Treasury fund.
- Final regulations - a flat per capita amount is determined based on all “covered enrollees”
 - Not a percent of premium approach.
 - Double counting issue here?
 - Planning opportunities?

Fees and Assessments

- Annual health insurer fee
 - What constitutes subject “health insurance”?
 - Statute defines coverage by reference to what is NOT “health insurance”
 - Excluded: Qualifying AD&D, hospital fixed indemnity and specified disease or illness
 - JCT report indicates Medicare, Medicaid, dental and vision and “other health” are counted
 - Treatment/effect of reinsurance
 - Legislative history suggests can cede risk and reduce “net written premiums”
 - Will regulators agree? Will doing so really reduce issuer costs? What about the use of foreign reinsurers?
 - Application of the controlled group rules
 - Do you apply the small issuer exception across a controlled group?
 - How do the controlled group rules apply to tax-exempt organizations?
 - May be opportunities to modify profits or organizational structure to minimize fee liability
 - Products – separately price coverages and services? Use split-funded or MPPs? More self-funding with stop-loss?
 - Organizational structures – Use more JVs? ACOs?

Beyond the ACA

- Wellness programs
 - ACA
 - Allows for increased surcharges to 30% beginning in 2014, with possibility of increases up to 50%
 - Provides for external review available for reasonable alternative
 - Quasi-legal review by IRO
 - Implications to plan administration
 - Continued legal uncertainty
 - ADA
 - *Seff v. Broward County*
 - Issue remains regarding use of premium surcharges/rewards
 - GINA –
 - Issue of spousal HRAs and firewall between Title I and Title II
 - Additional issues
 - Participation versus outcome-based
 - Validity of combo arrangement
 - Retroactive application of preferential rates?
 - How to allow for employee choice? (IRC section 125 plan issues)

Beyond the ACA

- Mental health parity
 - Under the ACA
 - Nonquantitative treatment limitations subject to external review
 - Again, a quasi-legal review; implications for plan administration
 - Litigation
 - Uptick in federal mental health parity litigation
 - State mental health parity laws alive and well (i.e., *Harlick v. Blue Shield* in 9th Circuit)
 - More guidance on the horizon?
 - DOL has added parity-related materials online
 - But no new relief/guidance yet

Beyond the ACA

- Schedule C reporting and expanded ERISA “fiduciary” definition
 - Schedule C reporting
 - Currently effective
 - Generally only applicable to plans with set-asides
 - Such as where funded in whole or in part by VEBAs or other welfare benefit funds
 - ERISA section 408(b)(2) regulations expected in near future for health plans
 - Expanded “fiduciary” definition
 - Re-proposal of rules to come
 - Existing definition already raises fiduciary concerns where brokers recommend ASO services
 - Occasional investment advice will be enough
 - Lower threshold will cause prohibited transactions

Beyond the ACA

- DOL H&W plan audits
 - Seeing increased activity; now including ACA-related provisions
 - Grandfathered status
 - Notice to participants
 - Copy of plan terms in effect on March 23, 2010
 - Age 26 dependent coverage notice
 - Wellness
 - Amounts and nature of premium surcharges/rewards
 - Reasonable alternatives
 - Annual and lifetime limits
 - Amounts
 - Enrollment notice regarding lifetime limits
 - Copy of preventive services
 - Claims and appeals and external review
 - Copy of internal claims and appeals and external review process
 - Copy of notices of adverse benefit determination, final internal adverse determination and final external review decision
 - Copy of IRO agreement

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