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HEALTH CARE REFORM: NOW WHAT?

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Where do we go from here?

- While there may be legislative challenges to Health Care Reform, particularly after the November election, the constitutionality of Health Care Reform is now settled as a result of the U.S. Supreme Court's decision
- Now what?

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Past compliance activities weren't wasted efforts

- Steps employers have already taken to comply with Health Care Reform won't need to be unwound as a result of the Court's decision
- Employees will be pleased that their older dependent children will continue to be eligible for health coverage until age 26 and that the prohibition regarding lifetime limits on the dollar value of essential health benefits will continue to apply

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Past compliance activities weren't wasted efforts

- Other insurance market reforms, such as the restrictions regarding annual limits on the dollar value of essential health benefits and the ban on pre-existing condition exclusions must be fully implemented by 2014

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Additional plan changes will be required in the future

- Contraceptives – Non-grandfathered health plans must offer contraceptive drugs and devices to female participants on a first dollar basis with no participant cost-sharing effective as of the first day of the plan year beginning on or after August 1, 2012
  - An exception is available for religious employers

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Additional plan changes will be required in the future

- Medical FSA Cap – Employee pre-tax contributions to a medical flexible spending account (FSA) will be capped at $2,500 per participant per year
  - The IRS recently issued guidance to clarify that this is a plan year vs. calendar year limit and begins to apply as of the first day of the first plan year beginning on or after January 1, 2013

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Additional plan changes will be required in the future

  - Employers have until December 31, 2014 to amend their Section 125 plans for the new limit as long as the plan is operated in compliance with the new limit as of the effective date
- Waiting Period – Beginning in 2014, health plans may not impose a waiting period of longer than 90 days for newly eligible employees

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Don't forget about the nondiscrimination rules

- Self-funded group health plans have been subject to nondiscrimination rules for many years
- Those rules prohibit discrimination in favor of highly compensated individuals with regard to eligibility and benefits
- Historically, fully-insured group health plans have not been subject to nondiscrimination rules

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Don't forget about the nondiscrimination rules

- That distinction changed under Health Care Reform. Now fully-insured, non-grandfathered group health plans will be subject to similar nondiscrimination rules to the rules for self-funded plans
- In December 2010, the IRS announced that it is drafting regulations to implement this new requirement and that it will not require fully-insured, non-grandfathered group health plans to comply with this provision until plan years beginning after a certain period of time following the issuance of regulations

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Don't forget about the nondiscrimination rules

- Current Nondiscrimination Rules for Self-Funded Plans:
  - Highly compensated individuals means top 25% highest paid employees
  - Union employees are generally included in determining who is in the highly compensated group but are disregarded in the actual testing
  - If there are differences between employee groups in terms of required contributions, waiting periods or benefits, each sub-group must be tested separately for nondiscrimination

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Don't forget about the nondiscrimination rules

- For each group, two requirements must be satisfied:
  - Sub-group must benefit a reasonable, nondiscriminatory classification of employees
  - Sub-group must have sufficient ratio of benefitting non-HCIs to benefitting HCIs – difference can't be unreasonable
    - Generally if all the HCIs are in a sub-group, at least 38.75% of the non-HCIs must also be in the sub-group

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New participant notices must be provided

- Insurance Market Reforms – Several participant notices were required when the insurance market reforms initially took effect
  - For example, employees were required to be notified of a health plan's amended definition of dependent child and the opportunity for older children to enroll

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New participant notices must be provided

- Summary of Benefits and Coverage – The most significant new participant notice required under Health Care Reform is the summary of benefits and coverage (SBC)
  - The purpose of the SBC is to provide certain information in a prescribed format to participants in an employer's health plan so participants can easily compare the information to other plans they may be eligible for, including the coverages which will be offered on state exchanges

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New participant notices must be provided

- The SBC must be provided to participants at open enrollment effective with open enrollment periods beginning on or after September 23, 2012
- Further newly-eligible enrollees must be provided with an SBC effective as of the first day of the first plan year beginning on or after September 23, 2012
- Employers will be looking to the insurer or third party administrator of the employer's health plan for assistance in preparing and providing the SBC

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New participant notices must be provided

- "Excepted benefits" such as stand alone dental and vision plans and most medical FSAs are not subject to the SBC requirement
- An SBC is required for an HRA but if the HRA is integrated with the employer's group medical plan, the HRA can be combined with the medical plan for SBC purposes

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New participant notices must be provided

- Who is entitled to receive the SBC?
  - "Participants and beneficiaries" which appears to include spouses and dependents
  - However, only one SBC is required to be provided to the family unless any beneficiaries are known to reside at different addresses

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New participant notices must be provided

- When must the SBC be provided?
  - As part of the initial enrollment process
  - During annual reenrollment, at least 30 days prior to the first day of the plan year
    - If SBC for insured plan can't be given within this time frame, it must be provided within 7 days of issuance
  - Upon special enrollment, within time prescribed for providing SPD (during 1st 90 days)
  - Upon request – 7 business day deadline (proposed regulations required within 7 calendar days)
  - At least 60 days prior to the effective date of any material modification affecting the information in the SBC
    - This 60-day advance notice requirement does not appear to apply to changes being made as of the first day of a plan year

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New participant notices must be provided

- How may the SBC be distributed?
  - In paper form
  - Electronically – for participants and beneficiaries already enrolled in the health plan, same as rules for distribution of other participant notices under ERISA
    - Exception #1 - For individuals who are eligible but not yet enrolled, the SBC may be provided electronically if the format "is readily accessible" and a paper copy is provided free of charge upon request

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New participant notices must be provided

- Example: SBC is posted on employer's intranet with a postcard or email sent to the individual advising them of the same and ability to obtain a free paper copy
- Exception #2 – Can provide electronically to individuals who enroll online (initially or at annual open enrollment)

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New participant notices must be provided

- Notice of Exchange Availability – Beginning in 2013 employers must provide individuals with a notice regarding the availability of the state exchanges which must be in place by 2014, and the premium credits and cost-sharing subsidies available to low income individuals if they enroll in coverage on the exchange

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DOL audit activity

- The U.S. Department of Labor ("DOL") has begun random audits of employers to determine if they have been operating in compliance with the initial requirements of Health Care Reform
- Employers are being asked to produce documents to show plans have been amended for the insurance market reforms described above

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DOL audit activity

- Employers are also being asked to supply copies of the participant notices that were provided to participants in implementing the insurance market reforms
- If the plan is grandfathered, the participant notice(s) of grandfathered plan status provided by the plan must be produced
- If the plan is not grandfathered, employers are being asked to demonstrate that the plan was amended to comply with the additional insurance market reforms applicable to non-grandfathered plans

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Employers must comply with more reporting requirements

- W-2 Reporting of Health Benefit Costs – Effective for 2012 and later tax years, employers must include the aggregate cost of employer-sponsored health benefits on the W-2 statements issued to employees
  - This new reporting requirement initially applies to W-2s issued in January 2013
  - Until further notice, it is not applicable to employers with fewer than 250 individuals to whom the employer must issue a W-2

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Employers must comply with more reporting requirements

- The total value of all health insurance plans must be included except for contributions to an HSA and employee contributions to an FSA
- Value of stand-alone dental and vision plans is excluded
- Cost reported is based on coverage tier selected by employee (e.g., employee, employee + 1, full family)
- Tracked on a monthly basis
  - So if an employee is enrolled in single coverage for six months and fully family coverage for six months, the W-2 total must reflect six months at each tier (12 months total)

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Employers must comply with more reporting requirements

- The cost is generally based on either the premium charged by the plan's insurer or the applicable COBRA premium minus the 2% administrative charge
- Both the employer's and the employee's contribution toward the cost are reported

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Employers must comply with more reporting requirements

- Quality of Care - Non-grandfathered health plans must submit an annual report to the U.S. Department of Health and Human Services (HHS) addressing whether the plan's benefits satisfy various criteria relating to cost and quality of care in areas such as case management, discharge planning and wellness
  - HHS was required to issue regulations by no later than March 23, 2012. The regulations have yet to be issued. The reports will be due as of a date established in the yet-to-be issued regulations

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Employers must comply with more reporting requirements

- State Exchanges - Beginning in 2013, employers will be required to interact with the state exchanges to verify an employee's eligibility for employer group health coverage in order to administer the potential financial assistance for low income individuals applying for exchange coverage
  - Guidance is expected to be issued in 2013

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Employers must comply with more reporting requirements

- IRS Reporting for Pay or Play - Beginning in 2014, employers with 50 or more full-time employees must report to the IRS whether they offer minimum essential coverage to employees. This information is required in order to administer the pay or play penalty
  - Regulations are expected to be issued detailing the reporting requirements

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Get ready for new taxes and fees

- Premium Tax for Research - For plan years ending on and after October 1, 2012, a new premium tax will be assessed to finance comparative clinical effectiveness research
  - For the first plan year the fee is based on the average number of covered lives (employees and dependents) under a health plan multiplied by $1. The multiplier increases to $2 for subsequent plan years and no longer applies for plan years ending after October 1, 2019

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Get ready for new taxes and fees

- "Excepted benefits" such as stand alone dental and vision plans and most medical FSAs are not subject to the tax
- If an HRA is integrated with the employer's self-funded group health plan, **no** separate tax applies
  - However, if the HRA is integrated with the fully-insured group health plan, a separate tax **does** apply (but is only based on employees; dependents disregarded)

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Get ready for new taxes and fees

- In the case of fully-insured plans, the tax is payable by the insurer. In the case of self-funded plans, the tax is payable by the employer
- The tax will be reported on IRS Form 720 and paid once per year by July 31 (July 31, 2013 for the initial year)

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Get ready for new taxes and fees

- Medicare Hospital Insurance Payroll Tax - Currently, the Medicare hospital insurance payroll tax for employees is 2.9% (1.45% paid by the employee and 1.45% paid by the employer, with self-employed individuals paying 2.9%)
  - Beginning in 2013, higher income taxpayers with wages in excess of $200,000 (if single) or $250,000 (if married and filing jointly) will be subject to an additional .9% Medicare hospital insurance payroll tax on wages in excess of those thresholds

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Get ready for new taxes and fees

- In addition, these individuals will be subject to a 3.8% tax on their net investment income which includes interest, dividends and royalties. However, net investment income for this purpose does not include distributions from a 401(k) plan or other qualified retirement plans
- The IRS has recently issued FAQs on this tax
- The FAQs clarify that employers should withhold for the new tax on wages paid to an employee in excess of $200,000 for the year

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Get ready for new taxes and fees

- Temporary Reinsurance Program - Health Care Reform establishes a new temporary reinsurance program for insurers in the individual market
  - The purpose of the program is to transfer risk from insurers in the individual market to the group market over a three-year period beginning in 2014
  - Approximately $25 billion must be raised to finance the program and it will be collected through a per capita contribution fee assessed against insurers in the case of fully-insured plans and against third party administrators in the case of self-funded health plans

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Assistance for employers

- Medical Loss Ratios - Employers sponsoring fully-insured group health plans (as opposed to self-funded plans) may be receiving rebates pursuant to the medical loss ratio (MLR) rules of Health Care Reform
  - The purpose of the MLR rules is to require insurers to deliver transparency and value in connection with health insurance policies
  - Under the rules, insurers must spend a minimum percentage of collected premium dollars on claims as opposed to profits and indirect costs such as administration and marketing

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Assistance for employers

- Insurers must report their MLR data for a calendar year to HHS by June 1 of the following year
- If the MLR requirements are not satisfied, rebates must be issued by the following August 1
- 2011 is the first year this requirement applies, with any rebates issued by August 1, 2012
- Any MLR rebate will typically be issued to the employer as the policyholder with respect to a fully-insured group health plan

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Assistance for employers

- While the rebate may be welcome dollars for the employer, the portion of the rebate attributable to participant (employee) contributions will generally be considered a plan asset under ERISA
- The ERISA fiduciary rules require plan assets to be used for the exclusive benefit of participants

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Assistance for employers

- The portion of the rebate attributable to participant contributions is generally equal to the percentage of the premium paid by participants

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Assistance for employers

- The U.S. Department of Labor (DOL) has issued guidance as to permissible methods of applying the portion of any MLR rebates which constitute plan assets
- Those methods include cash refunds, using the proceeds to reduce future premiums, and/or using the rebate to enhance benefits (e.g., introduce a wellness benefit)

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Assistance for employers

- Rebates provided to participants in cash or which cause a reduction in the employee's pre-tax premium contributions in the year in which the rebate is paid are subject to federal income taxes and payroll taxes
- The rebate should be distributed as soon as administratively feasible. If the rebate is not used within 3 months, ERISA requires the rebate to be held in trust

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Assistance for employers

- Similar rules apply to fully-insured plans sponsored by state and local governmental employers and church employers even though the health plans of these employers are not subject to ERISA
- The guidance concerning state and local governmental plans indicates that the portion of the rebate attributable to participant contributions should be divided evenly among participants or divided based upon employees' premium contributions

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Assistance for employers

- Wellness - Currently, under the HIPAA nondiscrimination rules, employees enrolled in an employer's health plan may be provided with incentives/penalties to participate in a wellness program based on one or more health status factors
  - The wellness program must satisfy certain requirements, including a cap on the incentive/penalty; it may not exceed 20% of the cost of coverage under the employer's health plan

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Assistance for employers

- Health Care Reform increases the 20% limit to 30% beginning in 2014
- Further, the IRS, DOL and HHS are provided with discretion under Health Care Reform to issue regulations increasing the 30% limit to as high as 50%

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Health benefit planning for 2014

- The centerpiece of the Health Care Reform legislation is the establishment of the state exchanges, the individual mandate and the employer “pay or play” penalty -- all which will take effect in 2014

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Health benefit planning for 2014

- Exchanges - the first component of this new structure will be that each state must establish an exchange to help individuals and groups shop for health coverage in a more efficient and comprehensive manner

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Health benefit planning for 2014

- Governor Snyder proposed an exchange for Michigan in the form of a non-profit corporation (Senate Bill 693)
- The Michigan legislature has been resistant to enact the legislation, believing that Health Care Reform may be repealed after the November election
- If Michigan does not set up its own state exchange, the federal government will step in and establish an exchange for Michigan

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Health benefit planning for 2014

- Individual mandate – individuals must obtain health insurance with minimum essential coverage or pay a penalty
  - Minimum essential coverage is available through public programs, the exchange or an employer plan
  - Non-grandfathered employer plans may have to make additional changes in 2014 in order to constitute minimum essential coverage (e.g., coverage for clinical trials)

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Health benefit planning for 2014

- The penalty is the greater of a flat dollar amount or a percentage of household income
  - The flat dollar amount is $95 for 2014, $325 for 2015 and $695 for 2016. For later years, the flat dollar amount will be increased for changes in the cost-of-living
  - The percentage of household income is 1% for 2014, 2% for 2015 and 2.5% for 2016 and later years

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Health benefit planning for 2014

- Low income individuals (with household income no greater than 400% of the federal poverty level) will receive assistance
  - These individuals will be provided with premium credits to reduce their cost to obtain coverage on the exchange (capped at a maximum percentage of their household income)
  - Some of these individuals will also be eligible for cost-sharing subsidies to help pay their out-of-pocket costs
  - The exchanges will be responsible to determine whether an individual is eligible for this assistance but will need to interact with employers to verify

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Health benefit planning for 2014

- Employer mandate – employers will be required to offer health coverage to their employees and their dependents or pay a "free rider" penalty
  - The penalty only applies to employers with 50 or more full-time employees
    - A full-time employee is an employee who works, on average, 30 or more hours per week

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Health benefit planning for 2014

- IRS Notice 2012-58 provides important guidance to help employers determine which employees will be considered full-time for purposes of the penalty:
  - If a **new hire** is reasonably expected to work full-time, the employer will not be subject to the pay or play penalty with respect to that individual if he or she is offered health coverage on or before the conclusion of the employee's initial three calendar months of employment

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Health benefit planning for 2014

- If a **new hire** is a variable hours employee or seasonal employee, the employee is not required to be offered health coverage unless the employee actually works, on average, at least 30 hours per week during a "measurement period" of between 3 and 12 months

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Health benefit planning for 2014

- If a variable hours employee or seasonal employee works the required number of hours during the measurement period, the worker must be treated as full-time during a subsequent "stability period" which must be a period of at least 6 months and no shorter than the initial measurement period

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Health benefit planning for 2014

- If a variable hours employee or seasonal employee does **not** satisfy the full-time requirement during the measurement period, his or her stability period may not be more than one month longer than the initial measurement period
- During the stability period, the employer will not be subject to the pay or play penalty with respect to such a variable hours employee or seasonal employee if he or she is not provided with health coverage, even if the individual works, on average, at least 30 or more hours per week

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Health benefit planning for 2014

- If an employee is a variable hours employee if, as of his or her hire date, it can't be determined whether the employee is reasonably expected to work, on average, at least 30 hours per week
- The guidance does not include a definition of seasonal employee for this purpose but does allow employers to use a reasonable good faith interpretation which would appear to include retail workers employed during holiday seasons, agricultural workers and ski instructors

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Health benefit planning for 2014

- Example: Employer adopts a 12-month measurement period for newly-hired variable hours employees
- Variable hours employee A is hired on May 9 of year 1 and works, on average, at least 30 hours per week during his initial measurement period

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Health benefit planning for 2014

- Variable hours employee A must be treated as a full-time employee for the subsequent stability period (which must be for a period of at least 12 months) regardless of whether he works less than full-time during the stability period
- Variable hours employee B is hired on May 9 of year 1 and does **not** work, on average, at least 30 hours per week during her initial measurement period

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Health benefit planning for 2014

- Variable hours employee B is not required to be treated as full-time for the subsequent stability period (which may not be longer than 13 months) even if she works on a full-time basis during the stability period

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Health benefit planning for 2014

- Employers can apply a measurement period/stability period test for **ongoing employees** similar to the one for variable hours and seasonal employees
- If an ongoing employee doesn't satisfy the "on average, at least 30 hours per week" test for a measurement period, the employer will not be subject to a penalty if it does not offer the employee health coverage for the subsequent stability period (which can't be longer than the measurement period)

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Health benefit planning for 2014

- The employer may adopt a "administrative period" of up to 90 days in between the measurement period and the stability period under the safe harbor for **ongoing employees**
- The purpose of the administrative period is to give employers time to determine when **ongoing employees** are eligible for coverage and to notify and enroll employees

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Health benefit planning for 2014

- Example: The employer adopts a 12-month measurement period beginning on October 15 of year one and ending on October 14 of year two
- Instead of immediately beginning the stability period on October 15 of year two, the employer adopts an administrative period and begins the 12-month stability period on January of year three

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Health benefit planning for 2014

- There is a similar administrative period available with respect to newly-hired variable hours employees and seasonal employees

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Health benefit planning for 2014

- If the employer **does not** offer a health plan and at least one full-time employee enrolls in health coverage through the exchange and becomes eligible for the premium credit, the employer must pay a penalty of $2,000 per full-time employee per year
  - The first 30 full-time employees are disregarded
  - The penalty is determined and assessed on a monthly pro rata basis

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Health benefit planning for 2014

- If the employer **does** offer health coverage but has at least one full-time employee who is enrolled in health coverage through the exchange and receives the premium credit, the employer is subject to a penalty of $3,000 per individual receiving the credit (or $2,000 per full-time employee disregarding the first 30, if less)
  - Low income employees who are eligible for employer health coverage can only qualify for the premium credit if the employer's health coverage isn't **valuable** enough or isn't **affordable**

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Health benefit planning for 2014

- The employer's plan isn't **valuable** enough if it doesn't provide minimum essential coverage (cover at least 60% of the average employee's eligible expenses)
- Guidance has been issued to help employers determine if coverage is valuable enough
- It is expected that the vast majority of employer health plans will satisfy this requirement

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Health benefit planning for 2014

- The employer's plan isn't **affordable** if the employee's required premium exceeds 9.5% of the employee's household income
- The IRS has provided a safe harbor where employers will not be subject to the $3,000 penalty for a year if the premium for single employee coverage under the employer's lowest cost health option does not exceed 9.5% of the employee's wages for that year (as defined for purposes of Box 1 on Form W-2)
- The safe harbor is available at least through the end of 2014

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Should employers discontinue offering a health plan once the pay or play mandate takes effect in 2014?

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Discontinue health plan?

- Advantages
  - The employer will trade a $2,000 per full-time employee penalty in exchange for the "cost" of maintaining the health plan
    - The "cost" is more than the premium cost. It also includes administrative costs, consulting costs, legal compliance costs, accounting costs, etc.

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Discontinue health plan?

- The employer will no longer have to comply with Health Care Reform or other federal laws regarding the employer's health plan such as COBRA and HIPAA
- Some lower income individuals may be better off going to the exchange because of the government-provided financial assistance (premium credits and cost-sharing subsidies)

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Discontinue health plan?

- Disadvantages
  - The actual cost of discontinuing the health plan will be more than the $2,000 per FTE penalty. While the cost of maintaining a health plan is a deductible business expense, the employer $2,000 penalty is **not deductible**

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Discontinue health plan?

- Will employers offer replacement compensation/benefits?
  - If an employer provides additional compensation to employees in lieu of health coverage, it may permanently increase the wage base, increase payroll taxes, increase the cost of compensation-related benefits (such as disability and life insurance and retirement benefits), and may actually disadvantage lower income employees if the additional pay causes them to lose eligibility for premium credit/subsidy

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Discontinue health plan?

- If an employer provides a stipend or reimbursement benefit for employees to obtain coverage on the exchange, what will the formula be?
  - Will it vary by family status, whether spouse has other coverage or an employee's seniority/length of service?
  - How frequently will it be adjusted (for example, for changes in status)?
  - How will it be administered?

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Discontinue health plan?

- Will the coverage offered on the exchange be attractive to employees and how much will it cost?
- Each option on the exchange must offer a package of "essential health benefits"
- There will be four prescribed coverage levels:
  - Bronze designed to provide benefits actuarially equivalent to 60% of full value
  - Silver designed to provide benefits actuarially equivalent to 70% of full value

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Discontinue health plan?

- Gold designed to provide benefits actuarially equivalent to 80% of full value
- Platinum designed to provide benefits actuarially equivalent to 90% of full value

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Discontinue health plan?

- Example of Silver Plan from Kaiser Family Foundation

Deductible	
Single	$1,550
Family	$3,100
Coinsurance	70/30%
Single Limit	$2,650
Family Limit	$5,340
Out of Pocket Maximum	
Single	$4,200
Family	$8,440

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Discontinue health plan?

- Estimated Single Cost & Government Subsidy for Silver Plan

Annual Income	$30,000	$50,000	$70,000+
Age 30 Cost	$3,440	$3,440	$3,440
Gov't Subsidy	$932	$0	$0
Employee Cost:	$2,508	$3,440	$3,440
Age 40 Cost	$4,500	$4,500	$4,500
Gov't Subsidy	$1,991	$0	$0
Employee Cost:	$2,509	$4,500	$4,500
Age 50 Cost	$6,978	$6,978	$6,978
Gov't Subsidy	$4,470	$2,228	$0
Employee Cost:	$2,508	$4,750	$6,978
Age 60 Cost	$10,172	$10,172	$10,172
Gov't Subsidy	$7,663	$5,422	$0
Employee Cost:	$2,509	$4,750	$10,172

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Discontinue health plan?

- Est. Family of 4 Cost & Gov't Subsidy for Silver Plan

Annual Family Income	$40,000	$70,000	$100,000+
Age 30 Cost	$10,108	$10,108	$10,108
Gov't Subsidy	$8,127	$2,513	$0
Employee Cost:	$1,981	$6,626	$10,108
Age 40 Cost	$12,130	$12,130	$12,130
Gov't Subsidy	$10,149	$5,504	$0
Employee Cost:	$1,981	$6,626	$12,130
Age 50 Cost	$16,858	$16,858	$16,858
Gov't Subsidy	$14,877	$10,232	$0
Employee Cost:	$1,981	$6,626	$16,858
Age 60 Cost	$24,042	$24,042	$24,042
Gov't Subsidy	$20,242	$17,416	$0
Employee Cost:	$3,800	$6,626	$24,042

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Discontinue health plan?

- Other possible responses:
  - Reducing employee hours to fewer than 30 per week
  - Outsourcing certain business functions
  - Introducing a low cost medical option with a low employee premium for single coverage

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