HEALTH CARE REFORM:

Supreme Court Decision

Lunch and Learn

July 2012

Introduction

- On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Affordability Reconciliation Act of 2010 were signed into law and have become known simply as “Health Care Reform”
- The implementation of Health Care Reform takes place over nine years beginning in 2010 and ending in 2018

Introduction

- Health Care Reform was designed to expand health insurance coverage by:
  - Expanding eligibility for Medicaid
  - Developing a new marketplace for purchasing insurance
  - Mandating individuals to enroll in health insurance
  - Imposing fines on employers who do not offer coverage, or offer coverage that is unaffordable
  - Subsidizing low and middle income enrollees in the described new marketplace program (the state health insurance exchanges)

Introduction

- Forces Driving Reform:
  - Growing uninsured population
  - Exponential growth in expenditures
  - Looming Medicare insolvency
  - Cost to quality comparisons

Introduction

- Today our focus will be group health benefit plans with respect to employers and employees as well as the individual mandate
  - Analysis of the Supreme Court Decision and the Status of Health Care Reform
  - Overview of the Health Care Reform Affecting Employee Health Benefits Focusing on:
    - General Requirements of Health Plans
    - W-2 Reporting
    - Tax Issues
    - State Exchanges
    - Employer and Individual Mandates

Supreme Court Decision

- The Supreme Court heard oral arguments in March regarding the constitutionality of Health Care Reform
- The arguments presented to the Supreme Court addressed four issues:
  - Whether the challenges to the individual mandate were barred prior to any penalties becoming payable (Anti-Injunction Act)
  - Constitutionality of the "individual mandate"
  - Severability of the individual mandate from the rest of the law
  - Whether Federal funding can be withdrawn if States do not expand Medicaid programs

Supreme Court Decision

- On June 28, 2012 the Supreme Court issued its opinion
  - The Supreme Court held that the Anti-Injunction Act did not apply
  - The Supreme Court held that the penalty for failure to comply with the individual mandate was actually a tax and the imposition of a tax on those who do not obtain health insurance is constitutional under Congress' taxing power
  - The majority found that it is unconstitutional to withhold all Federal funds provided to the States for Medicaid if the States fail to comply with the new Medicaid expansion requirements

Supreme Court Decision
Future of Health Care Reform

- The Supreme Court decision is not the last word and the future of Health Care Reform is still unknown
  - Upcoming elections
  - State decisions regarding Medicaid
- Regardless of the ongoing political debates, the law is in place and employers and individuals need to comply

2010 Provisions

- Small business tax credit
- Early retiree reinsurance
- Recognition of taxation of retiree drug subsidy
- Nursing mothers
- State high risk pools

2011 Provisions

- Restrictions on rescission
- Dependent coverage for adult children under the age of 26
- Changes to appeals process (outside independent review) some aspects delayed
- First dollar coverage required for certain evidence based preventive care (based on list published by the U.S. Preventive Services Task Force – changes periodically)

2011 Provisions

- Elimination of the pre-existing condition exclusion for children under age 19
- Elimination of lifetime limits related to essential health benefits
- Reasonable annual limits related to essential health benefits

2011 Provisions

- Participants can select primary care provider
- No preauthorization or increased cost-sharing for emergency
- No preauthorization or referral requirement for OB/GYN services

2011 Provisions

- Over the counter medications are no longer eligible for reimbursement under a health flexible spending account, health reimbursement arrangement or health savings account
- Insurance rebates required to the extent that more than 20% of the premium revenue is spent on costs other than benefit claims
- Tax on distributions from a health savings account is increased from 10% to 20%
- Adoption assistance limits increased and extended

2012 Provisions

- Report health care quality and wellness initiatives to Health and Human Services (HHS)
- Form W-2 Reporting of health care costs (delayed from 2011)
- Summary of Benefits and Coverage (SBC)/Uniform Glossary and 60-day advance notice of changes to the SBC
- Comparative Effectiveness Research fees of $2 per average number of enrollees/lives assessed ($1 for 2012 policy/plan years)
- Medical Loss Ratio rebates
- Pending: Nondiscrimination Requirements

2012 Provisions
W-2 Reporting

- The cost of employer-sponsored health coverage must be reported on Form W-2 for the 2012 calendar year (issued in January 2013)
- The cost is generally based on the COBRA rate
- Transitional relief for 2012 for certain small employers who filed fewer than 250 Forms W-2 in 2011
- Special rules for terminated employees

2012 Provisions
W-2 Reporting

- Certain health care costs are exempt from these new reporting requirements:
  - Dental and/or vision coverage costs that are not integrated into a group health plan
  - Employee contributions to health flexible spending accounts (FSAs), but employer contributions to a health FSA must be reported
  - Contributions to a health savings account (HSA)

2012 Provisions: W-2 Reporting

- Health reimbursement arrangement (HRA)
- Independent hospital indemnity or fixed indemnity coverage paid for on an after-tax basis by the employee
- Employee Assistance Programs, on-site clinics and wellness programs that do not charge a COBRA premium

2012 Provisions
Summary of Benefits and Coverage (SBC)

- The employer and the insurer are responsible for distribution of the SBC for an insured plan
  - Insurer must provide SBC to employer
- An SBC must be provided with respect to each benefit package for which the participant or beneficiary is eligible; except upon renewal, when a new SBC is required only for the benefit package in which the participant or beneficiary is enrolled
- SBCs are not required for certain excepted benefits (i.e., stand-alone dental, vision plans, most health FSA s, or retiree only plans)

2012 Provisions
Summary of Benefits and Coverage (SBC)

- 60-day advance notice requirement of material modifications
  - Notice is required when material changes are made to the SBC at times other than renewal

2012 Provisions
Summary of Benefits and Coverage (SBC)

- In general, the SBC must contain the following:
  - Uniform definitions of standard insurance and medical terms
  - Description of coverage
  - Exceptions, reductions and limitations of coverage
  - Cost sharing, including deductible, coinsurance and copayment obligations
  - Renewability and continuation of coverage

2012 Provisions
Summary of Benefits and Coverage (SBC)

- Coverage examples (e.g. pregnancy)
- Statement that the SBC is only a summary and that the plan document or insurance contract must be consulted for full coverage terms and provisions
- Separate contact information for questions

2012 Provisions
Summary of Benefits and Coverage (SBC)

- The SBC must be presented in a uniform format:
  - Use terminology understandable by the average enrollee
  - Not exceed four double-sided pages in length and
  - Not include print smaller than 12-point font
- The SBC must contain culturally and linguistically appropriate language

2012 Provisions
CER Fees

- Comparative Effectiveness Research fees ("CER fees") are required to fund the Patient-Centered Outcomes Research Institute, the purpose of which is to advance comparative effectiveness research and help patients, clinicians, purchasers and policy-makers make informed health decisions
- Employers required to pay for the CER fees associated with self insured plans
- Insurers pay the CER fees associated with fully insured plans

2012 Provisions
Medical Loss Ratio Rebates

- Beginning January 1, 2011, insurers are required to spend a minimum percentage of premium dollars per year on claims, claims services and quality of care (Medical Loss Ratio)
- Failure to achieve this Medical Loss Ratio will result in rebate to the policyholders
- The policyholder will receive this rebate from the insurer
- Rebates for 2011 will be paid in August 2012

2013 Provisions

- Health flexible spending account limited to $2,500, indexed for inflation
- Additional 0.9% Medicare payroll tax on wages in excess of $250,000 for joint return filers ($200,000 for others)
- 3.8% Medicare contribution tax on unearned income for joint filers with modified AGI in excess of $250,000, $200,000 for singles, $120,000 for married filing separately
- Employer notice provided to employees beginning on March 1, 2013 regarding exchanges

2013 Provisions
$2,500 Limit on FSAs

IRS issued Notice 2012-40 which provides:

- The $2,500 limit does not apply for plan years that begin before 2013
- Unused salary reduction contributions to the health FSA for plan year beginning in 2012 or later that are carried over into a subsequent grace period will not count against the limit for that subsequent year
- If a cafeteria plan has a short plan year beginning after 2012, the $2,500 limit must be prorated

2013 Provisions
$2,500 Limit on FSAs

- Applies only to salary reduction contributions under a health FSA, and does not apply to certain employer non-elective contributions (e.g., flex credit)
- The $2,500 limit on salary reduction contributions to a health FSA applies on an employee basis
- The Treasury Department and the IRS are considering whether the “use-or-lose” rule should be modified

2013 Provisions
Medicare Payroll Tax

- Employers will be responsible for collecting and remitting the additional 0.9% tax on wages that exceed $200,000 without regards to the wages of a married employee's spouse
- If the amount withheld from wages is insufficient, the individual employee will be required to report and pay taxes on the individual return
- The additional 0.9% tax also applies to self-employment income that exceeds the dollar amounts above

2013 Provisions
Medicare Contribution Tax

- The tax is equal to 3.8% of the lesser of:
  - net investment income (generally, net income from interest, dividends, annuities, royalties and rents, and capital gains, as well as income from a business that is considered a passive activity or a business that trades financial instruments or commodities), or
  - modified adjusted gross income (basically, adjusted gross income increased by any foreign earned income exclusion) that exceeds $200,000 ($250,000 if married filing a joint federal income tax return, $125,000 if married filing a separate return)

2013 Provisions
Notice Regarding Exchange

- By March 1, 2013, all employers must notify all current employees of the following
  - The employee's right to purchase health insurance coverage through a state insurance exchange, the services provided by the exchange and how to contact the exchange;
  - The employee's possible eligibility for government subsidies; and
  - The employee's possible loss of an employer subsidy, if any, (in the form of a tax-free contribution to the employer-provided health coverage) if health insurance coverage is purchased through the exchange
- The notice must be given to new hires after March 1, 2013
- No specific penalty in Health Care Reform or the Fair Labor Standards Act for failure to provide such notice

2014 Requirements

- Elimination of pre-existing condition exclusions for all participants
- No annual dollar limits
- Waiting periods cannot exceed 90 days
- No cost sharing in excess of the limits on high deductible health plans
- Limit on wellness incentives is increased from 20% to 30%
- Increase in small business tax credit to 50% (35% for tax-exempt entities)

2014 Provisions

- Cover routine costs of patients who are part of clinical trials
- Automatic enrollment for companies with over 200 full-time employees (30 hours or more)
- Establishment of State health insurance exchanges
- Individual mandate requiring all individuals to have health insurance
- Employer mandate regarding coverage

2014: Auto-enrollment for Large Employers

- Employers with 200 or more full-time employees will be required to auto-enroll employees into their employer-sponsored health plan but can opt out
- Originally, effective January 1, 2011, implementation is delayed until the DOL issues rules expected prior to 2014
  - Definition of full-time employee
  - Clarity around which plan to enroll employee into if multiple plans offered
  - Specifics on opt-out notification

2014 Provisions
State Exchanges

- January 1, 2014: State health exchanges are generally required to be established for individuals and small employers of 100 or fewer employees, provided that
  - Prior to 2016, States may limit the Exchanges to employers with less than 50 employees
  - Beginning 2017, States may open the Exchanges to all employers
- Exchanges will have a variety of insurance options to satisfy the new mandates
- If States fail to open an exchange, Federal government is authorized to step in and establish an exchange

2014 Provisions
State Exchanges

- Types of plans to be offered by insurers through the exchange
  - **Bronze** = 60% actuarial value
  - **Silver** = 70% actuarial value
  - **Gold** = 80% actuarial value
  - Platinum = 90% actuarial value
  - **Catastrophic plan**

    Only available to individuals < 30 years old, or those exempted from the individual mandate due to unaffordability or hardship

    Plan must cover:

    - » "minimum essential benefits"
    - » a minimum of three primary care visits per year
- All exchange "metal" plans must cover essential health benefits, limit cost-sharing and have a specified actuarial value

2014 Requirements
Individual Mandate

- Beginning in 2014, most U.S. citizens and legal residents must obtain "minimum essential" health insurance coverage or pay a penalty
- Those exempt from the penalty include:
  - Members of a religious organization that meets the "religious conscience" exemption;
  - American Indians with coverage through the Indian Health Service;
  - Undocumented immigrants;

2014 Requirements
Individual Mandate

- Individuals without coverage for less than three months in a year;
- Individuals serving prison sentences;
- Individuals for whom the lowest-cost plan option exceeds 8% of annual income
- Individuals with incomes below the tax filing threshold
- Individuals having a hardship as determined by the Secretary of the DOL
- Individuals residing outside of the U.S. or are bona fide residents of any possession of the U.S.

2014 Provisions
Individual Mandate

- **Individual Mandate to Obtain Health Coverage:** Beginning in 2014, individuals must obtain a minimum-level of health insurance coverage or pay a penalty
- **Minimum Essential Coverage includes:**
  - Medicare, Medicaid, TRICARE
  - Insurance purchased through an Exchange, on the individual market
  - Employer-sponsored coverage, OR
  - Grandfathered plans
- **Penalties for Failure to Obtain Coverage:**
  - In 2014: greater of $95 or 1.0% of income
  - In 2015: greater of $325 or 2 % of income
  - In 2016: greater of $695 or 2.5% of income
  - Includes a hardship exemption
  - Flat rate penalty is capped at three times the per person amount for a family
  - Assessed penalty for dependents is half the individual rate

2014 Provisions
Individual Mandate

- Subsidies ("health insurance premium tax credits") are available if a household meets two conditions:
  - Household income must be less than 400% of the Federal Poverty Level (FPL), which varies with family size. For a family of four in 2012, 400% FPL = $92,200
  - The household's portion of the insurance premium must exceed 9.5% of household income
- State Medicaid may be expanded
  - Under the law, States were to expand Medicaid to all non-elderly individuals making less than 133% of the FPL or risk losing all Medicaid funding (significant portion covered through Federal funding)
  - After the Supreme Court decision, States can now decide whether to provide expanded programs

2014 Provisions
Employer Mandate

- Law does not require employers to offer health coverage to their employees
- However, large employers will be subject to a penalty beginning in 2014 if they:
  - Do NOT offer coverage
  - Offer coverage that is NOT affordable, or
  - Offer coverage that DOES NOT meet the minimum essential standards

2014 Provisions
Employer Mandate

- For purposes of the penalty, a *large employer* is an employer who has 50 or more full-time employees or full-time equivalents
  - Full-time employees: those that work 30 or more hours a week calculated on a monthly basis
  - Full-time equivalents are also counted in the determination of whether an employer is a large employer for purposes of the penalty
  - The penalty only applies with respect to full-time employees

2014 Provisions
Employer Mandate–Penalties

- If full-time employees (and dependents) are not offered minimum essential coverage, penalty applies if at least **one** full-time employee receives Federal assistance to purchase through an Exchange:
  - Penalty is equal to $2,000 multiplied by the total number of full-time employees not taking into account the first 30 employees

2014 Provisions
Employer Mandate–Penalties

- Penalty also applies if the health coverage offered is either:
  - Unaffordable because the employee's required contribution (for single employee coverage) is more than 9.5% of employee's household income, or
  - The plan pays for less than 60% of covered health care expenses

2014 Provisions
Employer Mandate–Penalties

- If employer coverage is not affordable the penalty is equal to:
  - At least $3,000 multiplied by the number of full-time employees receiving assistance, BUT
  - No more than $2,000 multiplied by total number of full-time workers, but not taking into account the first 30 employees

2014 Provisions
Employer Mandate - Reporting

- Insurers and/or employers (if self funded) who provide minimum essential coverage to individuals during a calendar year must submit the following information to the Treasury
  - Name, address and tax identification number of the primary insured and the name of each dependent covered
  - Dates during which the individual(s) was covered under minimum essential coverage
  - Any premium credits or cost-sharing subsidies

2014 Provisions
Employer Mandate - Reporting

- If essential health benefits coverage is sponsored by an employer, the following information must also be submitted
  - Names, address and employer identification number of the employer maintaining the group health plan
  - Portion of the premium paid by the employer

2014 Provisions
Employer Mandate - Reporting

- In addition, the insurer or employer must provide the following information to each individual whose information is submitted
  - Name, address, telephone number, and contact person of the entity that submitted the information; and
  - The information submitted to the Treasury with respect to such individual
- Reporting is due on the following January 31
- Expect additional guidance

2014 Provisions

Employer "Pay or Play" Analysis

- Individual and Employer Mandates
- Economic Considerations
- Non-Economic Considerations
- Unknown Factors

2014 Provisions
Employer "Pay or Play" Analysis

- Current insurance costs vs. penalty cost
  - Number of employees/participants
  - Cost of insurance coverage
  - Level of benefits offered
  - Cost of providing coverage that provides for "minimum essential benefits"
  - Cadillac Tax
- Cost of coverage under the Exchange

2014 Provisions

Employer "Pay or Play" Analysis

- Employee Expectations
- Industry Standards
- Unions
- Types of coverage options available through the Exchange
- Demographics of workforce
- Survival of Health Care Reform
- Increase in the penalties over time for employers and individuals

2018 Provisions

- Cadillac plan tax becomes effective
  - 40% tax on “excess health coverage”
  - Tax imposed on issuers of fully-insured plans and on plan administrators with respect to self-funded plans
  - $10,200 for single and $27,500 for family
  - Retirees and high risk professions: $11,850 for single and $30,950 for families
  - Adjusted for inflation

Summary

- The status of Health Care Reform remains in question
- Review the cost of health care on 2012 Forms W-2
- Prepare for the reduction on health FSA amounts
- Prepare for the additional Medicare payment tax and Medicare contribution tax

Summary/Next Steps

- Encourage an open dialogue with your employer as 2014 approaches
- Review the Summary of Benefits and Coverage
- Identify whether plans are affordable and available

Q & A

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