

**HEALTH CARE REFORM:**  
*Supreme Court Decision*

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# 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

- 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
  - Compliance Requirements for Employers
  - Employer and Individual Mandates
  - Next Steps and Considerations



# 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  - Whether Federal funding can be withdrawn if States do not expand Medicaid programs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
  - 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



# 2012 Requirements

- 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 Requirements 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 Requirements

## 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 Requirements

## 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 Requirements

## Summary of Benefits and Coverage (SBC)

- SBCs must be provided to current participants on the first day of the first open enrollment period that begins on or after September 23, 2012
- The SBC requirements apply to new enrollees on the first day of the first plan year that begins on or after September 23, 2012
- For group and individual health insurance coverage, the new requirements apply to health insurance issuers beginning on September 23, 2012



# 2012 Requirements

## Summary of Benefits and Coverage (SBC)

- SBCs are required to be distributed to plan participants and beneficiaries for employer sponsored group health plans whether insured or self-insured, but are not required for “excepted benefits”
- The employer is responsible for the distribution of the SBC with respect to a self insured plan
- The employer and the insurer are responsible for distribution of the SBC for an insured plan
  - Insurer must provide SBC to employer



# 2012 Requirements

## Summary of Benefits and Coverage (SBC)

- 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 Requirements

## Summary of Benefits and Coverage (SBC)

- Generally the SBC must be provided with any written/electronic enrollment materials
  - Special enrollment – 90 days after enrollment
  - Automatic reenrollment – 30 days before the enrollment
  - SBC may be provided in hard copy or electronically so long as certain conditions are met
- 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 Requirements

## 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 Requirements

## 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 Requirements

## 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 Requirements

## Summary of Benefits and Coverage (SBC)

- **PENALTY** – If a self-funded group health plan, its administrator, or a group health plan insurance issuer “willfully fails to provide the information required” by these new regulations, the non-compliance party shall be subject to a fine of not more than \$1,000 per such failure



# 2012 Requirements

## 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 Requirements

## 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



# 2012 Requirements

## Medical Loss Ratio Rebates

- Rebates paid to a group policyholder that is an ERISA plan sponsor may be considered a “plan asset” and subject to the fiduciary requirements of ERISA
- Technical Release 2011-04
  - Is the rebate a plan asset?
  - What are the plan sponsor’s fiduciary requirements?
- Plan sponsors need to review plans now to determine whether they address rebates



# 2013 Requirements

- 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 Requirements

## \$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
- Plans may adopt required amendments at any time through the end of calendar year 2014
- 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 Requirements

## \$2,500 Limit on FSAs

- Relief is provided for salary reduction contributions exceeding the \$2,500 limit that are due to a reasonable mistake and not willful neglect
- 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 Requirements 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 Requirements

## 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 Requirements

## 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 give 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 Requirements

- 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) employees
- Establishment of State health insurance exchanges
- Individual mandate requiring all individuals to have health insurance
- Employer mandate regarding coverage



# 2014 Requirements

## 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 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 Requirements

## Individual Mandate

- The penalty consists of the greater of a dollar amount or a percentage of household income
- The penalty applies to each individual, up to a maximum of three per household:
  - 2014: the higher of \$95 or 1.0% of taxable income
  - 2015: the higher of \$325 or 2.0% of taxable income
  - 2016: the higher of \$695 or 2.5% of taxable income
  - After 2016: the same as 2016, but adjusted annually for cost-of-living increases



# 2014 Requirements

## 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 Requirements 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 Requirements 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



# 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



# 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



# 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 Requirements

## 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 Requirements

## 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
  - If the health insurance is in the small group market offered through an Exchange, information the Treasury may require for purposes of the tax credit for employee health insurance expenses of small employers



# 2014 Requirements

## 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 Requirements

## Employer “Pay or Play” Analysis

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



# 2014 Requirements

## 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 Requirements

## 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 Requirements

- 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/Next Steps

- The status of Health Care Reform remains in question, but employers still need to comply
- Ensure procedures are in place to gather, report and provide the cost of health care on 2012 Forms W-2
- Update plans, summaries and open enrollment materials to reflect the reduction on health FSA amounts
- Employers need to be prepared to withhold the increased Medicare payroll taxes
- Individuals need to prepare for the additional Medicare payment tax and Medicare contribution tax



# Summary/Next Steps

- Encourage an open dialogue with your employees or employer (as applicable) as 2014 approaches
- Finalize Summary of Benefits and Coverage
- Begin to review CER fee requirements
- Identify whether plans are affordable and available
- Prepare to receive Medicare Loss Ratio rebate amounts with respect to 2011 insured benefit coverage





# Q & A



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