HEALTH CARE REFORM:
Countdown to the Supreme Court Decision

A Webinar in Collaboration with
Alltrust Insurance

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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

• Health care Reform impacts everyone, but today we will be focusing on the impact on employers, employees and employee health benefit plans
Introduction

- Supreme Court Decision
- Possible Outcomes of the Supreme Court Decision and the Effect
- Health Care Reform Provisions for 2012-2014
- Next Steps
Supreme Court Decision

• The Supreme Court heard oral arguments in March regarding the constitutionality of Health Care Reform
• A ruling is expected from the Supreme Court in June 2012
• How did we get here? Five federal district courts ruled on PPACA on the merits, three sided with the law’s constitutionality and two sided against it. There have been two federal appeals court rulings split one to one – a third federal appeals court refused to hear the case as it determined that the case was premature.
Supreme Court Decision

- The arguments presented to the Supreme Court addressed four issues:
  - Whether the challenges are barred prior to the individual mandate provisions becoming effective
  - Constitutionality of the “individual mandate” under the Commerce Clause
  - If the individual mandate is ruled unconstitutional, is all or a portion of the law void or is the individual mandate “severable”
  - Can states be forced to expand their Medicaid costs or risk losing Federal funding
Possible Outcome of the Supreme Court Decisions and the Effect

• No decision because the individual mandate is not yet effective
  – If this were to occur, the uncertainty will continue until 2014
  – Employers (as well as governments and individuals) will be required to comply with current and future health care reform requirements

• Individual mandate is constitutional
  – The legal challenges end but the political battles likely to continue
Possible Outcome of the Supreme Court Decisions and the Effect

• Individual mandate is unconstitutional, but is severable
  – If this were to occur the law remains in place without the individual mandate
  – Employers would have to move forward and comply with the requirements of Health Care Reform
  – Congress would be left to determine whether to overturn or keep the remainder of the law
  – Without the individual mandate, additional concerns arise with respect to the remaining provisions of the law
Possible Outcome of the Supreme Court Decisions and the Effect

• Individual mandate is unconstitutional and not severable
  – If this occurs then the entire law would be struck down
  – Employers (and insurance companies) would need to decide whether to keep the current provisions and reforms in the plans

• Individual mandate is unconstitutional and partially severable
  – Portions of the law considered related to the individual mandate would be struck down
  – Ongoing decisions for the employers (and insurance companies) would depend on the portions that are considered unconstitutional.
2012 Requirements

- Report health care quality and wellness initiatives to Health and Human Services (HHS)
- Form W-2 Reporting of health care costs
- Summary of Benefits and Coverage (SBC)/Uniform Glossary
- 60-day advance notice of changes to the SBC
- CER fees of $2 per average number of enrollees/lives assessed ($1 for policy/plan years ending during fiscal year 2013)
2012 Requirements
W-2 Reporting

- As part of the Health Care Reform, the cost of employer-sponsored health coverage must be reported on Form W-2 for the 2012 calendar year (reported in January 2013).
- The cost is generally based on the COBRA rate.
- Transitional relief for 2012 for certain small employers who file fewer than 250 Forms W-2 in 2011.
- Special rules for terminated employees.
2012 Requirements
W-2 Reporting

• The following health care costs are exempt from these new reporting requirements
  – Dental and/or vision coverage that is not integrated into a group health plan
  – Most health FSAs—required to report employer contributions to a health FSA
  – Contributions to a health savings account (HSA)
  – Health reimbursement arrangement (HRA)
  – Hospital indemnity or fixed indemnity coverage that is offered as independent coverage and paid for on an after tax basis by the employee.
  – EAPs, 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 for 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)

• An SBC must be provided with respect to each benefit package for which the participant or beneficiary is eligible, except upon renewal, a new SBC is required only with respect to the benefit package in which the participant or beneficiary is enrolled.

• SBCs are not required for certain excepted benefits (i.e. stand-alone dental or vision plans or a health FSA).
2012 Requirements

Summary of Benefits and Coverage (SBC)

- Required to be distributed to plan participants and beneficiaries for employer sponsored group health plans whether insured or self insured, but not required for “excepted benefits”
- SBC must generally be prepared for each benefit package (with certain exceptions)
- 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)

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

• 60-day 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 content:
  – 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)

• In general, the SBC must contain the following content (con’t):
  – Coverage examples (additional guidance to be issued);
  – 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.

• 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-compliant 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.
- Proposed regulations were issued April 12, 2012
- 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
CER Fees

• Certain plans are exempt:
  – The CER fees do not apply if substantially all of the coverage under a plan is for excepted benefits, as defined under HIPAA (stand-alone dental and vision plans, accident-only coverage, disability income coverage, liability insurance, workers’ compensation coverage, credit-only insurance or coverage for on-site medical clinics)
  – Many health FSAs will qualify as excepted benefits
  – Some EAPs and wellness programs, HSAs, Archer MSAs, Medicare supplement plans and Tricare supplement plans

• Retiree only plans not exempt
2012 Requirements
CER Fees

- Fees are expected to be paid on Form 720 and the earliest date for filing is July 1, 2013 for plans that have plan years ending after September 30, 2012
- Fees are calculated based on the average number of enrollees in the plan during the plan year
  - Actual enrollee count: calculate the number of enrollees on each day and divide by the number of days in the plan year
  - Snapshot dates: count the number of participants on any given day in a plan year quarter and divide by 4. This method must be applied consistently using the same day of each quarter. The snapshot method permits the number of lives covered by family coverage to be estimated by multiplying the number of participants by 2.35
  - Form 5500: based on the number of participants as of the beginning and end of the plan year as reported on Form 5500
  - Insurers cannot use the Form 5500 method, but they can use the actual count and snapshot methods as well as two other methods based on information reported to the NAIC or state regulators.
2013 Requirements

- Additional 0.9% Medicare tax on wages in excess of $250,000 for joint return filers ($200,000 for others)
- 3.8% 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
- Health flexible spending account limited to $2,500, indexed
- Employer notice provided to employees beginning on March 1, 2013 regarding exchanges
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%
- Cover routine costs of patients who are part of clinical trials
2014 Requirements

- Establishment of state health insurance exchanges for individuals and small businesses with 100 or less employees
- Individual mandate requiring all individuals to have health insurance
- Employer mandate regarding coverage
2014 Requirements
“Pay or Play” Analysis

• Individual and Employer Mandates
• Economic Considerations
• Non-Economic Considerations
• Unknown Factors
2014 Requirements
“Pay or Play” Analysis – State Exchanges

• January 1, 2014: State health exchanges are required to be established
• Exchanges will have a variety of insurance options to satisfy the new mandates
• If States fail to open an exchange, federal government has the option to step in and establish an exchange
2014 Requirements
“Pay or Play” Analysis – Individual Mandate

• Beginning in 2014, to avoid penalty, individuals will be required to have “minimum essential coverage:”
  – Subsidies for those up to 400% of Federal Poverty Level, or if employer coverage is not “affordable”
  – Medicaid will be expanded

• For 2014, penalty is $95/uninsured adult or 1% of household income over filing threshold
• For 2015, penalty is $325 or 2%
• For 2016 and after, penalty increases to $695 or 2.5%
2014 Requirements
“Pay or Play” Analysis – 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
“Pay or Play” Analysis – 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 Requirements
“Pay or Play” Analysis – Employer Mandate

Employers must report annually:
– Whether they offer health coverage to their full-time employees and dependents
– The total number and names of full-time employees receiving health coverage
– The length of any waiting period; and
– Other information about the cost of the coverage
2014 Requirements
“Pay or Play” Analysis – Economic Considerations

• 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
“Pay or Play” Analysis – Non-Economic Considerations

- Employee Expectations
- Industry Standards
- Unions
- Types of coverage options available through the exchange
- Demographics of workforce
Provide Coverage or Pay Penalty? Unknowns

- Survival of Health Care Reform
- Costs of coverage under the exchange
- Increase in the penalties over time for employers and individuals
Next Steps

• Prepare for 2012 Requirements
• Summary of Benefits and Coverage/Uniform Glossary
• Plan Fees
• W-2 Reporting Requirements
• Prepare for 2013 requirements
• Evaluate 2014 Options – play or pay
• Discuss options with consultants, legal and/or insurers
• Do not lose sight of other requirements – such as HIPAA provisions
Q & A
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