

***The Supreme Court Ruling on
Health Care Reform***

**INDO-US Chamber of Commerce
October 17, 2012**

Presented By:

**Kirsten Vignec, Shareholder
Hill Ward Henderson**

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
- Since passage of the law, numerous additional laws have been passed amending portions of original laws, and rules/guidance issued

Introduction

Forces Driving Reform:

- Growing uninsured population
- Exponential growth in expenditures
- Potential Medicare insolvency
- Cost to quality comparisons

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

- **What Health Care Reform Does Not Do:**
 - No Public Health Insurance
 - Rationing of Care
 - Tort Reform
 - Inter-State Insurance

Introduction

- Health Care Reform affects everyone, but today our focus will be on group health benefit plans with respect to employers and employees as well as the individual mandate, specifically looking at:
 - Supreme Court Decision
 - Future of Health Care Reform
 - Analysis of Key Provisions for Employers 2012 and Beyond
 - Pay or Play Analysis
 - Next Steps

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 - Whether Federal funding can be withdrawn if States do not expand Medicaid programs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

- 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
 - Legislative actions
 - New challenges
- Regardless of the ongoing political debates, the law is in place and employers and individuals need to comply

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
- **REPEALED**: Community Living Assistance Services & Support (CLASS Act)

2012 Provisions

- 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
- **REPEALED:** Expanded 1099 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

Additional Resources

- **Interim implementation guidance:** IRS Notices 2011-28: <http://www.irs.gov/pub/irs-drop/n-11-28.pdf>
- **2012 W-2 form:** <http://www.irs.gov/pub/irs-pdf/fw2.pdf>

2012 Provisions

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 Provisions

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 Provisions

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 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 FSAs, or retiree only plans)

2012 Provisions

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 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

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 Provisions

Comparative Effective Research 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

Comparative Effectiveness Research 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
 - 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 Provisions

Comparative Effectiveness Research 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

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
- Notices regarding rebates for 2011 will be due by the insurance companies in July and will be distributed in August 2012

2012 Provisions

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

2012 Provisions

Nondiscrimination

- **Expands nondiscrimination rules to cover fully insured group health plans**
 - Also includes HRAs or stand-alone Medical Reimbursement Plans (MRPs)
 - Originally applied to non-grandfathered plans for plan years beginning on or after September 23, 2010
 - No enforcement until guidance issued

2012 Provisions

Nondiscrimination

- **Penalties**

- An employer who sponsors a discriminatory insured group health plan will be subject to an excise tax liability of **\$100 per day per employee affected with a maximum penalty of \$500,000**

2012 Provisions

Nondiscrimination

- Health Care Reform provides that rules “similar” to the nondiscrimination rules under Section 105(h) of the Internal Revenue Code will apply to fully insured plans
- Section 105(h) provides for two nondiscrimination tests: the “eligibility test” and the “benefits test”

2012 Provisions

Nondiscrimination

- The eligibility test provides that a plan cannot discriminate in favor of highly compensated individuals (“HCIs”) as to eligibility to participate
 - HCIs are
 - the five highest paid officers, or
 - shareholders who own more than 10% of the value of the employer stock, or
 - the highest paid 25% of all employees

Nondiscrimination

- The benefits test ensures that benefits provided for participants who are HCIs (and their dependents), are also provided to non-HCIs (and their dependents)
- The benefits test requires that the plan not be discriminatory on its terms or in operation

Nondiscrimination

- To be nondiscriminatory on its terms:
 - required employee contributions must be identical for each benefit level
 - maximum benefit level must not vary based on age, years of service, or compensation
 - the same type of benefits must be available to HCIs and to non-HCIs
 - different waiting periods must not be imposed
- Whether a plan discriminates in actual operation is a facts and circumstances determination
- These rules are based on Section 105(h) – the issued guidance may be different

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
- Medical expense deduction limits
- 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
- 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 Provisions

\$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 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
- Examples: (1) Both spouses make \$150,000, no money will be withheld - additional taxes on return (2) Manuel makes \$249,000, spouse makes \$0, will receive refund
- 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)

Provisions

Medicare Contribution Tax

- Applies to estates and trusts, too
- Exceptions: Active business income; IRA and retirement plan withdrawals; all self-employment income; tax-exempt income

2013 Provisions

Medical Expense Deductions Threshold

- Schedule A medical deduction threshold goes from 7.5% to 10% of AGI
 - Delayed until 2017 if either spouse turns 65 by year-end
 - AMT rate remains at 10%

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 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 Provisions

- 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 Provisions

Auto-Enrollment

- Employers with 200 plus full-time employees will be required to auto-enroll employees into their employer-sponsored health plan
 - Employees 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

What is an exchange?

A marketplace for individuals and small businesses to shop for insurance.

- Offer a choice of health plans
- Standardize health plan options
- Allow consumers to compare plans based upon price (compare apples to apples)
- Intended to provide a more competitive market
- Serve as a neutral party that can offer consumers assistance in enrollment, information and determining eligibility for any subsidies

- Each state must establish a health insurance **exchange** or the Federal exchange will apply
- **Who can participate?**
 - **In 2014, small employers** can offer an exchange plan as their employer health plan via a cafeteria plan
 - **Individuals:** Self-employed or unemployed individuals can also purchase insurance via the Exchange beginning in 2014 – Individuals who are employed but do not have access to affordable minimum essential coverage
 - In 2017, states can allow **large employers** to participate

2014 Provisions

Exchange Plans

Types of exchange plans to be offered by insurers

- **Bronze** = 60% actuarial value
- **Silver** = 70% actuarial value
- **Gold** = 80% actuarial value
- **Platinum** = 90% actuarial value
- All exchange “metal” plans must cover essential health benefits, limit cost-sharing and have a specified 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

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
- **Penalties for failure to obtain coverage:**
 - In 2014: greater of \$95 or 1.0% of income
 - In 2015: greater of \$325 or 2.0% of income
 - In 2016: greater of \$695 or 2.5% of income
 - Includes a hardship exemption
 - 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

- 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
 - Individuals without coverage for less than three months in a year
 - Individuals serving prison sentences

2014 Provisions

Individual Mandate

- 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

- 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

Individual Mandate

- **Medicaid expansion:** Expands eligibility to individuals and families up to 133% of the federal poverty level (FPL)
 - If cost effective, states can opt to subsidize employer-sponsored premiums for this group
 - In 2014, state can receive additional FMAP for this expansion population
- **Premium and cost share assistance:**
 - Individuals and families with household income of 133 - 400% FPL may be eligible for sliding-scale assistance in the form of:
 - Tax credits to help pay premiums; and
 - Out-of-pocket reductions to help with cost sharing (e.g., co-payments and co-insurance)

2012
133% FPL
Individual =
\$14,856
Family of 4 =
\$30,657

2012
400% FPL:
Individual=
\$44,680
Family of 4=
\$92,200

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 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 is more than 9.5% of employee's household income, or
 - The plan pays for less than 60% of covered health care expenses
- There is an open question as to what constitutes unaffordable – additional guidance is expected

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

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 Mandate Pay or Play Analysis

- Individual and Employer Mandates
- Economic Considerations
- Non-Economic Considerations
- Unknowns

2012 Provisions

Employer Mandate

Pay or Play Analysis

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

2014 Provisions

Employer Mandate

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/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



This presentation is made available by Hill Ward Henderson for educational purposes only to provide you general information and a general understanding of the law, it is not intended to provide nor does it constitute legal advice. The presentation should not be used as a substitute for specific legal advice from a licensed professional attorney. Further, the subject matter contained in this presentation is complex and subject to change. Any tax statements in this material are not intended to suggest the avoidance of U.S. federal, state or local tax penalties.