

# *Health Care Reform 2012: Recent Developments and Next Step Planning*

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# 38757617**



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# Today's agenda

- Supreme Court review of the health reform law
- Form W-2 Reporting
- New \$2,500 Health FSA cap: Non-calendar Health FSAs
- Delayed: Summary of Benefits Coverage & 60-day advance notice
- Contraceptive Coverage under Preventive Care rules
- Comparative Effectiveness Research (CER) fees
- Status of non-discrimination testing rules (for non-grandfathered, insured plans)
- Status of state & federal insurance exchanges
- Essential health benefits package
- Maximize Minimum Loss Ratio rebates
- Wellness plans & guaranteed Return on Investment (ROI)
- Planning for 2012 and beyond

# *Supreme Court Review*



***How Possible Decisions  
May Affect Employer  
Mandate Rules***



# *Employer Mandate to OFFER a GHP*

- Effective plan years on or after January 1, 2014
- Applies if employer averaged over 50 full-time employees on business days in *preceding* calendar year
  - Aggregate based on controlled group rules for taxes
- Mandate: offer health plan coverage to all true full-time employees and dependents
  - *Employee* coverage must be affordable
  - Automatic enrollment if over 200
  - Annual penalties: \$2,000 per employee; \$3,000 if not affordable

# *Individual Mandate*

## **Individual mandate starts in 2014**

- **Requires individuals hold health coverage or pay a penalty (limited exceptions)**
  - Fines (assessed as “taxes”) for failure to purchase
    - \$95 or 1.0% of adjusted income in 2014
    - \$325 or 2.0% of adjusted income in 2015
    - \$695 or 2.5% of adjusted income in 2016

# Supreme Court Review

- **Judicial Challenges to Health Care Reform**
  - **Dispute between Eleventh & Sixth Circuit rulings, among others**
  - U.S. government says appropriate exercise of Congress' power to:
    - Broadly regulate activities affecting interstate commerce, and
    - Levy taxes
  - Challengers (including 26 states, trade groups) contend:
    - Requiring the purchase of health insurance regulates “inactivity,” which falls outside the commerce power
    - Penalty is not a “tax” of the kind permitted under the federal taxation power

# Supreme Court Review

- **November 14, 2011: Supreme Court Announces Agreement to Review PPACA**
  - Decision expected prior to June 30, 2012 (end of Supreme Court term)
  - Court to reserve 5.5 hours for oral arguments in March
  - Supreme Court will review:
    - Constitutionality of Individual Mandate
    - Severability – does the entire law fall, or just component pieces?
    - Constitutionality of Medicaid expansions financial liability on States
  - Opted *not* to review challenges to coverage requirements for private employers
  - Political implications?

# *W-2 Reporting*



*With Newest Guidance*



# W-2 Reporting

## Effective Date is Size-Dependent / For Grandfathered *and* Non-Grandfathered Plans

- **Larger Employers**: Reporting is required for ERs issuing 250 or more Form W-2s starting January 2013 (reflecting coverage received during 2012)
  - Per IRS Notice 2011-28
- **Smaller Employers**: Employers issuing fewer than 250 Form W-2s are first required to report this information in *January 2014* (reflecting coverage received during 2013)
  - Voluntary reporting is allowed in advance of deadlines

# W-2 Reporting

- **Contributions reported** - Reportable cost includes both the ER and EE portions.
  - “Cost” measurement also includes health coverage received by the EE plus any person that may be covered because of a relationship to the employee (such as spouse)
- **What coverage to report?**
  - Coverage means any group health plan made available to the employee that is excludable from income under Code Section §106
  - **Calculating the cost**: Using the monthly COBRA rate (minus 2%, if applicable) is specifically approved

# *New, Low Health FSA Limits*



***Getting in Front of  
Educational Issues***



# Looming for 2013

## Health FSA contributions capped at \$2,500 in 2013

- Indexed to CPI

## Implications for 2012

- \$2,500 cap applies on a *calendar* year basis
- What if your the Health FSA has a non-calendar year plan?
- Plans allowing larger health FSA elections affected
  - Example: July 1 – June 30 election period with employee electing \$6,000. If \$500 is funded monthly, this person exceeds \$2,500 cap during 2013 even though election was made in 2012
  - Crucial Q: Will employee's salary reduction exceed \$2,500 in 2013?
- Use plan language and enrollment form wording to automatically adjust amounts collected in 2013
- Keep 2012 Health FSA automatically limited at point of deduction from payroll like Dependent Care elections

# *Delay of Mini Summary & 60-Day Advance Notice Rules*



# Summary of Benefit Coverage

## Mini Summary Delayed

- Group health plans and health insurance issuers to provide a four-page (double-sided) Summary of Benefits Coverage
- March 2012 compliance date presented a serious challenge
- Overwhelming public comments asked for additional time

## DOL granted indefinite postponement until final regulations are issued

- DOL: “It is anticipated that the Departments’ final regulations, once issued, will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply.”

## When will the rules kick in?

- Postponement may extend into 2014, until PPACA employer coverage mandate applies

# 60-Day Advance Notice of Plan Changes: Delayed

- **Great News I:** Applies only to mid-year changes to information in the Summary of Benefit Coverage
  - Advance notice will not apply to any changes employer makes at its annual renewal / marketing of insurance or at the start of a plan year
  - Employers will not need to put renewals “to bed” early
  - Example : ABC Company has a January 1 plan year. ABC realizes in March it should have raised the plan deductible to save premium costs. The employer must give 60-days advance notice of the change.
- **Great News II:** The delay of the Summary of Benefits Coverage also delays the 60-day advance notice rule
  - Expected effective date likely in 2014 or perhaps later

# *New Fee for Comparative Effectiveness Research Institute*



*Waiting for Guidance on  
Payment Process*



# Comparative Effectiveness Research

- **What is *Comparative Effectiveness Research*?**
  - The fee paid by employer plans will fund “*medical outcomes*” analysis to assess relative success of medical protocols
- **New research fee kicks in for plan years after September 30, 2012**
  - Fee assessment period starts in 2012, but will be paid in 2013
  - Fee borne by plan sponsor (directly or pass through)
  - \$1 for plan years ending in 2013/ \$2 in 2014
  - Paid per covered life
  - Scheduled for sunset 1/1/2020 (but do revenue raisers ever sunset?)
- **Guidance pending, fees may relate to Form 5500 submission**

# *Contraceptive Coverage as Preventive Care*



*Required in  
Non-Grandfathered Plans*



# *Preventive Care Services (Recap)*

## **Preventive Services at 100%**

- First dollar coverage, no cost-sharing
- Grandfathered plans shielded from compliance
- Health plans may not cost-share for an office visit made primarily to receive preventive services
  - No deductibles, no copays, etc.
  - Special rule for separately billed services -- but doctors likely to code visits to favor patients
- Not 100% coverage if treatments result from / identified through preventive services
- List of A and B services (available from HUB International)

# Women's Preventive Care Coverage

HHS issued new guidelines (August 1, 2011)

- Must be offered women at no additional cost for plan years starting on or after August 1, 2012:
  - FDA-approved contraception methods and contraceptive counseling
  - Well-woman visits
  - Sexually-transmitted infection counseling
  - Human immunodeficiency virus (HIV) screening and counseling
  - Breastfeeding support, supplies, and counseling
  - Domestic violence screening and counseling
- All non-grandfathered plans subject to rule
- Limited exemption for “religious employers” for contraceptive services
  - Strong lobbying by Churches to expand exemption

# *Nondiscrimination Rules: Still Delayed*



*Status Remains Pending*

# *Status of Nondiscrimination Rules*

## **Compliance delayed & remains pending**

- IRS delayed application of testing to insured plans in Notice 2011-1
- IRS attorney indicates they may delay release of rules until 2014, and then may limit application of rules to employers with under 50 employees
  - HUB is lobbying for delay or non-enforcement position even after 2014
- Grandfathered plans will remain excused from compliance as long as grandfathered

# How to Comply When IRS Releases Nondiscrimination Rules

## Compliance Key

- Offer a plan design that is non-discriminatory on its face
  - No eligibility rules or benefits that favor highly compensated employees
  - Can distinguish among the general population
  - Goal: Make the auditor go away

## How to appease the highly compensated

- Shift to using employee benefits / perks not subject to health reform or discrimination rules

## Penalties are different from Self-Funded testing violations

- Self-reported
- \$100/day for each day of noncompliance X number of affected (meaning the non-highly compensated people)
  - Plus in some cases, potential participant lawsuits or civil penalties

# *State & Federal Insurance Exchanges*



*How will Exchanges  
Affect Employers?*

# What is an Exchange?

- **Ambiguous definition, depends on user perspective**
  - On-line marketplace structured to enable consumers to make easy, “apple to apples” comparison of health insurance purchases
  - Infrastructure to support PPACA coverage mandate (enforcement tool)
- **HHS Definition:**
  - *“An Exchange is an organized marketplace to help qualifying individuals and employer groups buy health insurance in a way that permits easy comparison of available plan options based on price, benefits, and quality. The Exchanges will carry out a number of functions required by health care reform, including certifying QHPs (qualified health plans), administering premium tax credits and cost sharing reductions, and responding to customer requests for assistance”*
    - HHS Agency Information Collection Activities, 76 Fed. Reg. 24032 (April 29, 2011)

# *When do the Exchanges go on-line?*

- **Exchanges to be established by 2014**
  - Coincides with “pay or play” HCR employer coverage mandate
  - Each State must establish its own Exchange
    - Exchanges may operate under different rules
    - Only required to meet minimum HHS operating standards
  - “Regional” Exchanges okay, with HHS approval
  - State failure to comply by deadline triggers invite to HHS to create a federal version of the Exchange to operate in that State

# *When do the Exchanges go on-line?*

- **Significant work already underway**
  - HHS launched website with exchange option info (July 1, 2010)
    - <http://www.healthcare.gov/>
  - HHS published proposed Exchange regulations (July 11, 2011)
  - HHS web portal archives previously unavailable data
    - Individual v. family coverage policies by state
    - Percentage of applicants denied coverage
    - Percentage applicants charged more due to health factors

# Who may purchase ?

- **Eligible Individuals**
  - Starting in 2014
  - Individuals may only enroll in a plan through the Exchange of their state of residence
  - Only *lawful residents* may obtain Exchange coverage
- **Eligible Employers**
  - Starting in 2014 for small employers only (100 or fewer)
    - States hold “option” through 2016 to limit to 50 or fewer employees
    - “SHOP” Exchange (Small Business Health Options Program)
  - Starting in 2017 states may allow large employers to use the Exchange (101 or more)

# *Who must use the Exchange?*

- No Direct “Mandate” to use Exchange
  - Eligible employers *allowed*, but not required to use Exchange
  - If Exchange is used, then the employer must make all full-time workers eligible for one or more qualified plans through the Exchange
    - Uses the new 30-hour federal definition of “full-time”
    - This rule makes PPACA non-discrimination rules largely moot except for employers with under 50 employees that choose not to voluntarily provide group health plan coverage

# *Exchanges Rely on Employer Data*

Employers may face penalties because of what the government learns from Exchange-collected data

- Employer Reporting Requirement (2015)
  - Names, SSNs, Home Address of Employee & *Dependents*
  - Month-by-Month on Whether Each Person is Covered or Not and Cost
  - Reporting rules still unclear
- Exchanges Used for Enforcement Against Individuals & Employers:
  - Individual Enrolls on Exchange with Federal Assistance
  - Exchange will Know Individual's Household Income (IRS Data Check), Whether Employed (Using IRS Information), and Whether Employer Coverage is Affordable
  - Law directs State Exchanges to Report to Federal government

# *Exchange Product Choices*

- **Exchange plans must deliver compliant coverage**
  - Offer plans covering essential benefits at four different coverage levels
    - Bronze, silver, gold, and platinum coverage at 60%, 70%, 80%, and 90% benefit payment levels, respectively
    - Insurers must also create a corresponding “child only plan” specifically devised for individuals under age 21 and catastrophic coverage for adults under 30
    - Federal option on all Exchanges

# *Essential Health Plans*



***New Developments***



# Essential Health Plan Provisions

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse treatment, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Wellness & preventive services
- Chronic disease management
- Pediatric services (oral and vision care)
- ***HHS regulations could further expand***

# *Essential Health Plan Package*

- **Essential benefits v. Minimum Essential Coverage**
  - PPACA defines a qualifying plan as covering “essential health benefits”
    - New essential benefit guidance – exemptions for self-funded plans, groups over 100 employees, grandfathered plans
  - “Minimum essential benefit” is the standard for employers’ mandate coverage
    - Minimum essential benefit describes coverage employer must provide to avoid the pay or play tax
    - As of now, minimum essential coverage is still undefined except it must be at least as rich as “bronze” level plan

# *Employee Communication on Exchanges Required Starting March 2013*



*Will you communicate  
the minimum or more?*



# Notice of Exchange Coverage

- *Who provides the notice?*
  - ***All employers subject to Fair Labor Standards Act must comply – not just employers over 50 employees in “pay or play” mandate***
- *When does the Notice requirement start?*
  - Disclosure requirement starts on March 1, 2013
    - Nine months before Exchanges go on-line
  - All workers hired on or after March 1, 2013 must receive notice at hire
  - All Employees working on the effective date must be provided with the new Notice by March 1, 2013
- *What Information must Employers Provide?*
  - Option for coverage in State Exchanges
  - Whether plan is in compliance
  - Explanation to employee of implications of buying Exchange coverage v. using Employer sponsored group health plan
  - Availability of federal tax credit
  - Unclear whether DOL can / will provide model notice
    - Exchanges are state-created, and their rules may vary

# *Insured? Maximize Your Share of Any MLR Rebate*



***Adopt Suggested  
Amendments***



# *Maximize Your Rebate*

Minimum Loss Ratio rules allow insured employers to maximize their share of any rebate, often up to the amount of premiums the employer paid

- Plan documentation must allow for this to occur, and amendments are required
  - ERISA plans
  - Government plans
  - Church plans
    - Additional special notice rule or rebate not available to church body at all

# *Not Sold on Wellness & Over 50 Employees?*



***In 2014 There's a  
Guaranteed ROI***



# Wellness ROI for Groups Over 50

## Wellness Rules Allow Employers to Shift 30% (Possibly 50%) of Premium Cost to Employees

- Outline of process for offering compliance wellness plan
- Compare employer share of cost for affordable coverage to employer cost of affordable coverage with wellness “incentive”
- Example: Employer not currently offering a group health plan but subject to large expenses for 2014
  - Hit to profits in absence of wellness
  - Cost shift allowed by wellness and its deterrent effect is potential game-changer

# *PPACA: Advanced Planning*



*2012 and beyond*



# *What do I need to do in 2012?*

## ***Sample to do List (non-exhaustive):***

- Comply with 100% preventive benefits (incl. women's)
- Communicate new \$2,500 Health FSA limit
- Start tracking value of health coverage for W-2 Reporting if applicable
  - Employers issuing fewer than 250 W-2s receive additional delay
- New “research” fee kicks in, payable in 2013
  - Fee borne by plan sponsor
  - \$1 for plan years ending in 2013/ \$2 in 2014
  - Paid per covered life
- Wait for guidance & effective date on pending obligations *before* complying
- Consider implications of nondiscrimination rules for insured plans
  - If IRS ends non-enforcement, anticipate 6-month+ transition period

# Create Your Strategies / Tactics

Non-Exhaustive:

Begin “pay or play” determinations and strategy

- Cost Projections / budget measures
- Plan documentation changes / required notices
- Identify and delegate compliance functions

Carefully examine eligibility

- Who is full-time?
- Determine cost estimates as soon as possible
- Count employees in 2013 for compliance at 50 employees
- Review use of independent contractors/outside service providers
  - Caution now because IRS audit area
  - Complaints will trigger audit & penalties

# *Thank You!*



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