Health Care Reform: Next Steps for Employers

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NFP Benefits Compliance
PPACA Topics We Will Discuss Today

- Preventive Care: Women’s Health Services and Religious Exemption
- Medical Loss Ratio (MLR)
- Summary of Benefits and Coverage (SBC)
- Health FSA Annual Limit
- Form W-2 Cost of Coverage Reporting
- P-COR Fee
- Notice of Exchange
- Annual Quality of Care Reporting
- Premium Variations for Employer-sponsored Wellness Programs
- Employer Mandate and Plan Eligibility
PPACA: Background
PPACA: The Law

- PPACA consists of 2 bills:
  - Patient Protection and Affordable Care Act (HR 3590)
  - Health Care and Education Affordability Reconciliation Act of 2010 (HR 4872)
- President Obama signed PPACA March 23, 2010 and HCERA March 30, 2010
- Together commonly referred to as Health Care Reform, PPACA or the ACA
- Immediate challenges were brought by various groups. By the end of 2010, there were 25 separate court actions files.
- Most lawsuits were quickly dismissed, but a split occurred among the Appellate Courts:
  - Dismissed on merits by DC District Court
  - Individual mandate upheld by the 6th Court of Appeals
  - Individual mandate struck down by 11th Circuit Court of Appeals
  - Dismissed for lack of jurisdiction by the 4th Circuit Court of Appeals
Supreme Court Ruling
PPACA: Post-Supreme Court

- Response by Congress and the Administration
  - Election campaign messages: party and candidates
- Public’s Response – 2012 elections
- Agency Guidance
  - Expect a deluge of regulations and guidance from HHS, DOL, IRS
- Further Court Challenges?
  - It’s over!
PPACA Timeline

Major reform takes effect!
- Individual mandate
- Insurance reform
- Individual premium and cost share subsidy
- State based insurance exchanges (individuals & small groups)
- Employer “pay or play” mandate

2010:
- Enacted March 23, 2010
- Certain immediate reforms take effect

2011:
- First wave of changes impacting most employer plans

2012:
- Set of relatively modest changes

2013:
- Nothing happens!

2014:

2015:

2016:

2017:
- States may open exchanges to large employers

2018:
- Excise tax takes effect
2012
Preventive Care and
Women’s Health Services
 Effective for plan years starting on or after Sept. 23, 2010:

- Non-grandfathered plans must provide coverage for certain preventive services with no cost sharing for participants

- The covered services are those:
  - That the US Preventive Services Task Force rates A or B
  - Immunizations recommended by the Advisory Committee on Immunization
  - Preventive care and screenings for children and women supported by the Health Resources and Services Administration (HRSA)

- Can apply copayment for out of network services or can exclude out of network preventive services

  A listing of covered services is available at: healthcare.gov/law/about/provisions/services/lists.html

Non-grandfathered plans need to provide coverage for these services with no cost sharing effective for plan years starting on or after Aug. 1, 2012.

These services include:

- well-woman visits
- screening for gestational diabetes
- human papilloma virus testing
- annual counseling for sexually transmitted infections
- annual counseling and screening for human immune-deficiency virus
- contraceptive methods and counseling
- breastfeeding support, supplies, and counseling
- screening and counseling for interpersonal and domestic violence
Women’s Health Services, Religious Exemption

• In regards to contraception coverage, there is an exemption for religious employers.

• A religious employer is defined as one that meets all of the following criteria:
  • the inculcation of religious values is the purpose of the organization
  • the organization primarily employs persons who share the religious tenets of the organization
  • the organization serves primarily persons who share the religious tenets of the organization
  • the organization is a non-profit organization under 6033 of the Internal Revenue Code
A non-profit organization that does not qualify for religious exemption may qualify for the one year safe harbor delay:

- have not provided contraceptive coverage because of religious objections since Feb. 10, 2012
- distribute notice with enrollment materials explaining that the plan does not cover contraception for that plan year
- complete a certification and maintain on file

Would be exempt from providing contraceptive coverage with no cost sharing until the plan year starting on or after Aug. 1, 2013.

Administration is preparing a policy where such organizations would not be required to subsidize the cost of contraceptive services following August 2013. The employer could purchase a policy without contraception coverage. The insurer would provide the coverage directly to participants at no charge.
2012 Medical Loss Ratio (MLR) Rebates
Insurers must spend a minimum amount of their premium revenue on medical care and quality improvement – or issue rebates to consumers.

The target is 85 percent for large group issuers.

The target is 80 percent for individual and small group issuers*

* A state may define a small group market as 50 employees or less until 2016. After 1/1/2016, small group is defined as 100 employees or less.
MLR Rebates

- The insurer must provide rebates owed no later than August 1st of the following year. The first distribution deadline is Aug. 1, 2012.

- Insurers should provide rebates to group policyholder through lower premiums or other non-taxable methods, when possible.

- “If the plan or its trust is the policyholder, in the absence of specific plan or policy language to the contrary, the entire rebate would constitute plan assets, and the policyholder would be required to comply with ERISA's fiduciary provisions …” DOL Technical Release 2011-04

- When employees have paid premiums on pre-tax basis, premium reduction is the route recommended by the IRS to reduce tax implications to employees and have the least administrative effort for employers according to the DOL.
How Should Rebate Be Used?

- **Permissible plan purposes**
  - Premium reduction for plan participants
  - Benefit enhancements to the plan
    - No explicit guidance on what constitutes “benefit enhancement”
    - Likely means using to provide discounted premiums for an enhanced benefit policy
  - Refund
    - A premium holiday
- **Questionable plan purposes**
  - Wellness program
    - Likely does not constitute a benefit enhancement
      - Does not have the same participants
      - Employer may have different policies, but only one wellness program
How Should Rebate Be Used?

- Questionable plan purposes
  - HSA
    - Participant contributions can be used to make non-employer contributions if:
      - Participant is participating in an HDHP plan in the year the rebate is made
      - HSA annual contribution limit is not met
      - Participant is not participating in health FSA or HRA
  - Unacceptable plan purposes
    - FSA
      - No qualifying event
    - HRA
      - Must be funded through employer contributions
Tax Consequences

- Group Policies – employee after-tax premium payments
- Group Policies – employee pre-tax payments (MLR rebate limited to employees participating in group health plan in both years)
- Group Policies - employee pre-tax payments (MLR rebate paid regardless of whether employee participated in 2011 plan)

- Not taxable. MLR rebate is part of policyholder’s prior year premiums.
- Rebate is taxable.
- Rebate is taxable.
Summary of Benefits and Coverage - Overview

- Applies to all group medical plans

- Uniform design, language, and format:
  - 4 pages, double-sided, 12 point font
  - Includes a glossary of standard insurance terms
  - Coverage examples describing a sample treatment plan for a medical condition (maternity care and managing diabetes) and the cost sharing provisions for that plan.

- Applies to open enrollment periods beginning on or after Sept. 23, 2012

- Applies to newly eligible and special enrollees on the first day of the first plan year following Sept. 23, 2012.

Sample documents and instructions are available at: http://www.dol.gov/ebsa/healthreform/
<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the premium?</td>
<td>$</td>
<td>The premium is the amount paid for health insurance. This is only an estimate based on information you’ve provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.</td>
</tr>
<tr>
<td>What is the overall deductible?</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there an overall annual limit on what the insurer pays?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com. If you aren’t clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.
Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn’t a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

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**Allowed Amount**
Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

**Appeal**
A request for your health insurer or plan to review a decision or a grievance again.

**Balance Billing**
When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount

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**Co-payment**
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

**Deductible**
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won’t pay

(See page 4 for a detailed example.)
When should an SBC be sent to participants and beneficiaries?

- Initial application or enrollment - as part of any written materials distributed for enrollment. If none distributed, must be provided on the first day participant or beneficiary is eligible to enroll in the coverage.
- Special enrollment - must be provided to HIPAA special enrollees no later than 90 days from enrollment.
- Renewal - only for benefit options in which participant or beneficiary is already enrolled.
  - Automatic renewals - No later than 30 days prior to the first day of new policy year
  - Non-automatic renewals - by the date the renewal application materials are distributed
- Upon request - provide within seven business days following the request.

Effective Sept. 23, 2012
Summary of Benefits and Coverage

• Fully insured plan
  • carrier is responsible for distributing to the employer. The employer may then be responsible for distributing to participants.
  • Dual responsibility for insurer and employer
Summary of Benefits and Coverage

How should an SBC be distributed?

SBC may be provided in paper format or electronically.

The same rules apply as how to distribute SPD’s electronically:
- May email if access is an integral part of their job
- May email a notification of where to find on the intranet
- The email system results in actual receipt of transmitted information
My plan is a calendar year plan with renewal on Jan. 1, 2013. I need to distribute a Summary of Benefits and Coverage during the next open enrollment, which begins on Dec. 1, 2012. True or False?

True. The Summary of Benefits and Coverage is effective for open enrollment periods beginning on or after Sept. 23, 2012. Thus, calendar year plans renewing in December 2012 are required to distribute the Summary during the renewal period.
2013 Health FSA Annual Limit
Effective Jan. 1, 2013, health FSA participants will be limited to an annual contribution limit of $2,500.

Does not include employer contributions (contributions that cannot be cashed out or allocated to other purposes)

Will be adjusted for cost of living increases in subsequent years
2013
Form W-2 Cost of Coverage Reporting
The requirement applies to 2012 data to be reported on W-2’s issued in January 2013 (was delayed one year).

Small employer exception- Employers who file less than 250 Form W-2’s in the previous calendar year.

Total aggregate cost:
- COBRA applicable premium
- Premium charged by the carrier
- Modified COBRA premium- If the employer subsidizes the COBRA cost, then the employer may report a reasonable good-faith estimate of the full cost. This approach recognizes situations where an employer with a self-insured plan subsidizes the cost of COBRA by under-estimating the actual cost of health benefits.

Reported in Box 12 of the Form W-2, using the code DD.

Copy of IRS Instructions
2013 Form W-2 Reporting: What needs to be reported?

<table>
<thead>
<tr>
<th>Applicable Employer-sponsored Coverage</th>
<th>Included</th>
<th>Not Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major medical coverage</td>
<td>Employee FSA contributions (through salary reductions)</td>
<td></td>
</tr>
<tr>
<td>Executive medical plan coverage</td>
<td>HRA coverage*</td>
<td></td>
</tr>
<tr>
<td>Combined medical/dental/vision plan</td>
<td>HSA and Archer MSA contributions</td>
<td></td>
</tr>
<tr>
<td>Employee assistance program (EAP)</td>
<td>Non-coordinated coverage for specific illness or disease (i.e., cancer coverage)</td>
<td></td>
</tr>
<tr>
<td>Employer contributions to health FSA (including employer flex credits)</td>
<td>Coverage under HIPAA-excepted benefit, including stand-alone vision or dental plan</td>
<td></td>
</tr>
<tr>
<td>On-site medical clinics</td>
<td>Coverage for long-term care</td>
<td></td>
</tr>
<tr>
<td>Prescription drug coverage</td>
<td>Multi-employer plans*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-insured group health plans not subject to COBRA (e.g., plans sponsored by church organizations)*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coverage provided under a government plan that provides coverage primarily for members of the military and their families</td>
<td></td>
</tr>
</tbody>
</table>

* Subject to transition rules (discussed below)

Importantly, coverage under a health reimbursement arrangement (HRA), coverage under a multiemployer plan, and self-insured group health plans not subject to COBRA are subject to transitional rules under Notice 2011-28, meaning that the IRS may limit the applicability of those provisions in future guidance. That said, any change will be prospective only and will not apply earlier than Jan. 1 of the calendar year beginning at least six months after the date of issuance of any change.
My employees are concerned that the amount included on their W-2 for the cost of coverage is taxable. What do I tell them?

“Q1. Does the cost of an employee’s health care benefits shown on the Form W-2 mean that the benefits are taxable to the employee?

A. No. There is nothing about the reporting requirement that causes or will cause excludable employer-provided health coverage to become taxable. The purpose of the reporting requirement is to provide employees useful and comparable consumer information on the cost of their health care coverage.”

http://www.irs.gov/newsroom/article/0,,id=237894,00.html
2013
Patient Centered Outcomes Research Fee (PCOR Fee)
Patient Centered Outcomes Research (PCOR) Institute

- Also known as the Comparative Effectiveness Research Fee
- $2 times the average number of **covered lives** ($1 for plan years ending before Oct. 1, 2013)
- Payable by the insurer, or the plan sponsor for self-insured plans
- Does not apply to most excepted benefits (standalone dental or vision) but does apply to retiree-only
- Reported on IRS Form 720 and due July 31 of the following year.
- Will fund Patient Centered Outcomes Research Institute that will research the effectiveness of medical treatments, procedures, drugs, and other strategies.
Three methods of calculating the number of covered lives:

- **Actual count method** - Calculate the sum of the lives covered for each day of the plan year and divide that sum by the number of days in the plan year.

- **Snapshot method** - Add the totals of lives covered on one date in each quarter, or an equal number of dates for each quarter, and divide the total by the number of dates on which a count was made.

- **Form 5500 method** - Utilize the number of participants reported on the Form 5500 for the plan year.
Notice of Exchange

- Effective March 1, 2013
- On or prior to 3/1/13, employers must distribute to current employees and subsequent new hires
- Applies to employers who are subject to the FLSA
- Content requirements:
  - Notifies of the existence of the Exchange
  - A description of the Exchange’s services
  - That they may be eligible for a premium tax credit or cost-sharing reduction
  - Contact information
2013 Annual Quality of Care Reporting
2013: Annual Quality of Care Reporting

- Required of non-grandfathered group health plans and health insurance issuers
- Report medical management program, wellness activities, practices that affect the quality of care. Specifically, whether the plan:
  - improves health outcomes for treatment or services through activities such as effective case management, chronic disease management, care coordination
  - implements activities to prevent hospital re-admits
  - improves patient safety and reduces medical errors through technology, clinical practices, evidence-based medicine
  - implements wellness and health promotion activities
- Report must be made available to enrollees during open enrollment
- Will be an annual report. PPACA did not specify a due date. Regulations were due March 23, 2012. Have not yet been released.
2014
Required Informational Reporting
Insurers must report to IRS:
- name, address, taxpayer identification number of primary insured and others insured
- dates covered during calendar year
- whether coverage is qualified health plan
- premiums paid and contributions or premium assistance received
- employer identifying information and portion paid by employer
- due by Jan. 31 each calendar year (2015 first report due)

Written statement to covered individuals:
- must detail the information reported to IRS (above)
2014: Required Informational Reporting

- Applicable large employers and “offering employers”:
  - report to the IRS whether minimum essential coverage was offered to employees
  - IRS will use this information to verify employer-sponsored coverage and to administer employer mandate provisions
  - due by Jan. 31
  - may be coordinated with previous reporting requirement

- Written statement to full-time employees:
  - must detail the information reported to IRS (above)
Premium Variations for Employer-sponsored Wellness Programs
Employers will be able to vary premiums by as much as 30% for employee participation in certain health promotion and disease prevention programs.

The Secretaries of Labor, HHS, and the Treasury can authorize this to increase up to 50%.
2014
Employer Mandate
2014: Employer Mandate

- Effective Jan. 1, 2014, there is a penalty tax assessed for certain large employers for:
  - Failing to offer health care coverage to all full-time employees (and their dependents): or
  - Offering coverage that is determined to be either “unaffordable” or “unqualified”. (Code § 4980H)

- The penalty tax is due if at least one full-time employee purchases health insurance through an Exchange and receives a premium tax credit or cost-sharing reduction subsidy.
2014: Employer Mandate

- Who is an employer for purposes of the shared responsibility provision?
  - A large employer with an average number of 50 full time equivalent employees during the year.

- Calculating 50 full time equivalent employees
  - Step 1: Add up all employees who work 30 hours a week. Keep this number to the side.
  - Step 2: Separately, add up all the hours of service in a month for employees who are not full time.
  - Step 3: Divide the number from Step 2 by 120.
  - Step 4: Add the number from Step 3 to the number in Step 1.

- If the average number of employees for the year is 50 or more, then the employer is an applicable large employer for purposes of the shared responsibility provision.

Code § 4980H(c)(4)(A)
2014: Employer Mandate

- Exception for seasonal employees, defined as working 120-days (or fewer)
  - “Seasonal worker” means a worker who performs labor or services on a seasonal basis as defined by the DOL, including agricultural workers covered by 29 CFR § 500.20(s)(1) and retail workers employed exclusively during holiday seasons.

- IRS Request for comments in Notice 2011-36
  - How to determine the hours of service of an employee, including those not compensated on an hourly basis.
2014: Employer Mandate

Do you offer coverage?

No

$2,000 per FTE (minus first 30)
Only applies if one full-time employee receives federal premium assistance for exchange coverage.
2014: Employer Mandate

Do you offer coverage?

Yes

Does the plan provide minimum value?

No

Lesser of:
$3,000 per FTE receiving tax credit or
$2,000 per FTE (minus first 30)

Only applies if one full-time employee receives federal premium assistance for exchange coverage.
2014: Employer Mandate

Do you offer coverage?
- Yes

Does the plan provide minimum value?
- Yes

Is the coverage affordable?
- No

Lesser of:
- $3,000 per FTE receiving tax credit
- $2,000 per FTE (minus first 30)

Only applies if one full-time employee receives federal premium assistance for exchange coverage.
2014: Employer Mandate

Do you offer coverage?
- Yes
  Does the plan provide minimum value?
    - Yes
      Is the coverage affordable?
        - Yes
          No Penalty
2014: Employer Mandate

- Do you offer coverage?
  - Yes
  - Does the plan provide minimum value?
    - Yes
    - Is the coverage affordable?
      - Yes: No Penalty
      - No
    - No
  - No
    - $2,000 per FTE (minus first 30)
      Only applies if one full-time employee receives federal premium assistance for exchange coverage.
  - Less of:
    - $3,000 per FTE receiving tax credit or
    - $2,000 per FTE (minus first 30)
      Only applies if one full-time employee receives federal premium assistance for exchange coverage.
Employer Mandate Considerations

- Planning for employer mandate
  - Evaluate plan cost and design: Affordable and Qualified?
  - Evaluate employee population
  - Consider tax consequences
  - Consider employee compensation and retention
  - Assess total rewards strategy
PPACA: Employer Action Items

Develop Your Game Plan for Compliance:

- Assess plans subject to PPACA
- Determine PPACA obligations
- Work with insurer and/or TPA for compliance
- Stay on top of regulations and guidance
Questions?