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Health Care Reform: What Employers Need to Know

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Overview

•Brief discussion about Supreme Court Holding

•What Employers and Plan/Sponsors need to do:

- What should have already been implemented
- 2012 Requirements
- 2013 Requirements
- Preparing for 2014 Health Care Reform

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Supreme Court Ruling

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Supreme Court Ruling

- June 28, 2012
  - Decision 5-4 upholding almost all of the PPACA
    - Chief Justice Roberts joined more liberal justices
    - Act constitutional under Congressional power to tax
    - Individual mandate upheld
    - States may opt out of Medicaid expansion
      - Little impact on employer sponsored plans
      - Around a dozen states contemplating opting out
  - Continued phased-in compliance obligations

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While You Were Waiting

- Many plan sponsors delayed taking action while waiting for decision
  - Near Term Compliance
  - Long Term Strategic Decisions
- Governmental agencies delayed issuing regulations
  - Flood of regulations expected:
    - Automatic enrollment, non-discrimination for insured plans, employer play or pay mandate

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Don’t Delay Further

- Employers and Plan Sponsors should evaluate current compliance efforts
  - What should you have already done?
  - What needs to be done this year or next?
  - What long-term issues do you need to think about?

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Remaining Uncertainty

- Some expect that all, or some of PPACA could be overturned with pending election season
  - Would require Romney to win the election
  - Would require Republicans to control 60 seats in Senate
    - Must beat Democrats ability to filibuster
  - OR: Republicans could pass a bill that guts the funding of PPACA
- Eliminating some provisions will be politically unpopular
  - Ex: No pre-existing conditions for children; coverage of adult children

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Current Compliance

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What Should You Have Done?

- Lifetime Dollar Limits Prohibited
- Annual Dollar Limits Phased-Out
- No Coverage of OTC medications, drugs or biologicals without a prescription
- Restrictions on rescission of coverage
- Restrictions on pre-existing conditions for children under age 19 (NGR only)
- Preventive Care Requirements (NGR only)
- Modification to Claims/Appeals (NGR only)

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What Should You Have Done?

- Continued coverage for adult children until age 26
  - Differing rules for grandfathered plans
- Patient Protection Requirements (NGR only)
  - Right to Choose Primary Care Provider
  - Emergency Room Care
- Annual reassessment of grandfathered status
- Small Business Health Care Tax Credit

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Health Care Reform Issues for 2012/2013

What you should be working on now . . . .

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W-2 Reporting Requirements

- 2012 W-2s must include cost of health plan coverage
  - Applies to W-2s issued beginning in January 2013 for the 2012 calendar year
  - Box 12, Code DD
  - See table of benefit costs to be included
  - Listen to our prior webinar on the topic:
    - http://www.wnj.com/News-and-Events/Events/Are-You-Ready-for-W-2-Reporting-of-the-Cost-of-Emp

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Summary of Benefits and Coverage

- Must begin distributing SBC:
  - With open enrollment periods beginning on or after September 23, 2012 (currently eligible employees)
  - By first day of plan year beginning on or after September 23, 2012 (for newly eligible employees)
- See hand-out example
- Listen to our prior webinar on the topic:
  - http://www.wnj.com/News-and-Events/Events/Preparing-the-Summary-of-Benefits-and-Coverage-for

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Medical Loss Ratio Rebates

- Some Michigan insurers are expecting to pay rebates:
  - Small group market: 4% paying rebates, avg. rebate $98.25
  - Large group market: 1% paying rebates, avg. rebate $101.20
- Rebates will generally be paid to the employer.
- Fiduciary duty and plan asset rules govern these funds.
  - Consider plan provisions about rebates
  - Were funds paid from a trust?
  - Consider relative proportion of premiums paid by employees

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Medical Loss Ratio Rebates

- What to do with rebates that are plan assets?
  - Could issue rebates (ERISA and governmental plans)
    - Calculation expenses
    - Tax with-holding issues
  - Could reduce future premiums (ERISA and governmental plans)
    - Cafeteria plan must include provision allowing automatic adjustment
    - Is the change “significant” so that employees must be given choice?
  - Could enhance benefits (ERISA plans)
- Must use the rebates within 3-months to avoid ERISA trust requirements
  - Rebates expected to issue by August 1, 2012

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Preventive Care

- Women's preventive health services finalized
  - Non-grandfathered group health plans must cover without cost sharing with plan years that begin on or after August 1, 2012.
    - No copays, deductibles, co-insurance payments for in-network visits
  - See the attached list of categories that must be covered
- Exceptions for:
  - Grandfathered plans, FSAs, stand-alone dental and vision plans
  - Certain non-profit religious organizations exempt

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Fees to Fund Comparative Effectiveness Research

- Applies to nongrandfathered group health plans
  - Plan years ending on or after October 1, 2012 through plan years ending on or after October 1, 2019
    - $1 per enrollee first year
    - $2 per enrollee for subsequent years
- Fee based on average number of lives covered during the year
- Fees will be submitted using Form 720, "Quarterly Federal Excise Tax Return."
  - Need to submit only once during year—by July 31.
  - File for the plan year that ended during preceding year.

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Fees to Fund Comparative Effectiveness Research

- Fees will not apply to the following plans:
  - Plans for expatriates working in other countries are exempt
  - Stop loss/indemnity reinsurance policies exempt
  - Most Health FSAs exempt
  - HRAs integrated with plan sponsor’s self-funded health plan exempt.
  - EAPs, wellness programs, disease management programs that do not provide significant medical benefits

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Health FSA Limits

Health FSA contributions limited to $2500 beginning after 12/31/2012.

- Requires plan provision limiting contributions.
- Indexed to inflation for subsequent years.
- Employer contributions that cannot be cashed out do not count toward limit.
- Special rules apply to non-calendar year plans

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Preparing for 2014

What you need to be planning for . . . .

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The Framework for 2014

•Substantial insurance market reforms go into effect:

- Individual mandate to have essential health coverage
- Employer play or pay provisions go into effect
- State insurance exchanges for individual and small-group markets

•Goal is to increase number of people covered by insurance

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Notice of Exchanges

Must provide notice of exchange to:

- Current employees by March 1, 2013
- To new employees hired on or after March 1, 2013

Content of Notices

- Individual coverage will be available through an Exchange beginning 1/1/2014.
  - Services provided by Exchange and contact information
  - Possibility for premium tax credits or cost-sharing reductions
- Consequences if employee decides to purchase a qualified health plan through an exchange in lieu of employer-sponsored coverage—i.e. loss of employer tax-free contributions.

Still waiting for guidance . . . .

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Employers Must Offer Minimum Essential Coverage

What constitutes "minimum essential coverage" for 2014?

- Stand-alone HRAs—probably no longer viable
- Mini-med plans—probably no longer viable
- "Excepted benefits" won't count as health plan coverage
  - Dental
  - Vision
  - Insured medical indemnity plans

If fail to provide minimum essential coverage to all full-time employees

- penalty: $2,000 per full-time employee (at least 30 hrs per week)

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Affordable Coverage

Coverage must be "affordable"

- Costs no more than 9.5% of employee's household income
  - › Proposed safe harbor: 9.5% of employee's W-2 income.
- Plan provides "minimal value"—plan pays at least 60% of the total expenses incurred

Potential penalties:

- $3,000 per employee who qualifies for subsidized coverage through exchange

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Reporting Requirements

Beginning in 2014, employer group health plans (including self-insured plans) will have to report health coverage information to the IRS:

- Names, addresses and taxpayer ID numbers of primary insured
- Names and taxpayer IDs of dependents covered
- Dates of coverage
- Name, address and EIN of employer maintaining the plan
- Portion of premium (if any) that employee must pay
- Any other information required by IRS

Must report to individuals the information reported to IRS

Still waiting for guidance . . . .

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Mandates for 2014

Pre-existing condition exclusions prohibited for everyone

Annual limits prohibited on essential health benefits (phase-out period ends 2013)

- What are essential health benefits?
  - Ambulatory Services
  - Emergency Services
  - Hospitalization
  - Maternity/Newborn Care
  - Laboratory Services
  - Mental Health/Substance or Abuse, including Behavioral Health
  - Prescription Drugs
  - Rehabilitative/Habilitative Services/Devices
  - Pediatric – including Chronic Disease
  - Preventive/Wellness and Chronic Disease Management
  - Pediatric Services, including Oral/vision care
- State-by-state determination?
  - Any of three largest small group plans by enrollment
  - Any of three largest state employee health plans by enrollment
  - Any of three largest federal employee health plan options by enrollment
  - Largest insured commercial HMO operating in state by enrollment

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Mandates for 2014

Coverage for clinical trials

- May not deny right to participate in clinical trial or discriminate against any qualified individual who participates in clinical trial
- May not deny, limit or impose additional conditions on coverage for routine patient costs for items and services furnished in connection with participation in the clinical trial

Cost sharing limitations apply to all plans beginning 2014

- Out-of-pocket maximums may not exceed HDHP limits (indexed)
- Currently: $5,950 self-only/$11,900 family

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Nondiscrimination Rules for Insured Plans

- Will apply requirements similar to self-insured nondiscrimination rules to insured plans
- Notice 2011-1 (issues 12.31.2010) postponed application of the rule
- IRS still wrangling with this issue
  - Probably won't see rules until late 2012 or 2013
  - Probably won't go into effect until 2014 or 2015

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Eligibility Issues

Automatic Enrollment—delayed until 2015 or later

- Will apply to employers with more than 200 employees
  - Must automatically enroll new full-time employees in one of health plans it offers (subject to waiting period)
  - Employees may opt out

Beginning 2014: maximum 90-day waiting period for coverage

- applies only to otherwise eligible full-time employees
- Allows maximum three-month waiting or eligibility period
- Still waiting for additional guidance

Increased Wellness Incentives Permitted – 30%

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Will Employer Coverage Survive?

Will employers continue to offer health benefits?

- Need to attract and retain vs. cost of providing coverage
  - › Tax-free benefits vs. taxable income
  - › New variable: additional costs (penalties) if decide not to provide coverage
  - › Will your company be at an economic disadvantage in the labor markets if it doesn't provide coverage?
- Need to remain competitive within industry
  - Will others drop coverage?
  - Will that give them a competitive advantage?

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Long Term Planning

Questions to Ask Yourself:

- Is plan coverage affordable?
- Is plan coverage good enough?
  - Must meet at least the Bronze plan on the Exchange
- Is plan coverage too good?
  - Cadillac Tax kicks in 2018
- How can plan costs be contained?
  - Wellness programs
  - Cost-sharing
  - Creative structuring

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Questions?

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