State & Federal Health Care Reform Update
Community Center
Grand Haven, Michigan
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(Materials included in the following outline are not intended to provide legal advice and are for seminar use only.)
CONSTITUTIONALITY

- **Headed to the Supremes**  D.C. (not Motown) (11/14/2011) - Circuit Court Conflicts
  - **Pro**
    - Thomas More Law Center v Obama (CA6, 2011)
    - Seven Sky v Holder (DC Cir, 2011)
    - Kindler v Geither (DCt Ed Mo, 2011) Appealed
  - **Con**
    - Baldwin v Sebelius (9th Cir, 2011)
    - Florida v HHS (11th Cir, 2011)
  - **Supreme Court Certiorari**  11/14/2011 Issues
    - Constitutionality Individual Mandate  2 hours Fla v HHA (11th Cir)
    - Severability  1½ hours
    - Medicaid Expansion  1 hour
    - Premature Taxation - Not Until Paid 1 hour (4th Cir)
CONSTITUTIONALITY

**Background**

- **Pubic Opinion** 48% oppose – 40% support
- **Insurer Fear** Mandate struck down, obligation to cover w/o pre-existing condition exclusion guaranteeing adverse selection
- **Administration Position** Individual mandate (and the associated tax penalty) is severable from the remainder of the legislation
PLAN DESIGN

- Trend-Employers Abandoning Plans - % Insured dropped from 45.0% to 44.5%, uninsured % increased to 17.1%
- Employer Plans – High Deductibles
  - Employers with HSA’s – 41% with 12% adding HSA option in 2012 (34% increase)
  - HRA Programs Premiums higher but better employer cash flow
PLAN DESIGN

- **HSA Issues**
  - **Over 65**
    - *Hall v Sibelius* (D.C. Cir, 2/7/2012) Over 65 cannot refuse Part A or lose Social Security benefits
    - *Workers* cannot draw Social Security because benefits = automatic enrollment = Medicare Part A which is disqualifying coverage
  - **New HSA Forms** 5305-B (trust), 5305-C (custodial) December 2011
**HSA’s LIKELY HRA’S DISAPPEAR**

- **Group Health Plans** may not impose lifetime limits on the dollar value of health benefits, and annual limits must be within certain ranges
  - Restricted annual limits could have been waived. The Administration stopped accepting applications on September 22, 2011
- **Stand Alone HRAs** in effect prior to September 23, 2010 do not have to comply with annual limit requirements for plan years beginning before January 1, 2014
  - Under recent guidance, no annual waivers necessary before January 1, 2014.
  - If an employer that maintains an HRA also maintains other coverage, whether or not that coverage is integrated with the HRA, that other coverage must comply with the annual limit restrictions or obtain a waiver.
- **After 2014** – stand-alone HRAs likely will not exist
CURRENT PLANS  DEFINED BENEFIT – Employer takes bulk of risk of increased costs

ALTERNATIVE APPROACH – DEFINED CONTRIBUTION  Three Parts – No Employer Plan

- Cafeteria/§125 Plan  Employer Specified Contribution
- Qualifying Employees  Employer contribution offset by federal subsidy or tax credit and employees required to go to public exchange
- Other Employees
  - No offset of employer contribution
  - Buy Coverage through arranged, third party private exchange
INDIVIDUALS with income up to 400% of poverty level receive a cost sharing subsidy

<table>
<thead>
<tr>
<th>Income % of poverty level</th>
<th>Premium Cap as a % of Income</th>
<th>Income $ (family of 4)</th>
<th>Max OP Premium</th>
<th>Premium Savings</th>
<th>Subsidy</th>
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<tr>
<td>133%</td>
<td>3%</td>
<td>$31,900</td>
<td>$992</td>
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<td>$66,150</td>
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<td>$77,175</td>
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<td>$88,200</td>
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<td>$1,480</td>
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DEFINED CONTRIBUTION – PRIVATE EXCHANGE ALTERNATIVE

- **Set Cost** – predetermined contribution rate with modest annual increases perhaps with HSA employer contribution
- **Employee Participation** - Pre-tax contribution through §125/cafeteria plan for balance of premium/contribution
- **Financial Issues**
  - “Pay or Play” Penalty $2,000 per full-time employee
  - Cadillac Plan Excise Tax  Avoid imposition
DEFINED CONTRIBUTION – PRIVATE EXCHANGE ALTERNATIVE

Market Place Responses

- **Bloom Health Corp**, Minneapolis 2012 HCSC, BCBS Michigan, Well Point are majority equity holders
- **Highmark Inc**, Pennsylvania, Pilot Program, 77 medical, 2 dental vision options
- **BCBS Kansas City** 10 options
ELIGIBILITY

- **Automatic Enrollment**
  - **200 + 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
  - **Full-Time Employee Threshold** not specified – assumed to be 30 hours or more
  - **Effective Date** - 2015 DOL Tech. Release 2012-9 (2/14/12), IRS Notice 2012-17, delayed to 2015 or later
  - **Hours Threshold Determination** Likely based on look back periods of not more than 12 months

- **90-Day Waiting Period** applies only to otherwise eligible full-time employees and allows three-month waiting or eligibility period
HEALTH CARE REFORM
ELIGIBILITY

- **Nondiscrimination** – 2014/15 Notice 2011-1 (12/31/2010) Postpones application until guidance is issued (likely not until 2012 or 2013), likely 2015 or 2015

- Group five highest paid officers, 10% shareholder, top 25% in pay
  - **Self-Insured Plans** If discriminatory, highly compensated individuals subject to tax
  - **Insured Plans** If discriminatory, highly compensated individuals will not be taxed. Instead, the employer is subject to a $100 per day, per participant excise tax, capped at the lesser of $500,000 or 10% of the employer’s healthcare expenses for the previous year
CONTRIBUTIONS
2014

New State Fees (Michigan) – Paid Claims Assessment Act PA 142 MCLA

- Effective January 1, 2012
- 1% of claims paid - Michigan Residents & Providers only
- Paid by Insurer, HMO or Plan Sponsor (self insured)
- Form 4926 Electronic Funds Transfer Registration
- Form 4930 Quarterly Worksheet – April, July, October, January, first one due 4/30/2012
- Form 4931 Annual return
HEALTH CARE REFORM
FEDERAL TAX INCREASES
2012

- Federal – IRS Notice 2011-85  Annual fees on non grandfathered insured and self-insured benefit plans to fund comparative effectiveness outcomes research
  - $1 per enrollee for years beginning after 9/30/2012
  - $2 thereafter
  - ? HRA exempt (pending IRS ruling request)

- Federal – Stealth Plan Taxes
  - Brand Name Prescription Drug Manufacturers  Prorata share of $2.8 - 4.1billion
  - Health Insurance Providers  prorata share of $8 – 14.3 billion

- FICA Tax Rate 2013 increase  .9% for wages or self-employment income over $200,000 single/separate/$250,000 married filing jointly

- Net Investment Income Tax 2013 3.8% of lesser of net investment income or employment income AGI > 200/250K
CONTRIBUTIONS
2014

- **Pay or Play Penalty** – 50 + Large Employer Equivalent of 50 + FTE
  Employees subject to assessable payment if any full-time employee is certified to receive an applicable premium tax credit or cost-sharing reduction *and* either:
  - The employer does not offer FTEs (and their dependents) the opportunity to enroll in minimum essential coverage; or
  - The employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage that either is unaffordable or does not provide minimum value

- **Affordable** If the employee’s required contribution to the plan does not exceed 9.5% of the employee’s *household income* for the taxable year
CONTRIBUTIONS
2014

- **Pay or Plan Proposed Safe Harbor** 9.5% of wages employer paid to an employee (Box 1 amount), instead of 9.5% of *household income*
  - Only applicable for employer shared responsibility provision
  - Does not affect employee’s eligibility for health insurance premium tax credits
  - Determined after the end of the calendar year and on an employee-by-employee basis
  - Could be used prospectively

- **Penalties**
  - $2,000 x FTE (-30) if no minimum essential coverage
  - $3,000 x # of employees who actually receive credits/enroll in exchange (capped at above penalty)
PPACA ENFORCEMENT – FEES CURRENT

- **Form 8920** Self-Reporting of Failures
- **Excise Tax** $100 per day
- **Timing** Due date of employer’s Federal tax return
PUBLIC EMPLOYER HARD CAP – BASICS

- **Dollar Cap** A PUBLIC EMPLOYER that offers or contributes to a MEDICAL BENEFIT PLAN shall pay no more of the annual cost or illustrative rate and any payments for reimbursement of co-pays, deductibles or payments into HSAs, FSAs, or similar accounts for health care costs than a total amount equal to
  - $5,500 times the number of employees with single coverage
  - $11,000 times the number of employees with individual and spouse coverage
  - $15,000 times the number of employees with family coverage
for a MEDICAL PLAN coverage year beginning on or after January 1, 2012

- **Inflation** Adjusted by medical care component of CSI

- **Annual Cost/Illustrative Rate** Undefined
PUBLIC EMPLOYER HARD CAP – BASICS

- **Public Employer**
  - State
  - Local
  - Other Political Subdivision
  - Community College
  - Intergovernmental, metropolitan or local department agency or authority
  - School District
  - Public School Academy
  - Intermediate School District
  - Higher Education Institution

- **Medical Benefit Plan**
  - Plan established and maintained by a carrier, a VEBA (501(c)(9)), or more public employees
    - Provides for payment of medical benefits including but not limited to hospital and physician services, prescription drugs, and related benefits for public employees or elected public officials
    - Excludes retiree payments
    - Excludes stand alone Dental/Vision
PUBLIC EMPLOYER HARD CAP – BASICS

- **Medical Plan Coverage Year?**
  - Limits (Deductibles, etc.) calendar year?
  - Plan Year 9/1 – 8/31?
  - Renewal period/policy year?
  - District’s Fiscal Year 7/1 – 6/30?

- **Effective Date**
  - **General** Medical plan coverage years beginning on or after 1/1/2012
  - **Collective Bargaining** All agreements executed on/after 9/15/2011
    - Existing agreements continue until expiration
    - Calculation exclusion until employees are covered

- **Parent + Child? Two person groups?** What multiplier
  - Individual/Spouse? $11,000
  - Family $15,000
PUBLIC EMPLOYER HARD CAP – BASICS

- **Percentage Cap/E Cost Sharing**  By a majority vote of its governing body a PUBLIC EMPLOYER, excluding this State, may elect to comply with this section for medical plan coverage year [as follows] …a PUBLIC EMPLOYER shall pay not more than 80% of TOTAL ANNUAL COSTS of all of the MEDICAL BENEFIT PLANS it offers or contributes to for its employees and elected public officials [inserted]
  - Yearly election can switch methods
  - Danger inflation risk, ? Return to hard cap

- **Collective Bargaining**  Unions likely to propose this alternative
PUBLIC EMPLOYER HARD CAP – BASICS

Total Annual Costs

- Include Employer payments for
  - Premium or illustrative rate of plan (undefined)
  - Reimbursement of co-pays, deductibles and payments into HSAs, FSAs, or similar accounts

- Exclude Beneficiary payments
  - for copayments, coinsurance, deductibles, out-of-pocket expenses, or service related expenses
  - to HSAs, FSAs or similar accounts

- HRA Contributions
  - Actual? (20-80% of amount available)
  - Actuarial projection?
PUBLIC EMPLOYER HARD CAP – BASICS

- **Calculation**  Aggregate Basis
  - “may allocate payments among employees…as it sees fit”
  - “may allocate employees share as it sees fit”

- **Do the Math**  Current Costs and Projected Costs (Renewal Rates)
  - Dollar Cap
  - Percentage Cap

- **Noncompliance**  10% Penalty
  - **Schools**  School aid payment
  - **Local Gov’t**  Economic vitality incentive program

- **Enforcement/Regulatory Authority**  Not identified – problem – who will issue guidance, Treasury or Dept. of Education
PUBLIC EMPLOYER HARD CAP – BASICS
ENTITY EXEMPTION

- **Local Government – Exemption Mechanism** By a two thirds vote of its governing body an eligible local governmental unit
  - **Limited Definition**
    - Normal City, village, township, county
    - Other Municipal electric provider, airport or Huron Clinton MTA.
  - **Not**
    - Education Colleges, schools
    - Other Political Subdivision or intergovernmental, metropolitan, local department or agency which does not have a publicly elected Board
  - **Actual Example** Ogemaw County (West Branch) but chose new plan under the caps

- **Pooled Plans** If eligible government sponsors – all participating employees exempt?
  - **Plan Structure?** Identical plans for different offerings for different segments of employees?
  - **Concern: Control of Election** Controlling entity can opt back in
  - **Intergovernmental Cooperation Agreement** Use to compel collective decision making
PUBLIC EMPLOYER HEALTH PLAN
BARGAINING IMPACT

- **Mandatory Compliance**  Agreements must adhere to the rules

- **The Hammer**  PA Act 54 (2011) (amending PA 336 (1947)), If bargaining agreement expires, public employer must pass along increased costs of maintaining health, dental, vision, prescription or other insurance by automatic payroll deduction until successor agreement is in place
  - No additional benefits
  - No retroactive benefits

- **Increased Cost Difference** in premiums or illustrated rates by tier of coverage
PUBLIC EMPLOYER HEALTH PLAN
COPING STRATEGIES

- Compensation  Sleight of hand
  - More Dollars  Decrease employer contribution, increase pay
  - FICA Exempt  Not FICA if pre-tax premium, cafeteria plan
  - MPSERS Problem  Is subject to 24.6% assessment

- Plan Design Modifications  Minimize costs
  - Retain grandfathering
  - Eligibility Auditing
  - Change Overall Plan Package – lesser cost plan
  - Provider Networks – Carrier negotiates better rates, excluding unwilling providers
PUBLIC EMPLOYER HEALTH PLAN COPING STRATEGIES

- **↑ Employee Costs** (see Cafeteria Plan discussion)
  - Premium
  - Deductibles
  - Co-pays – Rx, office visits

- **↓ Utilization**
  - Wellness Plans
  - Financial Incentives
High Deductible Plan

- **HSA** Actual dollars contributed
  - **Problem** Unions demand up front funding
  - **Other Uses** Can’t limit to medical

- **Substitute HRA** hypothetical credit, (with retirement retention) for HSA – book/accounting credits/not actual funding
  - **Cost** Only the actual spend, ≠ actuarial equivalent
  - **At Retirement** Retirees amounts not included
  - **2014 No Tax**
PUBLIC EMPLOYER HEALTH PLAN COPING STRATEGIES

- Cafeteria/§ 125 Plan
  - Pre-Tax Premium/Employee Contributions: If pre-tax employee contributions are desired, the cafeteria § 125 plan is
    - Only Vehicle
    - Advantage: Not subject to FICA/not MPSERS
  - Defined Contribution Approach: Employee elects total spend – amount for health care and other fringe benefits non-covered items –
    - Allowed: Life, disability, optional coverages, dental, vision
    - Effective $ CAP: only the actual health spend covered
    - FICA: if elect fringes, none, if cash – is subject
    - MPSERS: Assessment
      - Not subject – RIM pp 5-7 and 5-21
      - Not subject cash in lieu pp 5-19
COPING STRATEGIES

- **Issues**
  - **Inclusion**? Since not exclusively required for medical care – is it counted at all?
  - **Only Medical Electing Employees**? Is it medical care only for employees who elect?

- **HSA/FSA Coordination** FSA must be limited purpose. Excepted Benefits (Dental, Vision, Preventive) or amounts above deductible

- **Concerns - Uncertain Regulations** Proposed, uncertain issuance of final regulations
PUBLIC EMPLOYER HEALTH PLAN
COPING STRATEGIES

- **Bidding Multi-Employer Groups**
  - Law Allows Inter-Local Agreements Urban Cooperation Act (MCLA 124.501 et. al.)
  - Law Requires Solicitation of Bids Public Employees Health Benefit Act (MCLA 124.71 et. al.) which permits pools to secure bids
  - Problem: Blues Refuse to underwrite pooled groups – time to pressure Legislature to compel
PUBLIC EMPLOYER HEALTH PLAN
EFFECTIVE PLANNING

- **Identify** all Plans
- **Calculate Costs** of each plan at each tier at current rates and projected renewal values
- **Determine/Communicate Overage** - communicate gap to employees and unions
- **Explore Coping Strategies**
  - Plan Design Modifications
  - ↑ Employee Costs
  - ↓ Employee Utilization
  - High Deductible Plans (HSA v HRA)
  - Utilize Cafeteria Plan
  - Consider Defined Contribution Approach
  - Consortia – Bidding Pools
BENEFITS
PREVENTIVE CARE

- Large list of treatments and services required without cost-sharing
  - No co-pays, deductibles, co-insurance for in-network visits
- Four lists of Recommended Services:
  - United States Preventive Services Task Force - Grade A & B recommendations
  - Advisory Committee on Immunization Practices (adopted by CDCP)
  - Health Resources and Services Administration (for infants, children and adolescents)
  - HRSA Guidelines for Women (under development, will be issued in August 2011)
  - Surprises Tobacco cessation interventions and medications; aspirin use for cardiac risk for certain age brackets; breastfeeding interventions; behavioral counseling for sexually transmitted infections, alcohol misuse, pediatric screening – a-v, lead, STD, heritable disorders, folic acid supplements

- Effective Date - 2013 Requirements apply to non-grandfathered group health plans for plan years beginning on or after August 1, 2012
- Calendar-Year Plans - January 1, 2013
## BENEFITS – PREVENTIVE CARE

<table>
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<tr>
<th>Treatment or Service</th>
<th>Frequency</th>
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<tr>
<td>Well Woman visits, including preconception and prenatal</td>
<td>Annually, or more often if necessary</td>
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<tr>
<td>care</td>
<td></td>
</tr>
<tr>
<td>Screening for gestational diabetes</td>
<td>With every pregnancy</td>
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<tr>
<td>DNA human papillomavirus (HPV) testing</td>
<td>No more than once every three years, if the</td>
</tr>
<tr>
<td></td>
<td>woman is at least 30 years old</td>
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<tr>
<td>Counseling for sexually transmitted infections</td>
<td>Annually</td>
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</table>
# BENEFITS – PREVENTIVE CARE

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>HIV counseling and screening</td>
<td>Annually</td>
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<tr>
<td>Contraceptives (all FDA approved contraceptive methods), sterilization</td>
<td>As prescribed for</td>
</tr>
<tr>
<td>procedures and patient education and counseling</td>
<td>all women with</td>
</tr>
<tr>
<td></td>
<td>reproductive</td>
</tr>
<tr>
<td></td>
<td>capacity</td>
</tr>
<tr>
<td>Breastfeeding support, supplies and counseling, including the cost of</td>
<td>Coinciding with</td>
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<tr>
<td>breastfeeding equipment such as breast pumps</td>
<td>each birth</td>
</tr>
<tr>
<td>Screening/Counseling for interpersonal and domestic violence</td>
<td>Annually</td>
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</table>
BENEFITS – PREVENTIVE CARE

- All FDA Approved Methods of Contraception
  - Six Categories
    - barrier methods
      - Non Prescription: male and female condoms, contraceptive sponge, spermicide creams, foams and jelly
      - Prescription (diaphragm and cervical cap)
    - hormonal methods
      - Estrogen and progestin oral contraceptives
      - Progestin-only oral contraceptives
      - Continuous-use oral contraceptives
      - Skin patch that utilizes estrogen and progestin to stop ovulation
      - Vaginal contraceptive ring (NuvaRing)
      - Injection of progestin that lasts three months (Depo-Provera)
  - Emergency contraception a.k.a. “morning after pill” or “Plan B”*
    - Prescription required for 18 and under in some states. 18+ over the counter
  - implanted devices
    - IUD
    - implantable rods of progestin under skin of a woman’s upper arm (Implanon)
  - Permanent sterilization methods for women and*
  - Permanent sterilization surgery for men*
BENEFITS – PREVENTIVE CARE
– EXCLUDED PLANS

- Grandfathered Plans
- Flexible Spending Accounts
- Stand-alone Dental Plans
- Stand-alone Vision Plans

** Health Reimbursement Arrangements are subject to these requirements, unless they are limited scope in nature

- Limitations
  - Not on List
  - Out of Network

- **Reverse Impact** Lab tests not specifically included – some carriers formerly covered without cost – not charging
BENEFITS – PREVENTIVE CARE
POLICY CONCERNS

- Preventative Services and Other Task Forces
  - No public accountability – no requirement for hearings or public comments
  - No opportunity to sue to reverse decisions
  - Volunteers – No vetting/approval process
BENEFITS – PREVENTIVE CARE POLICY CONCERNS

- Arbitrary Limitation of Benefits  FDA Trial/Study requirements
  - Only A & B benefits required
  - Examples
    - No mammograms ages 40 – 49
    - No PSA routine screening
    - Office visit, but not lab tests for annual physical
BENEFITS – PREVENTIVE CARE
POLICY CONCERNS

- **Slow Decisions**
  - HIV screening
  - Aspirin for stroke, heart attack reduction

- **Non-Essential Benefits**
  - Hepatitis C Screening for adults
  - Osteoporosis – Men
  - Depression – children
  - Obesity Counseling – adults
  - Alcohol Abuse – adolescents

- **Rationing** Empowered to consider cost vs benefits
BENEFITS – ESSENTIAL BENEFITS

Essential Benefits 2014

State by State Determination  Four benchmark plans
- Largest Plan by enrollment (three largest group provider)
- Largest State Employee Benefit Plans (three)
- Largest FEH BP (Federal Plans) three plans by enrollment
- Largest Insured/Commercial HMOs

Benefits
- Ambulatory Services
- Emergency Services
- Hospitalization
  - Maternity/Newborn
- Preventive/Wellness/
  - Oral/vision care
- Mental Health/Substance or Abuse
- Prescription Drugs
- Rehabilitative/Habilitative Services/Devices
  - Pediatric – including Chronic Disease

Contrast  Infertility treatment not an essential benefit but pregnancy prevention is a required preventive benefit

No Lifetime/Annual Limits 2014
REPORTING FORM W-2

- **IRS Notices 2011-28, 2012-9** You generally must comply for 2012 if:
  - You provide employer-sponsored group health plan coverage; and
  - You issue 250 or more W-2s within the preceding calendar year.

- **Smaller Employers** – Likely in 2014
W-2 REPORTING EXCEPTIONS

- **Multiemployer plan coverage** is not reported by the Employer (transitional relief).

- **Related employers** who concurrently employ an individual--each employer reports its own costs
  - Common Paymaster exception

- **Other exceptions:**
  - Federally recognized Indian tribal governments
  - Tribally chartered corporations wholly-owned by a Federally recognized Indian tribal government (transitional relief)
  - Self-insured group health plans not subject to any federal continuation coverage requirements (transitional relief).
  - Government plan for members of military
W-2 REPORTING
REPORTABLE BENEFITS

- Report aggregate cost of “applicable employer-sponsored coverage.”
  - **Problem**: no definitive list of coverage to be included
  - **Good-faith, reasonable interpretation** of statute is permitted
  - **General Rule** report both the employee and employer contributions (with exception for Health FSAs).

- **IRS Chart** See Slides 73 – 75 for latest IRS pronouncements on includible/excludable amounts
W-2
EXCLUDED BENEFITS

The following benefits must be excluded from the cost reported on the W-2 (are not applicable employer-sponsored coverage):

- **Long-term care**
- **Excepted Benefits** Coverage that is always an “excepted benefit” under HIPAA:
  - AD&D;
  - Short-Term Disability;
  - Long-Term Disability;
  - Liability Insurance, including auto insurance;
  - Coverage issued as a supplement to liability insurance (including medical coverage under an auto insurance plan);
  - Workers’ Compensation;
  - Credit-only insurance; and
  - Any similar insurance where medical care benefits are secondary or incidental.
W-2
EXCLUDED BENEFITS

- **Separate dental and vision** policy, certificate or contract of insurance

- **Independent, non-coordinated benefits**
  - Providing coverage only for:
    - specified disease or illness
    - hospital indemnity, or
    - other fixed indemnity insurance
  - Purchased only with taxable dollars.

- **HSA/Archer MSA contributions**
W-2
EXCLUDED BENEFITS

- **HSA** Employee’s salary reduction elections to a Health FSA.
- **“S” Corporations** cost of coverage that is included in a 2% shareholder’s income.
- **Discriminatory group health plans:**
  - **Old rule:** do not adjust reportable amount simply because plan is discriminatory
  - **New rule:** “excess reimbursement” subtracted from reportable cost.
W-2
DISCRETIONARY EXCLUSIONS

The following benefits may be excluded:

- Cost of non-integrated, self-insured Dental and Vision plans
- Contributions to a Health Reimbursement Arrangement (“HRA”) (transitional relief)
- Costs of self-insured plans that are not subject to federal continuation coverage requirements (transitional relief)
W-2
DISCRETIONARY EXCLUSIONS

- Multiemployer plans to which the employer contributes (transitional relief);
- Governmental employers plans provided to members of the military and their families
- Some EAPs, Wellness Programs, On-Site Clinics (transitional relief)
W-2 EXAMPLE

- Widget Company has 340 employees in 2011, and offers the following benefits:
  - **Major medical**: reported;
  - **Dental** (self-insured, integrated with medical): reported;
  - **Vision** (non-integrated, insured): must be excluded;
  - **HRA**: need not be reported;
  - **Health FSA** with employer and employee contributions:
    - employee’s contributions are not reported;
    - employer contributions are reported IF the employee’s total salary reductions are less than the value of the Health FSA;
W-2 REPORTING EXAMPLE ANALYSIS

- EAP: must report if COBRA premiums are charged to employees;
- Executive Physicals: reported;
- Life Insurance Benefits: not reported
- AFLAC Supplemental Insurance purchased through cafeteria plan: reported
- Travel Insurance Program: probably must be excluded.
W-2 REPORTING
TIMING/FORM

- **Form W-2 requirements:**
  - **Deadline** is January 31st of following year
  - **Terminating employees**, within 30 days of request ("early W-2s")

- **Reporting of Benefit Cost information** Form W-2, Box 12, Code DD:
  - 2011 No duty to report for 2011 or prior years.
W-2 TERMINATED EMPLOYEES

Transitional relief options:

- Cost of coverage for portion of year covered as active employee.
  - Ignore COBRA
  - Must use consistently for all terminated employees.
- Costs of both pre- and post-employment coverage;
- During 2012 only: not required to report costs on early W-2s issued before January 2013;
- No reporting required for an individual to whom the employer is not otherwise required to issue a Form W-2, such as a retiree or former employee receiving no compensation.
W-2 – COST OF COVERAGE

- Must include both the employer and employee cost, whether pre-tax or after-tax.
  - Exception Health Care FSAs (see next slide)
  - Include cost of coverage for employees and dependents, including imputed income
- No breakdown on a per plan basis.
- Aggregate numbers only.
W-2 – COST OF COVERAGE

FSA Special Rules Contributions to Health FSA:

- Employee contributions are NEVER included
- Employer contributions may have to be reported
  - Examples of employer contributions:
    - Flex dollars used to fund Health FSA
    - Employer matching dollars contributed to a Health FSA
    - Employer seed money contributions to a Health FSA
  - Report employer’s contributions only if total amount of employee’s cafeteria plan salary reduction is less than value of health FSA.
    - Example: Flex dollars $1000, employee salary reduction $1000, Health FSA election $1200 ($600 flex dollars, $600 employee contributions)
W-2 – COST OF COVERAGE

 Variety of options:

- Premium charged method;
- COBRA applicable premium method; or
- Modified COBRA premium method.

No administrative fee excluded

Different methods for different plans permitted.

Existing COBRA regulations unclear at best.

Be consistent!
W-2 – EMPLOYEE MID-YEAR CHANGES

- **Calendar year basis** for all employees, regardless of the plan year.
- **Changes** Must take into account any changes in coverage for the employee during the year.
- **Reporting** Any reasonable method is permitted:
  - Beginning of period cost;
  - End of period cost;
  - Average cost over period; or
  - Prorated period cost.
- **Consistency** is key.
W-2 – RETROACTIVE CHANGES

Example: Employee has a new baby in late December 2012, but you’re not notified until 2013. Health plan coverage is retroactive to date of baby’s birth.

Reportable cost for 2012? Known cost as of December 31st?

Duty to issue a corrected W-2?
W-2 – STRADDLING PAYROLL PERIOD – YEAR END

- **Employer has options:**
  - treat all the coverage as provided during the calendar year that includes December 31;
  - treat the coverage as provided during next calendar year;
  - allocate the cost of coverage between each of the two calendar years under any reasonable allocation method. Method should relate to the number of days in each year.
  - Consistency is important.
W-2 – RESPONSIBILITY

- **Final responsibility** is with the employer.
- **Contact Service Providers** to determine roles and responsibilities.
  - Payroll Administrator
  - Third Party Administrators
- **Evaluate Benefits** which need to be reported, and which can be excluded.
- **Service Provider Contracts Revisit**
- **Impose Penalties** noncompliant providers
HC REFORM - SUMMARY OF BENEFITS AND COVERAGE 2013

- **Final Regulations**  February 14, 2012
- **Effective Date**
  - **Original Timing**  By March 23, 2012
  - **Timing Extended**  DOL FAQ (DOL 11/17/2011) Extended to reasonable time plan years beginning after **9/23/2012**
- **Penalty**
  - Each individual who fails to receive an SBC is a separate violation
  - Willful failure to provide SBC: $1,000 for each violation
SUMMARY OF BENEFITS AND COVERAGE

- **Display**
  - Stand-alone document
  - Not more than 4 *double-sided* pages
  - At least 12 point font size
  - Understandable terminology
  - “Culturally and linguistically appropriate”
    - Support and Translation services if at least 10% or more of population in the county is literate only in Chinese, Spanish, Tagalog or Navajo

- **Form**
SUMMARY OF BENEFITS AND COVERAGE

- **Contents**
  - **Description/Cost Sharing** Description of the coverage, including cost-sharing for each category of benefits
  - **Actual Premium Excluded** No longer required
  - **Exceptions, Reductions, and Limitations** of coverage, along with cost-sharing information regarding deductibles, co-payments and co-insurance
  - **Coverage Examples** Hypothetical summaries of how the plan would pay benefits in certain common medical situations.
SUMMARY OF BENEFITS AND COVERAGE

 Contents (cont’d)

- Internet Address to “Glossary” - Uniform definitions of standard insurance and medical terms
  - 44 definitions in the proposed rules, with likely more coming.
  - Will need to check your plan language against these uniform definitions

- Internet Address For formulary

- Internet Address For Any provider network

- Statement Disclaimer SBC is only a summary and the plan document, policy or certificate of insurance should be consulted to determine governing provisions
SUMMARY OF BENEFITS AND COVERAGE

- **Recipients**
  - Participants and beneficiaries
    - One SBC per address
    - Separate SBC for each available plan option
      - Two HMOs, Two PPOs? Four SBCs!
      - Differences between single and family coverage can be explained in one SBC

- **Timing**
  - With new enrollment kit
    - Must update if information changes before coverage begins
  - Within 7 days of receiving request for special enrollment
  - With annual open enrollment kit
  - Within 7 days of a request
SUMMARY OF BENEFITS AND COVERAGE

- **Method of Distribution**
  - **Paper**
  - **Electronic** Must comply with ERISA electronic distribution safe harbor rules.
    - Workforce members with ready access to computers
    - Others who consent

- **Preparer Responsibility**
  - Insurers must provide SBC to health plans
  - Self-insured health plans
    - Plan sponsor OR designated administrator
    - address contractually
      - Drafting responsibility
      - Distribution responsibility
SUMMARY OF BENEFITS AND COVERAGE

- **Advance Notice of Plan Modifications Requirement**: Notice of material changes to health plan coverage
  - No later than 60 days *prior* to effective date of change
  - HHS to establish format
  - Effective March 2012
CONSTITUTIONAL CONFLICT – COMMERCE CLAUSE/REGULATION VS 1ST AMENDMENT RELIGIOUS FREEDOM

- Narrow Definition of Religious Organizations
  - Churches permanently exempt
  - Affiliates – hospitals, schools, social service and charitable agencies, 1 year reprieve
  - PPACA Exemption Extremely Narrow - Far narrower than IRC tax exempt religious and ERISA church plans
CONSTITUTIONAL CONFLICT – COMMERCE CLAUSE/REGULATION VS 1ST AMENDMENT RELIGIOUS FREEDOM

- Current False Compromise – Insurers Pay
  - Claim zero cost - ↓ of unintended pregnancies – studies are anecdotal, conclusory standards, cost savings are from decreases in public benefits – i.e. Medicaid, social programs for poor children
  - Actual Actuarial cost $21 - $45 per year without reduction in premiums affiliates pay for the coverage
  - Issues
    - Anti-life – pregnancy undesirable because of social cost
    - Discriminates against reproductive choice of poor women
    - Danger: abortion labeled as legitimate birth control mechanism
CONSTITUTIONAL CONFLICT – COMMERCE CLAUSE/REGULATION VS 1ST AMENDMENT RELIGIOUS FREEDOM

Coping
- Maintain Grandfathered status – preventive care requirements don’t apply
- Legislation Push for Legislation reversing narrow exemption/states will assist
- First Amendment Litigation – states will help
- Defined Contribution Plan – set contribution lower to assure that employee pays for the preventive choice
- Drop Coverage Entirely – pay more- release all to the public exchanges/private market
CONSTITUTIONAL CONFLICT – COMMERCE CLAUSE/REGULATION VS 1ST AMENDMENT RELIGIOUS FREEDOM

Exercise

- Favor ObamaCare L
  - Repeal ObamaCare R
- Commerce Clause allows forced purchase - mandated benefit L
  - Commerce Clause allows forced purchase – does not allow this R
- Commerce Clause predominate L
  - Religion clause predominate R
- OK to compel contraceptive coverage L
  - Not OK R
- OK to mandate morning after pill/sterilization coverage L
  - Not OK R
- OK to compel payment for abortion as pregnancy preventive measure L
  - Not OK R
- OK to deny treatment to elderly on cost benefit basis L
  - Not OK R
The chart below is based on IRS Notice 2012-9, which, until further guidance, contains the requirements for tax-year 2012 and beyond. Items listed as "optional" are designated as such based on transition relief provided by Notice 2012-9, and their “optional” status may be changed by future guidance. However, any such change will not be applicable until the tax year beginning at least six months after the date of issuance of such guidance.
## IRS GUIDE TO W-2 INFORMATIONAL REPORTING

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Report on form W-2</th>
<th>Do Not Report on Form W-2</th>
<th>Optional Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major medical</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental or vision plan not integrated into another medical or health plan</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dental or vision plan which gives the choice of declining or electing and paying an additional premium</td>
<td></td>
<td>X</td>
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<tr>
<td>Health Flexible Spending Arrangement (FSA) funded solely by salary-reduction amounts</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Health FSA value for the plan year in excess of employee’s cafeteria plan salary reductions for all qualified benefits</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Reimbursement Arrangement (HRA) contributions</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Health Savings Arrangement (HSA) contributions (employer or employee)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Archer Medical Savings Account (Archer MSA) contributions (employer or employee)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Hospital indemnity or specified illness (insured or self-funded), paid on after-tax basis</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Hospital indemnity or specified illness (insured or self-funded), paid through salary reduction (pre-tax) or by employer</td>
<td>X</td>
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<td></td>
</tr>
<tr>
<td>Coverage Type</td>
<td>Report on form W-2</td>
<td>Do Not Report on Form W-2</td>
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<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
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<td>---------------------------------------------------------</td>
</tr>
<tr>
<td>Employee Assistance Plan (EAP) providing applicable employer-sponsored healthcare coverage</td>
<td>Required if employer charges a COBRA premium</td>
<td></td>
<td>Optional if employer does not charge a COBRA premium</td>
</tr>
<tr>
<td>On-site medical clinics providing applicable employer-sponsored healthcare coverage</td>
<td>Required if employer charges a COBRA premium</td>
<td></td>
<td>Optional if employer does not charge a COBRA premium</td>
</tr>
<tr>
<td>Wellness programs providing applicable employer-sponsored healthcare coverage</td>
<td>Required if employer charges a COBRA premium</td>
<td></td>
<td>Optional if employer does not charge a COBRA premium</td>
</tr>
<tr>
<td>Multi-employer plans</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Domestic partner coverage included in gross income</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Military plan provided by a governmental entity</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Federally recognized Indian tribal government plans and plans of tribally charted corporations wholly owned by a federally recognized Indian tribal government</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
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</thead>
<tbody>
<tr>
<td>Self-funded plans not subject to Federal COBRA</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Accident or disability income</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Long-term care</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>Liability insurance</td>
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<td>X</td>
<td></td>
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<tr>
<td>Supplemental liability insurance</td>
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<td>X</td>
<td></td>
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<tr>
<td>Workers' compensation</td>
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<td>X</td>
<td></td>
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<tr>
<td>Automobile medical payment insurance</td>
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<td>X</td>
<td></td>
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<tr>
<td>Credit-only insurance</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Excess reimbursement to highly compensated individual, included in gross income</td>
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<td>X</td>
<td></td>
</tr>
<tr>
<td>Payment/reimbursement of health insurance premiums for 2% shareholder-employee, included in gross income</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>Other Situations</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Employers required to file fewer than 250 Forms W-2 for the preceding calendar year</td>
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<td></td>
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</tr>
<tr>
<td>Forms W-2 furnished to employees who terminate before the end of a calendar year and request, in writing, a Form W-2 before the end of that year</td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>Forms W-2 provided by third-party sick-pay provider to employees of other employers</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

75