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is presented by Spencer Fane Britt & Browne LLP
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Health Care Reform: What's Coming in 2013?

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Basic Overview

- Supreme Court decision upheld constitutionality of most health care reform provisions
- Key provisions are not effective until 2014 (as summarized below)
- Still plenty to think about for 2013
- May be some planning opportunities

Grandfathered Plans

- Definition: Health plan in effect on 3/23/10
  - Only limited benefit reductions
  - Only limited premium shifting to participants
- Caution: Changes that can cause loss of grandfathered status are cumulative
- Must continue to
  - Include notice of grandfathered status in communication materials, and
  - Maintain records documenting terms of plan in effect on 3/23/10

Higher Annual Limit

- Effective for plan years beginning after September 23, 2012:
  - Annual limit on certain “essential benefits” must be no less than $2,000,000 (up from $1,250,000)
  - Even grandfathered plans must comply
  - **Non**-essential benefits may be subject to lifetime and annual limits

“Essential Benefits”

- “Essential benefits” include at least the following (subject to regulatory guidance):
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance abuse disorder services
  - Prescription drugs
  - Rehabilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care

Minimum Loss Ratio Rebates

- Insured plans are subject to minimum loss ratios (even if grandfathered):
  - Based on percentage of premium income spent on clinical services and activities to improve health care quality
    - At least 85% in large group market
    - At least 80% in small group market
  - Any “excess” profits must be rebated to participants (or to plan sponsor)
  - Insurers must notify all participants (even if MLR was met)

Minimum Loss Ratio Rebates

- Allocation of rebates is fiduciary decision
  - Based on plan language, if any
  - Otherwise, in proportion to premium payers
  - May consider cost to the plan of contacting former participants
- Tax treatment of rebates
  - IRS Q&As address several possibilities
  - Rebates to employees will be taxable if they paid the premiums on a pre-tax basis
- Possible plan amendment allocating entire rebate to employer?

Health FSA Changes

- Employee's annual health FSA contributions capped at $2,500
- Recent guidance clarified that cap applies to plan years beginning on or after 1/1/13
- FSA balance carried over into the grace period will not count against $2,500 limit for following plan year

Health FSA Changes

- Husband and wife may each contribute up to $2,500 to his or her own health FSA
- What about employer flex credits?
- Plan amendment deadline: 12/31/14

W-2 Reporting of Health Coverage

- Total value of employer-provided health coverage must be reported on W-2s
  - Mandatory for 2012 (for W-2s to be provided in January of 2013)
  - Applies to private and public employers issuing 250 or more W-2s for prior year
- Report in Box 12, using Code “DD”

W-2 Reporting of Health Coverage

- Report total value of coverage
  - Including both employer and employee contributions
  - If insured, report insurance premium
  - If self-funded, report COBRA cost (minus 2%)
- Need not report
  - Employee HSA or FSA contributions
  - HIPAA “excepted benefits”

Summary of Benefits & Coverage

- Standardized Summary of Benefits and Coverage ("SBC")
  - Maximum of 4 pages (double-sided)
  - Must use template developed by agencies (with limited changes)
  - Effective for
    - Annual enrollments beginning after 9-23-12, or
    - Plan years beginning on or after 1-1-13

Summary of Benefits & Coverage

- SBC requirement applies to
  - grandfathered and non-grandfathered plans
  - self-funded and fully insured plans
- Does not apply to
  - HIPAA “excepted benefits,”
  - HSAs, or
  - Most health FSAs

Summary of Benefits & Coverage

- Electronic delivery options:
  - For current enrollees, must follow DOL rules
    - Simple if employees use internet at work
    - Requires consent from other employees
  - May post on internet for
    - Merely eligible employees, or
    - Employees enrolling online

Notice of Material Modification

- 60 days advance notice required for any "material modification" of coverage described in SBC
  - Versus 60-day post-reduction notice required under ERISA
  - Effective upon application of SBC rule
  - "Material modification" could include benefit improvement
  - Penalty of $1,000 per enrollee for noncompliance

Notice of Exchange Availability

- Must notify employees of availability of Exchange-provided coverage
  - Including possibility of tax credit or cost-sharing reduction
  - Effective 3-1-2013 (although no Exchanges until 2014)
  - No exemption for grandfathered plans or for small employers

Women's Preventive Health Care

- Preventive health services expanded to include 8 additional services for women, including:
  - breastfeeding equipment,
  - contraceptive methods and counseling,
  - screening for gestational diabetes, and
  - screening and counseling for domestic violence
- Effective for plan years beginning on or after 8/1/12

Women's Preventive Health Care

- Must be covered on first-dollar basis, with no cost-sharing
- Not applicable to grandfathered plans
- Also not applicable to churches and church-controlled organizations (under very limited definition)

Women's Preventive Health Care

- One-year enforcement delay (to plan years beginning on or after 8-1-13) for
  - Nonprofit employers . . .
  - That didn't already provide such coverage (or that were required to provide such coverage despite religious objections)
- Proposed "accommodation" may place compliance obligation on insurers or TPAs, rather than these employers

Taxation of Retiree Drug Subsidy

- Employers who provide “creditable coverage” under Medicare Part D may receive a subsidy for doing so
  - Because that subsidy is tax-exempt, usual tax rule would disallow deduction for related prescription drug expenses
  - However, current law allows such a deduction
  - This exception will be repealed as of 1-1-13, effectively causing subsidy to be taxed

Additional Medicare Tax

- Additional Medicare tax of 0.9% on compensation in excess of:
  - $200,000 if single
  - $250,000 if married filing jointly
- Not payable by employers
- But employer must withhold once employee has met $200,000 threshold
- Applies to taxable life insurance and vested nonqualified deferred comp.

Comparative Effectiveness Fee

- All health plans (both insured and self-funded) will pay annual fee to fund Patient Centered Outcomes Research
  - Effective for plan years ending after 9-30-2012 and on or before 9-30-2019
  - Fee is $1 per covered life during first year; $2 during second year; adjusted for inflation thereafter
  - Due by July 31 of the following year (so first payment due by 7-31-13)

Comparative Effectiveness Fee

- Not payable for “excepted benefits” or HSAs
- HRAs subject to fee
  - May be aggregated with self-funded plan if they have same plan year
  - May not be aggregated with insured plan, because insurer must pay fee for plan
- Various options for counting number of covered lives
- Fee is payable with IRS Form 720

Items Postponed to Later Years

- The following requirements were to have been effective by 2013, but have been postponed to later years:
  - Income-based nondiscrimination rules for insured plans
  - Automatic enrollment
  - “Quality of Care” reporting

Insured Plan Nondiscrimination

- Self-funded plans must comply with income-based nondiscrimination rules of Code Section 105(h)
- PPACA applied similar rules to insured plans
- Statutory effective date = plan years beginning on or after 9-23-10, but postponed while agencies consider how to apply these rules to insured plans

Automatic Enrollment

- Employers with more than 200 full-time employees must implement “automatic enrollment” of all new full-time employees
  - Employees could opt out
  - Effective “in accordance with regulations” to be issued under FLSA
  - Department of Labor has indicated that automatic enrollment guidance will not be ready to take effect by 2014

“Quality of Care” Reporting

- Plans must provide annual reports to HHS and participants (during open enrollment) of steps taken to improve quality of care – e.g.:
  - Wellness programs
  - Effective case management
  - Preventing readmissions
- Effective when HHS issues regulations (which was to be done by 3-23-12, but not expected in near term)

Affordable Insurance Exchanges

- Electronic marketplaces designed to connect health insurers with policy-holders
- Each state may:
  - establish its own exchange,
  - partner with HHS, or
  - allow HHS to run exchange in that state
- Currently, only 15 states (plus DC) have established exchanges

Individual Tax Credit

- May be used only to purchase coverage through an Exchange
- To qualify for tax credit:
  - Household income must be 100% to 400% of federal poverty level, and
  - Must not be eligible for
    - Medicaid, or
    - "Affordable" employer-sponsored coverage meeting "minimum value" requirement

Tax Credit Eligibility

- Plan is not “affordable” if premium for single coverage exceeds 9.5% of employee’s household income
  - Safe harbor allows employer to consider only employee’s W-2 income
- Plan meets “minimum value” requirement if it pays at least 60% of total benefit costs
  - Excluding premiums and non-covered items

“Shared Responsibility Penalty”

- Applicable to any employer . . .
  - With at least 50 full-time employees (including FTEs) during prior calendar year,
  - **If** any full-time employee receives a tax credit to purchase coverage through an Exchange
- For this purpose, “full-time” = 30 hours per week

Recent Guidance

- On 8-31-12, agencies issued temporary guidance on
  - Identifying “full-time” employees for purposes of employer shared responsibility penalty, and
  - 90-day limitation on eligibility waiting period
- May be relied upon through 12-31-14

“Full-Time” Employees

- In determining whether “variable hour employee” meets full-time standard (averaging 30 hours/week), plan may use
  - “Determination period” of up to 12 months
  - “Stability period” of up to 12 months (though at least as long as determination period), and
  - “Administrative period” of up to 3 months

90-Day Waiting Period

- Other eligibility conditions (e.g., salaried, hourly, particular division) are still permissible
- Employer may use determination period of up to 12 months to determine whether variable hour employee meets a “full-time” eligibility condition
- No shared responsibility penalty during any 90-day waiting period

Planning Possibilities?

- To rely on recent guidance for variable hour employees in 2014, should start counting hours in 2013
- Because affordability is measured by least expensive plan available to employee, employer may be able to avoid penalties by establishing low-cost plan for all full-time employees

Medicaid Expansion

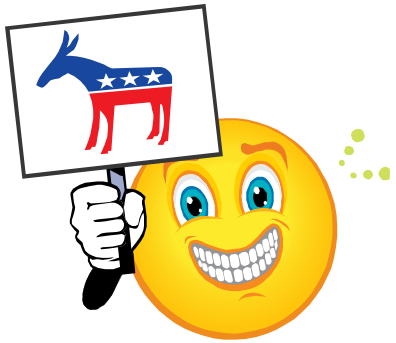
- In 2014, states may extend eligibility for Medicaid to all individuals with household income of up to 133% of federal poverty level (as opposed to current 100% level)
- Such individuals would then be ineligible for tax credit to purchase coverage through an Exchange

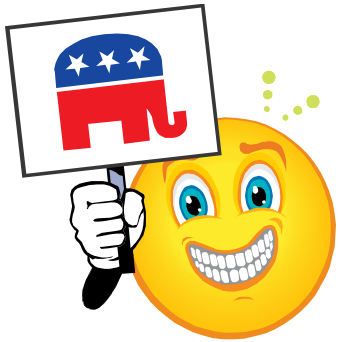
Supreme Court Decision

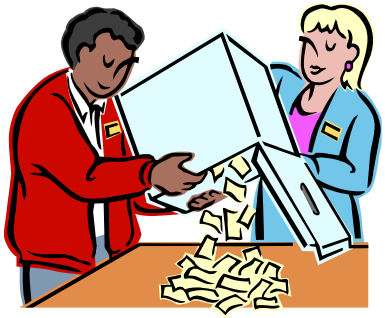
- Under Supreme Court decision, state will not lose existing Medicaid funding simply because it does not expand eligibility to 133% of poverty level
- But will this approach make more individuals in that state eligible for the tax credit, thereby exposing that state's employers to larger penalties?

Effect of Election?

- Who knows?





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