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Health Care Reform:

Full Speed Ahead

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Agenda

- The Supreme Court's Decision in *NFIB v. Sebelius* and Beyond
  - Key holdings: ripeness, taxing power, Medicaid expansion
  - *State of Oklahoma v. Sebelius*, challenge involving premium subsidies
- Employer Shared Responsibility (a/k/a Pay-or-Play)
- Other Important Requirements Affecting Employers
  - Summaries of benefits and coverage
  - Form W-2 reporting
  - MLR rebates
  - $2,500 medical FSA limit
  - Additional Medicare tax imposed on high-income taxpayers
  - PCORI fees

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Agenda (cont'd)

- Controversial Upcoming Guidance Items
  - Nondiscrimination
  - Affordability
  - Minimum value

Challenges to the Act

- *NFIB v. Sebelius* holding:
  - Dispute is timely
  - Individual mandate is a valid exercise of Constitution's "taxing power"
  - Dicta: Individual mandate is not a valid exercise of Congress's power under Commerce or Necessary & Proper clauses
  - Act's Medicaid expansion curtailed
- Looming Challenge:
  Whether low-income premium subsidies are permitted in a state that fails to establish an insurance exchange

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Employer Shared Responsibility

- Applicable Large Employer—an employer that employed at least 50 full-time employees:
  - Including full-time equivalent employees
  - On business days during the preceding calendar year
- Beginning in 2014, each applicable large employer is subject to an assessable payment if any full-time employee is certified as eligible to receive an applicable premium tax credit or cost-sharing reduction and either:
  - No-coverage prong: Employer fails to offer "minimum essential coverage" under an "eligible employer-sponsored plan"

Employer Shared Responsibility (cont'd)

- Coverage prong: The employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that, with respect to a full-time employee who qualifies for a premium tax credit or cost-sharing reduction, either is
  - "Unaffordable" or
  - Does not provide "minimum value"
- Full-time means "regularly scheduled" 30 hours/week or 130 hours/month
- No coverage prong penalty: an assessable payment equal to $166.67 multiplied by the number of the employer's full-time employees, excluding the first 30

Employer Shared Responsibility (cont'd)

- Coverage prong penalty: Lesser of
  - $250 per month multiplied by the number of full-time employees who qualify for and receive a premium tax credit or cost-sharing reduction from a health insurance exchange; or
  - Amount charged under the no-coverage prong
- "Minimum essential coverage" includes coverage under an "eligible employer-sponsored plan" but not excepted benefits
- Employer-provided health insurance coverage is "unaffordable" if the premium required to be paid by the employee exceeds 9.5% of the employee's W-2 income

Full-Time Employees—Ongoing

- Notice 2012-58: Employed for at least one full "standard measurement period"
- Standard measurement period: not less than 3 but not more than 12 consecutive calendar months, as chosen by the employer for all employees in the "same category"
- Categories include:
  - Collectively bargained employees and non-collectively bargained employees;
  - Salaried employees and hourly employees;
  - Employees of different entities; and
  - Employees located in different states

Full-Time Employees—Ongoing (cont'd)

- Must cover for corresponding "stability period," i.e., longer of—
  - Six months; or
  - The length of the standard measurement period
- Administrative period of up to 90 days allowed, can gap between the end of the measurement period and the start of the stability period
- Example: 12-month stability period begins January 1 and 12-month standard measurement period begins October 15. October 14 to January 1 is the administrative period. Previously-determined full-time employees must continue to be offered coverage during the administrative period

New Hires (Definitions)

- "Variable hour employee"—based on the facts and circumstances at the start date, it cannot be determined that the employee is reasonably expected to work on average at least 30 hours per week
- "Seasonal employee"—reasonable, good faith interpretation
- "Initial measurement period"—a period between 3 and 12 months, as selected by the employer
- "Administrative period"—counts as part of the measurement period; but with initial measurement period can't exceed 13 months plus partial month

Full-Time Employees—New Hires

- Employer
  - Measures the hours of service completed by the new employee during the initial measurement period; and
  - Determines whether the employee completed an average of 30 hours of service per week or more during this period
- Stability period must not:
  - Be more than one month longer than the initial measurement period, nor
  - Exceed the remainder of the standard measurement period, plus any associated administrative period for new hires in which the initial measurement period ends

Changes in Status—Full-Time/Part-Time

- Special rules apply where a new hire's status in the initial measurement period is not the same as his or her status in the first standard measurement period:
  - Change from full-time to part-time status must await the end of the stability period
  - Change from part-time to full-time must be implemented after the stability period; after the first standard measurement period

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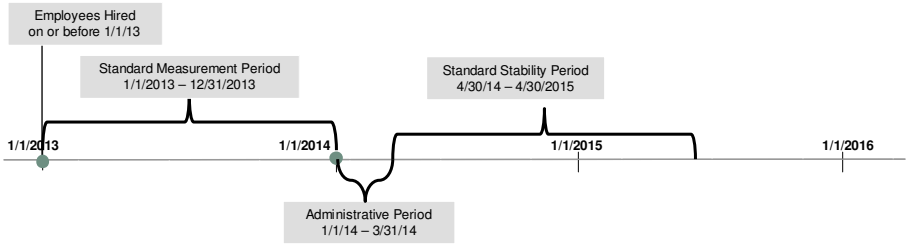
Additional New-Hire Limit

- The initial measurement period cannot exceed 12 months;
- The administrative period associated with the initial measurement period cannot total more than 90 days; and
- The combined initial measurement period and administrative period cannot last beyond the final day of the first calendar month beginning on or after the one-year anniversary of Employee's start date

Determining "Full-Time Employees"

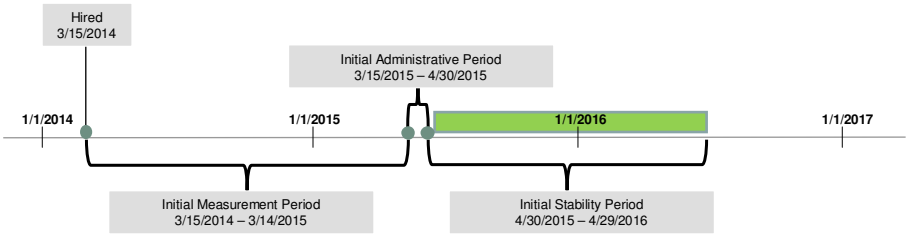
Assumption: Staffing firm uses 12-month calendar year "standard measurement period." To determine "ongoing employees'" as of Jan. 1, 2014, staffing firm counts as "full-time" all employees who worked an average of at least 30 hours per week during the period Jan. 1, 2013-Dec. 31, 2013



Example: On Dec. 31, 2013, staffing firm "looks back" and identifies employees employed on or before Jan. 1, 2013 who worked at least 1,560 hours during calendar year 2013. Assuming employee is still employed Jan. 1, 2014, firm must offer coverage or pay penalties during 12-month stability period as long as they remain employed. Firms offering coverage can take an "administrative period" up to 90 days to enroll the employee.

New "Variable Hour" Employees

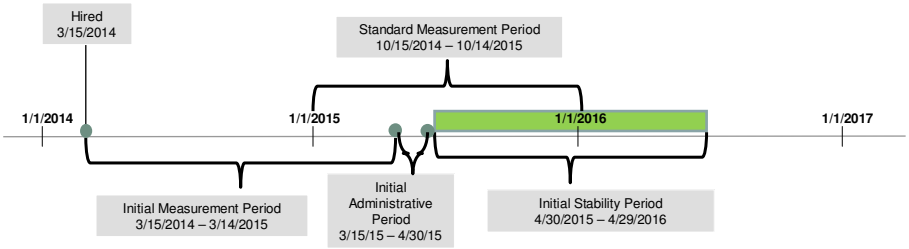
Assumption: Staffing firm uses 12-month "initial measurement period" for variable hour employees employed on or after Jan. 1, 2014. "Variable hour" employees are those whom the firm cannot reasonably determine on their start date will average at least 30 hours per week over the course of the initial measurement period.



Example: Employee starts work 3/15/2014. On 3/14/15, staffing firm "look backs" to see if employee worked at least 1,560 hours over the 12-month period. If so, staffing firm must offer coverage or pay penalties during 12-month "initial stability period" as long as they remain employed. Firms offering coverage can take an "administrative period" up to 13 months (and a fraction of a month) to enroll the employee.

Transition from New to Ongoing Status

New variable hour employees who work during an entire initial measurement period must also be tested based on the standard measurement period.



Waiting Periods—Notice 2012-59

- For plan years beginning on or after January 1, 2014, all group health plans (irrespective of size) and group health insurance issuer must not apply any waiting period that exceeds 90 days
- Waiting period means "the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective"
- Assessable payments not be imposed during a 90-day waiting period that complies with the requirements of the Act
- Notice 2012-59 coordinates the waiting period rules with the employer shared responsibility rules

Hidden Employer Tax under Medicaid

- Additional taxes under Code § 4980H
  - Exchange eligible full-time employees with HI between 138% and 400% of FPL
  - But in states that declined the Medicaid expansion, full-time employees with HI from 100% to 138% of HI will be exchange eligible
- Greater chance of triggering Code § 4980H(a) (no-coverage prong) penalty; and potentially higher exposure under Code § 4980H(b)

The Next Challenge: Premium Support

- PPACA opponents claim that Code § 36B premium tax credits are available only in states that affirmatively establish an exchange
- Code § 36B applies a broader rule
- If opponents challenge and prevail, then employers in states with Federally-facilitated exchanges have no Code § 4980H exposure, since no FT employee has access to the premium subsidy

Summaries of Benefits and Coverage

- Effective for open enrollments (or for plans without open enrollment, plans years) commencing on or after September 23, 2012
- SBC requirements apply to
  - Group health plans (whether insured or self-insured)
  - Health insurance issuer offering group health coverage
- Plan offering only "excepted benefits" excluded (e.g., stand-alone dental or vision plan)
- Medical FSAs
  - If integrated, included with GHP
  - If not integrated, separate SBC required

SBC Penalties

- Basic penalty structure of three agency rules (DOL, HHS and IRS) i.e.,
  - $100/day under ERISA and the Code imposed on the plan, and
  - $100/day under the PHS Act imposed on carrier (some mitigation is possible)
- Self-reporting of penalties is required (similar to COBRA)
- Additional penalty of up to $1,000/day where non-compliance is willful

SBCs—Distribution

- To employer: (i) within 7 business days after receipt of an application for health coverage, (ii) by the first day of coverage (if there are any changes) and in connection with written application. Or within 30 days before the first day of the new plan year if renewal is automatic
- To participants: As part of the written application or enrollment materials. If the plan does not distribute written enrollment materials, no later than the first date eligibility, if there are any changes

SBC—Delivery

- Both the health insurance issuer and the plan administrator of a group health plan are separately subject to the SBC rules
- This obligation is discharged as to any one party if the other furnishes the SBC
- Non-distributing party should
  - Review the form and content of the SBC to ensure accuracy
  - Periodically monitor whether SBC requirements are being complied with

SBC—Delivery (cont'd)

- Must be provided to:
  - Participants and beneficiaries who are eligible for coverage, and
  - Those who are enrolled in coverage
- Unless plan or insurer has knowledge of separate address of a beneficiary, the SBC may be provided to the participant on behalf of the beneficiary
- Department of Labor safe harbor for electronic delivery
- In addition, SBCs may be provided electronically to participants and beneficiaries in connection with on-line enrollment or renewal of coverage

Form W-2 Reporting

- Employers must report the aggregate cost of applicable employer-sponsored group health plan coverage on Form W-2, Box 12, Code DD for taxable years beginning on or after January 1, 2011
- Notice 2012-9 (replacing Notice 2011-28) provides guidance
- Rule applies to 2012 reporting, which will take place in January, 2013
- Employers can voluntarily choose to comply in 2011

Form W-2 Reporting (cont'd)

- The requirement to report employer-sponsored health coverage costs is informational only
- Amounts reported in Box 12, Form W-2 are not also included in employees' taxable income (for now)
- Until the issuance of further guidance, an employer is not subject to the reporting requirement for a calendar year if the employer was required to file fewer than 250 Forms W-2 for the preceding calendar year

Required Reporting Items

- Value of major medical coverage
- Value of health FSA in excess of employee's salary reductions
- Hospital indemnity or specified illness paid through salary reduction (pre-tax) or by employer
- Employee Assistance Plan (EAP) providing employer-sponsored healthcare coverage (but only if employer charges COBRA premium)
- Wellness programs providing employer-sponsored healthcare coverage (if employer charges COBRA premium)
- On-site medical clinics providing employer-sponsored healthcare coverage (but only if employer charges COBRA premium)
- Domestic partner coverage included in taxable wages

Optional Reporting Items

- Stand-alone dental or vision plans
- Contributions to HRAs
- EAPs (but only if employer does not charge COBRA premium)
- On-site medical clinics (but only if employer does not charge COBRA premium)
- Wellness programs (but only if employer does not charge COBRA premium)
- Multiemployer plans
- Self-funded plans not subject to COBRA
- Forms W-2 provided by third-party sick pay provider to employees of other employers

Excluded Reporting Items

- Salary-reduction health FSA
- Health Savings Arrangement (HSA) contributions (employer or employee)
- Archer Medical Savings Account (Archer MSA) contributions (employer or employee)
- Hospital indemnity or specified illness (insured or self insured) and paid on after-tax basis
- Governmental plans providing coverage primarily for members of the military and their families

Minimum Loss Ratio Rebates

- MLR rules do not apply to self-funded plans
- By August 1, 2012 carriers must have procedures in place to process 2011 plan year rebates
- Rebates are generally subject to ERISA plan assets rules
- DOL Tech. Rel. 2011-04
  - If employer pays all, rebate is not a plan asset
  - If employee pays all, rebate is a plan asset; must be returned to employees
  - Special rules apply in the case of fixed employer or employee contributions
- Cash payment, premium holiday or benefit enhancement

Minimum Loss Ratio Rebates (cont'd)

- Rebate must be applied to the plan that generated the rebate, but may be limited to current employees
- Rebate must be fully deployed within three months in order to avoid ERISA trust requirement
- Tax treatment
  - If employee contributions are pre-tax, i.e., made under a cafeteria plan, then employee portion is taxable to the employee in year of receipt (most common scenario)
  - Premium holidays automatically result in an increase in taxable compensation
- Similar rules apply to non-ERISA plans

Exchange Notices

- Effective date is March 1, 2013
- Employers must provide to employees notice of
  - Availability of coverage under a state-based or Federally facilitated health insurance exchange
  - Related items (e.g., tax credits or cost-sharing reductions)
- Model notice is not yet available

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$2,500 Medical FSA Limit

- Beginning January 1, 2013, total FSA contributions are limited to $2,500 per year (as adjusted for cost of living increases)
  - Limit applies to health FSAs
  - Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) are excluded
- The $2,500 limit on health FSA salary reduction contributions applies to "taxable years"—not clear whose

Notice 2012-40

- $2,500 limit applies on a plan-year basis; and plans may adopt the required amendments at any time through the end of calendar year 2014
- Grace periods—unused salary reduction contributions to the health FSA that are carried over into the grace period for that plan year will not count against the $2,500 limit for the next plan year
- Relief for certain salary reduction contributions exceeding the $2,500 limit due to reasonable mistake and not willful neglect, and that are corrected by the employer

Additional Medicare Tax

- Social Security and Medicare by FICA
  - 15.3% tax on "wages" paid by the employer and by employees
  - Hospital insurance or "HI" portion was 1.45% each
- Act increases the employee portion of the HI tax by 0.9% on workers with incomes of over $200,000 for single filers and $250,000 for joint filers
- Effective for taxable years commencing after December 31, 2012

IRS Q&As

- Threshold Amounts
  - Married filing jointly $250,000
  - Married filing separately $125,000
  - Single $200,000
  - Head of household (with qualifying person) $200,000
  - Qualifying widow(er) with dependent child $200,000
- Employer's obligation to withhold

June 11, 2012 IRS Q&As (cont'd)

- Employers must withhold the Additional Medicare Tax on compensation paid to an employee in excess of $200,000 in a calendar year
  - Without regard to marital status as claimed on an employee's Form W-4
  - Irrespective of whether an employee is liable for the tax; and
  - For employees who are non-resident aliens or US citizens living abroad
- Withholding required on non-cash wages

PCORI Fees

- Effective in 2013
- Patient-Centered Outcomes Research Institute (PCORI) fee
- Imposed on plan sponsors and issuers of individual and group policies
- Fees fund comparative effectiveness research
- Fee must be reported and paid by July 31 of the calendar year immediately following the last day of the plan year

Amount of PCORI Fees

- The fee is equal to the average number of covered lives for the policy year times the applicable dollar amount
- For policy years ending on or after Oct. 1, 2012, and before Oct. 1, 2013 - the applicable dollar amount is $1.
- For policy years ending on or after Oct. 1, 2013, and before Oct. 1, 2014 - the applicable dollar amount is $2.
- For policy years ending in any fiscal year beginning on or after Oct. 1, 2014 - the applicable dollar amount is the prior fiscal year's dollar amount plus an adjustment for medical inflation

Average Number of Lives

- Fully Insured Plans
  - Actual Count
  - Snapshot Method
  - NAIC Member Months Method
  - State Form Method
- Self-funded Plans
  - Actual Count
  - Snapshot dates
  - Form 5500 Method

PCORI–Special Rules

- If the plan sponsor of a self-funded plan has more than one self-funded plan (e.g., one for medical, another for pharmacy) it may treat them as a single self-funded plan (avoids double counting of members)
- FSA only: plan sponsor may treat each participant's account as covering a single life:
  - If FSA/HRA is coordinated with a self-funded plan, the two arrangements may be treated as one plan
  - FSA/HRA with insured plan—treated as two plans

Insured Plan Non-Discrimination

- Newly added PHSA § 2716 imposes on fully-insured plans non-discrimination rules based on Code § 105(h) governing eligibility and benefits
  - In 1986, Congress adopted the ill-fated Code §89
  - Code § 89 experience will inform rulemaking under PHS Act § 2716
- Is eligibility based on design or utilization?
- The fate of "multi-tier" plans (salaried v. hourly; management v. rank-and-file, internal v. external staff); Importance varies by industry type and sector (staffing, retail, and franchise most affected)

Affordability

- To avoid having to make assessable payments under Code §4980H, an applicable large employer must offer minimum essential coverage that is both "affordable" and offers minimum value
  - Coverage is "affordable" if the employee portion of the premium is 9.5% of W-2 wages or less
  - Is the 9.5% determined based on self-only coverage or family coverage?
  - Compare proposed regulation under Code § 36B (self-only coverage) with final regulation ("reserved")

Minimum Value

- Minimum value tests the portion of the plan's benefits paid by the plan v. those paid by the participant
  - Unrelated to who pays the premium
  - Must be 60% actuarial value or greater
  - But what services must be covered?
- A plan's actuarial value is based on the provision of benefits without regard to the plan's actual experience
- Notice 2012-31: Physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits, and laboratory and imaging services

Questions and Answers

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