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The Supreme Court Decision on Health Care Reform What If It Stays? What If It Goes? The Impact on Employer Group Health Plans

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Health Care Reform

- On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (the "PPACA").
- The Health Care and Education Reconciliation Act of 2010 was signed into law on March 30, 2010.
- Some significant changes take effect in 2012 and 2013.
- Another large group of changes take effect in 2014.

Supreme Court Review

- The United States Supreme Court heard oral arguments March 26-March 28.
- Two key issues --
  - Whether the individual mandate is a constitutional.
  - Whether the requirement that states must expand Medicaid eligibility to receive federal funding is constitutional.
- Neither issue directly affects employer group health plans, but if the Supreme Court finds that the individual mandate is unconstitutional, it must also decide whether the individual mandate is severable from the remainder of the legislation.

Supreme Court Review

- The Anti-Injunction Act ("AIA") prevents taxpayers from contesting a tax in court before it is paid.
- Neither side asserted that the AIA bars the Supreme Court from hearing the case.
- The Court appointed an attorney to provide arguments the case is premature.

Supreme Court Review

- Next issue is whether the individual mandate is constitutional.
- Under the Constitution, Congress has the "power to lay and collect taxes."
  - Key issue is whether the individual mandate generates a tax.

Supreme Court Review

- The Court is also considering whether the individual mandate is a valid exercise of power under the Commerce Clause.
- The Constitution provides that "Congress shall have Power…to regulate Commerce with foreign Nations, and among the several States, and with Indian Tribes."
- The existing Commerce Clause cases provide that Congress may regulate any economic activity that Congress rationally concludes is in the stream of, or substantially affects, interstate commerce.

Supreme Court Review

- Next issue is severability.
- In general, the Court favors severability over declaring an entire statute void, out of deference to the legislative branch.
- The Administration has argued that if severability becomes an issue, the Court should strike only the guaranteed-issue and community-rating provisions.
- The key inquiry is whether Congress would have preferred the remainder of the statute or no statute at all.
- It is interesting to note that Congress removed a severability clause from an earlier version of the bill.

#1 – The Individual Mandate is Constitutional

- The law remains in place.
- Employer group health plans must continue to comply with all requirements.
- Focus on 2012 and 2013 changes.
- Start thinking about 2014 changes.

#2 – The Individual Mandate is Not Constitutional But is Completely Severable From the Rest of PPACA

- The impact on employer group health plans is the same the law being upheld (#1 above).

#3 – The Individual Mandate is Not Constitutional But is Partially Severable From the Rest of PPACA

- The portions that are severable will remain in effect.
- Those that are not will cease to apply.
- Some or all of the portions of health care reform that apply to employer group health plans may remain in effect.
- Could take months to sort out.

#4 – The Individual Mandate is Not Constitutional and Not Severable From the Rest of PPACA

- The entire law is void.
- Employer group health plans would no longer have to comply with any of health care reform.
- Don't have to worry about upcoming change.
- Need to think about which changes to keep and which changes to unwind.

#5 – The Court Cannot Hear the Case Until Individuals Are Required to Pay the Penalty in 2015

- If the Supreme Court hangs its hat on the AIA, the impact is the same as the law being upheld (#1 above), at least for the time being.

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What If It Stays?

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What If It Stays?

- Additional preventive services for women.
- Summary of benefits and coverage (the "SBC").
- 60-day advance notice of changes impacting the SBC.
- W-2 reporting of the value of employer sponsored medical coverage.
- Medical loss ratio ("MLR") rebates for insured plans.
- Tax on Medicare retiree drug subsidies.
- $2,500 health FSA limit.
- Increase restricted annual limit to $2 million.

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Health Care Reform in 2012

What If It Stays? - Additional Preventive Services for Women (Non-Grandfathered Plans)

- On August 3, 2011, the Departments issued an amendment to health care reform's preventive care requirement.
- The new rules additionally require non-grandfathered group health plans to cover women's preventive services without charging a co-payment, co-insurance or a deductible.

What If It Stays? - Additional Preventive Services for Women (Non-Grandfathered Plans)

- This rule is intended to make sure women have access to a full range of recommended preventive services without cost sharing, including: well-woman visits; screening for gestational diabetes; human papillomavirus (HPV); DNA testing for women 30 years and older; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling.

What If It Stays? - Additional Preventive Services for Women (Non-Grandfathered Plans)

- Non-grandfathered health plans will need to cover these services without cost sharing for plan years beginning on or after August 1, 2012 (*i.e.*, January 1, 2013 for calendar year plans).
- Be sure to update the list of covered preventive services to reflect these additional items.
- As a reminder, need to look at the preventive services list each year for additions and deletions.

What If It Stays? - Additional Preventive Services for Women (Non-Grandfathered Plans)

- Originally the regulation would have allowed religious institutions the choice of whether or not to cover contraception services.
- On January 20, 2012, HHS announced that nonprofit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their insurance plan, will be provided an additional year, until August 1, 2013, to comply with the new law.
- The reason: "Scientists have abundant evidence that birth control has significant health benefits for women and their families, it is documented to significantly reduce health costs, and is the most commonly taken drug in America by young and middle-aged women."

What If It Stays? - Additional Preventive Services for Women (Non-Grandfathered Plans)

- On February 10, 2012 Obama announced that instead of requiring such employers to cover contraception, the insurance companies would be required to provide free birth control coverage in separate agreements with workers who request it.
- The Obama administration reaffirmed its stance on March 21, 2012 but proposed funding options that would relieve a self-insured religious employer from paying for that coverage.
- The Roman Catholic Archbishop of Washington and the University of Notre Dame were among more than 40 Catholic institutions that filed 12 lawsuits on May 21, 2012.
- They argue it violates the Religious Freedom Restoration Act and the First Amendment.
- They argue that the definition of "religious employer" is overly narrow.

What If It Stays? - Summary of Benefits and Coverage (All Plans)

- Health care reform expands ERISA's disclosure requirements by requiring that a four-page "summary of benefits and coverage" (the "SBC") be provided to applicants and enrollees before enrollment or re-enrollment in a group health plan.
- The SBC must accurately describe the benefits and coverage under the applicable plan.
- The SBC applies in addition to ERISA's SPD and SMM requirements.
- Applies to both grandfathered and non-grandfathered plans.

What If It Stays? - Summary of Benefits and Coverage (All Plans)

- The requirements do not apply to excepted benefits.
- For example an SBC need not be provided for stand-alone dental or vision plans or health FSAs if they constitute excepted benefits under the Departments' regulations.
- Some health FSAs and most HRAs will have to comply with the SBC requirements, but special rules apply if those types of coverage are integrated with the medical plan.

What If It Stays? - Summary of Benefits and Coverage (All Plans)

- In August 2011, the Departments issued proposed regulations regarding the SBC.
- On February 9, 2012, the Departments issued final regulations, and additional guidance.
- On March 19 and May 11, 2012, the Department of Labor issued two sets of FAQs about the SBC.

What If It Stays? - Summary of Benefits and Coverage (All Plans)

- A compliance document, a revised SBC template, a sample completed SBC, instructions and revised uniform glossary have all been posted to EBSA website.
  - FAQ 14 (May 11, 2012) explains that a previously posted template has been revised to correct an error listing the amount of insulin as $11.92 rather than $119.20 and to include the sample taglines for obtaining translated documents.
  - Be sure to use the documents labeled "corrected on May 11, 2012."

What If It Stays? - SBC Delayed Compliance Date (All Plans)

- The SBC requirement was originally effective March 23, 2012.
- The requirement to provide an SBC, 60-day advance notice of modification, and uniform glossary and the final regulations apply for disclosures to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees) beginning on the first day of the first open enrollment period that begins on or after September 23, 2012.
- For disclosures to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the requirement to provide an SBC, 60-day advance notice of modification, and uniform glossary and the final regulations apply beginning on the first day of the first plan year that begins on or after September 23, 2012 (i.e., January 1, 2013 for calendar year plans).

What If It Stays? - SBC Language Requirements (All Plans)

- The SBC must be provided in a culturally and linguistically appropriate manner similar to the rules regarding the group health plan claims and appeals notices.
- In general, those rules provide that, in specified counties of the United States, plans must provide interpretive services, and must provide written translations of the SBC upon request in certain non-English languages.
- In addition, in such counties, English versions of the SBC must disclose the availability of language services in the relevant language.
  - FAQ 13 (March 19, 2012) explains where to find sample language for this statement.

What If It Stays? - SBC Language Requirements (All Plans)

- This must be done in counties in which at least 10 percent of the population residing in the county is literate only in the same non-English language.
- The DOL and IRS publish a list of such counties.
  - FAQ 13 (March 19, 2012) explains how to access county-by-county data.
- In Arizona, Apache, Yuma and Santa Cruz counties are currently on the list.
  - Apache for Navajo; other two for Spanish.
- Under the final regulations, HHS will provide written translations of the SBC template, sample language and uniform glossary in Spanish, Tagalog, Chinese and Navajo.
  - FAQ 11 (May 11, 2012) explains where to find the written translations.

What If It Stays? - Content of the SBC (All Plans)

The regulations provide that the SBC must include the following information:

1. Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;
2. A description of coverage, including cost sharing for each category of benefits identified by the Departments;
3. Exceptions, reductions and limitations on coverage;
4. Cost-sharing provisions of coverage, including deductibles, coinsurance and co-payment obligations;

What If It Stays? - Content of the SBC (All Plans)

5. The renewability and continuation of coverage provisions;
6. Coverage examples specified by the Secretary;
7. For coverage beginning on or after January 1, 2014, a statement of whether the plan provides minimum essential coverage and whether the plan share of the total allowed cost of benefits meets applicable requirements;
8. A statement that the SBC is only a summary and that the plan document, policy or certificate of coverage should be consulted to determine the governing contractual provisions of coverage;

What If It Stays? - Content of the SBC (All Plans)

9. Contact information for questions and for obtaining a copy of the plan document or insurance policy, certificate or contract of insurance;
10. For plans that maintain one or more provider networks, an internet address for obtaining a list of network providers;
11. For plans that use a prescription drug formulary, an internet address for obtaining information on prescription drug coverage; and
12. Information for obtaining copies of the uniform glossary, which includes an internet address where an individual may review the uniform glossary, a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies of the uniform glossary are available.

What If It Stays? - Content of the SBC (All Plans)

- The final regulations do not require the SBC to include premium or cost of coverage information.
- The Departments recognize that the inclusion of premium information in the SBC could result in numerous SBCs being required to be provided to individuals.
- If premium information is not required, only a single SBC might be necessary.
- The Departments believe that premium information can be more efficiently and effectively provided by means other than the SBC.
- FAQ 16 (March 19, 2012) explains that if you choose to add premium information it should be added at the end of the SBC form.

What If It Stays? - Content of the SBC (All Plans)

- FAQ 15 (March 19, 2012) explains that an SBC is not permitted to substitute a reference to the SPD or other document for any content requirement of the SBC.
- FAQ 23 (March 19, 2012) explains that an SBC does not have to include a grandfathered plan statement.

What If It Stays? - Glossary Requirement (All Plans)

- The regulations also provide guidance on the uniform glossary requirements of Section 2715(g) of the Act which requires the Departments to develop a glossary of standard terms used in health insurance coverage.
- The uniform glossary must define the words identified in the regulations and may not be modified from the appearance (i.e., format) authorized in the regulations.
- The glossary must be provided to participants and beneficiaries in either paper or electronic form within 7 business days of request.

What If It Stays? - Glossary Requirement (All Plans)

- The preamble to the proposed regulations acknowledges that the generic definitions in the glossary may not necessarily help consumers understand what terms mean in the context of their own plan because the definitions in the glossary are not plan specific.
- Plan sponsors will need to be especially careful in coordinating definitions in their plan document, summary plan description and uniform glossary.
- Consider whether to revise plans and SPDs to coordinate with the uniform glossary to prevent confusion.
- Alternatively, plan sponsors that do not intend to conform the definitions in their plan document and summary plan description to the uniform glossary should be sure to adequately notify participants and beneficiaries of such decision.

What If It Stays? - When Must the SBC Be Distributed? (All Plans)

- The regulations generally provide that the SBC, for each benefit package offered for which the participant or beneficiary is eligible, must be distributed upon initial enrollment, open enrollment, HIPAA special enrollment, and as soon as practicable upon request, but in no event later than 7 *business* days following the request.
- FAQ 7 (March 19, 2012) clarifies the SBC must be sent out within 7 business days, not received.

What If It Stays? - When Must the SBC Be Distributed? (All Plans)

- If written application materials are required for renewal, the SBC must be provided no later than the date on which the materials are distributed.
- In general, if renewal or reissuance of coverage is automatic (that is, when written application materials are not required for renewal), the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.

What If It Stays? - When Must the SBC Be Distributed? (All Plans)

- With respect to insured coverage, in situations in which the SBC cannot be provided within this timeframe because, for instance, the issuer and the purchaser have not yet finalized the terms of coverage for the new policy year, the final regulations provide an exception.
  - The SBC must be provided as soon as practicable, but in no event later than 7 business days after the issuance of the policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.
  - The regulations provide this flexibility only when the terms of coverage are finalized in fewer than 30 days in advance of the new policy year; otherwise, the SBC must be provided upon automatic renewal no later than 30 days prior to the first day of coverage under the new plan or policy year.

What If It Stays? - Who Must Receive the SBC (All Plans)

- The SBC must be provided to all applicants, enrollees and policyholders or certificate holders.
- FAQ 8 (March 19, 2012) clarifies this includes COBRA qualified beneficiaries.
- Under the final regulations, the plan or issuer must also provide the SBC to special enrollees. The final rule provides that special enrollees must be provided the SBC no later than 90 days from enrollment (the same deadline as providing an SPD).

What If It Stays? - Who Must Receive the SBC (All Plans)

- Persons contemplating special enrollment can request an SBC, which would then have to be sent as soon as practicable, but in no event later than 7 business days following receipt of the request.
- The regulations clarify that if enrollees live at the same address (i.e., a participant and his or her spouse), only one SBC needs to be delivered to that address.
- If a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.

What If It Stays? - Appearance of SBC

- A group health plan and a health insurance issuer must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance.
- Must be presented in a uniform format (the SBC template).
- Must use terminology understandable by the average plan enrollee.
- Cannot exceed four double-sided pages in length (for a total of eight pages).
- Cannot include print smaller than 12-point font.

What If It Stays? - Form of SBC

- The additional guidance specifies that SBCs provided in connection with group health plan coverage may be provided either as a stand-alone document or in combination with other summary materials (for example, an SPD), if the SBC information is intact and prominently displayed at the beginning of the materials (such as immediately after the table of contents in an SPD) and in accordance with the timing requirements for providing an SBC.

What If It Stays? - Delivery of SBC

- For participants and beneficiaries who are already covered under the group health plan, the final regulations permit provision of the SBC electronically if the requirements of the Department of Labor's regulations at 29 CFR 2520.104b-1 are met. (Paragraph (c) of those regulations includes an electronic disclosure safe harbor.)
- For participants and beneficiaries who are eligible for but not enrolled in coverage, the final regulations permit the SBC to be provided electronically if the format is readily accessible and a paper copy is provided free of charge upon request.

What If It Stays? - Delivery of SBC

- FAQ 10 (March 19, 2012) provides additional guidance on electronic disclosure.
- FAQ 1 (May 11, 2012) provides an additional electronic distribution safe harbor.
  - Under this safe harbor, SBCs may be distributed electronically to participants and beneficiaries in connection with their online enrollment or online request for an SBC.

What If It Stays? - Delivery of SBC

- If the electronic form is an internet posting, the plan or issuer must timely advise the individual in paper form (such as a postcard) or email that the documents are available on the internet, provide the internet address, and notify the individual that the documents are available in paper form upon request.
- FAQ 12 (March 19, 2012) gives model language to provide an e-card or postcard in connection with evergreen website postings.
- Plans, and participants and beneficiaries (both covered, and eligible but not enrolled) have the right to receive an SBC in paper format, free of charge, upon request.

What If It Stays? - 60-Day Advance Notice of Changes Impacting SBC (All Plans)

- This notice must be provided only for changes other than in connection with a renewal or reissuance of coverage.
- At renewal, plans and issuers must provide an updated SBC in accordance with the requirements otherwise applicable to SBCs.
- To the extent a plan or policy implements a mid-year change that is a material modification, that affects the content of the SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the final regulations require a notice of modification to be provided 60 days in advance of the effective date of the change.

What If It Stays? - 60-Day Advance Notice of Changes Impacting SBC (All Plans)

- May provide an updated SBC reflecting the modifications or provide a separate notice describing the material modifications.
- A material modification for this purpose includes benefit enhancements or reductions.
- If a timely notice is delivered pursuant to the regulations, the ERISA summary of material modification requirement is also satisfied.
- Applies to both grandfathered and non-grandfathered plans.

What If It Stays? - Penalties for Noncompliance (All Plans)

- Section 2715(f) of the Act provides that a group health plan or issuer that willfully fails to provide the SBC to a participant or beneficiary is subject to a fine of up to $1,000 for each failure.
- The regulations clarify that a failure with respect to each participant or beneficiary constitutes a separate offense for purposes of this penalty.
- A plan sponsor who fails to distribute the SBC to 10 enrollees could be fined up to $10,000.

What If It Stays? - Penalties for Noncompliance (All Plans)

- The regulations also state that a failure to provide the SBC may also result in an excise tax of $100 per day for each individual affected by the failure.
- In FAQ 2 (March 19, 2012), the Departments indicated their approach is assisting rather than imposing penalties on employers.
- During the first year of applicability, the Departments will not impose penalties on employers and issuers working diligently and in good faith to comply with SBC rules.

What If It Stays? - W-2 Reporting – General Requirements (All Plans)

- Employers must report the aggregate cost of employer-sponsored health coverage beginning with the 2012 calendar year (i.e., on the Form W-2 issued in 2013). Reporting was optional for 2011.
  - The cost is reported in Box 12 using new code DD.
- Stated purpose is to provide employees with information on the actual cost of health care coverage.
- Aggregate cost does not need to be reported if:
  - Employer is not otherwise required to issue a Form W-2 (e.g., retiree receiving no compensation).
  - Employee terminates employment mid-year and requests W-2 before the end of the year.

What If It Stays? - Employers Subject to W-2 Reporting (All Plans)

- Employers that are subject to the W-2 reporting requirements:
  - All private sector employers.
  - Federal, state, and local governments.
  - Religious organizations.
- Employers that are not subject to the W-2 reporting requirements:
  - Employers filing fewer than 250 Forms W-2 for the preceding calendar year *(until further guidance is issued)*.
  - Federally recognized Indian tribal governments.
  - Tribally chartered corporations wholly-owned by a Federally recognized Indian tribal government *(until further guidance is issued).*
  - Third party sick pay providers who issue Forms W-2 to employees.

What If It Stays? - What is Reportable Employer Sponsored Health Coverage? (All Plans)

- Major medical plans.
- Dental and vision plans, *unless the coverage is considered a "limited scope" dental or vision benefit.*
- Employee assistance plans, wellness plans, and on-site medical clinics, *unless the employer does not charge a premium for COBRA coverage or is not subject to COBRA.*
- Specified disease or illness insurance and hospital indemnity or other fixed indemnity insurance, *unless the coverage is paid by the employee on an after-tax basis.*
- Employer contributions to a health flexible spending account (health FSA).

What If It Stays? - Exceptions to the Reporting Requirement (All Plans)

- Limited scope dental or vision benefits.
- Employee assistance programs, wellness programs, and on-site medical clinics *if the employer does not charge a premium with respect to COBRA coverage or is not subject to COBRA.*
- Specified disease or illness insurance and hospital indemnity or other fixed indemnity insurance *provided the coverage is funded by the employee on an after-tax basis.*
- Employee contributions to a health FSA.
- Health reimbursement arrangements.
- Amounts contributed to Archer MSAs or health savings accounts (these are reported elsewhere on the Form W-2).
- Multiemployer plans.
- Government plans maintained primarily for members of the military and their families.
- Self-insured group health plans that are not subject to any federal continuation coverage requirements (e.g., certain church plans).

What If It Stays? - Exceptions to the Reporting Requirements (All Plans)

- Coverage for long-term care.
- Certain types of coverage considered "excepted benefits" under HIPAA:
  - Accident or disability income insurance.
  - Supplemental liability insurance.
  - Liability insurance, including general liability insurance and automobile liability insurance.
  - Workers' compensation or similar insurance.
  - Automobile medical payment insurance.
  - Credit-only insurance.
  - Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

What If It Stays? - Multiple Employers (All Plans)

- If an employee works for multiple, related employers:
  - If one employer is the common paymaster, the common paymaster should report the aggregate cost of coverage for all related employers.
  - If there is no common paymaster, the related employers may either report the entire amount on one of the Forms W-2 provided to the employee, or the employers can allocate the cost among them.
- If an employee transfers to a new employer that qualifies as a successor employer, unless the predecessor and successor employer issue one Form W-2, each must report the cost coverage that employer provided.

What If It Stays? - Amounts Included in the Cost of Coverage (All Plans)

- The cost of coverage for the employee and anyone covered because of a relationship to the employee.
- Employer and employee contributions, regardless of whether they are pre-tax or after-tax.
  - Only employer contributions to health FSAs.
- The cost of coverage during employment. Including the cost of continuation coverage post-termination is optional, but employers must be consistent.
- If employer-provided health coverage is combined with another benefit, only the amount that is considered employer-provided health coverage, subject to exceptions for incidental coverage.

What If It Stays? - Rules for Including Health FSA Amounts in the Cost of Coverage (All Plans)

- If there are no employer contributions, the amount of the health FSA is not included in the cost of coverage.
- If the health FSA is offered through a cafeteria plan and there are employer flex credits:
  - If the amount of the employee's salary reduction (for all qualified benefits) equals or exceeds the amount of the health FSA for the plan year, the amount of the health FSA is not included in the cost of coverage.
  - If the amount of the health FSA for the plan year exceeds the employee's salary reductions, then the amount of the health FSA minus the employee's salary reduction election for the health FSA is included in the cost of coverage.

What If It Stays? - Amounts Excluded in the Cost of Coverage (All Plans)

- Excess reimbursements of highly compensated employees that are included in gross income under Code Section 105(h) are subtracted from the cost of coverage.
  - **Example**: Employer provides self-insured health coverage with a cost of $12,000. A highly compensated individual receives $4,000 in excess reimbursement, which is included in gross income. The reportable cost for the individual is $8,000.
- The cost of coverage for a 2% shareholder-employee of an S corporation who is required to include the premium payment in gross income.
- The cost of the portion of a benefit that is not considered employer-sponsored health coverage using a reasonable allocation method, with exceptions for incidental coverage.

What If It Stays? - Optional Treatment of Incidental Benefits (All Plans)

- If the cost of employer-sponsored health coverage in a program that provides other benefits is incidental, (e.g., incidental health benefits that are provided in a long-term disability program) the employer may, but is not required to, report the cost of such coverage.
- If the cost of non-health benefits in a program that primarily provides employer-sponsored health coverage is incidental, the employer may, but is not required to, exclude the cost of the non-health benefit.

What If It Stays? - Methods of Calculating the Cost of Coverage (All Plans)

- An employer may calculate the cost of coverage using:
  - The COBRA premium, provided that the employer calculates the COBRA premium in good faith compliance with a reasonable interpretation of COBRA.
  - The actual premium charged (for insured plans).
  - A modified COBRA premium
    - If an employer subsidizes the cost of COBRA coverage, the employer may determine the cost of coverage using a reasonable good faith estimate, if such estimate is used for determining the subsidized COBRA premium.
    - If the COBRA premium charged by the employer in the current year is equal to the COBRA premium in the prior year, the employer may use the COBRA premium in the prior year as the reportable cost in the current year.
- An employer may use composite rates (e.g., employee and family rates), provided that the employer is consistent.

What If It Stays? - Reflecting Cost and Coverage Changes (All Plans)

- The cost of coverage is reported on a month-by-month basis for the calendar year. Mid-year changes in cost must be reflected when:
  - The plan is a non-calendar plan year.
  - An employee makes an election change (with exceptions for changes that occur mid-month or mid-payroll period).
- Exceptions:
  - When an election change impacts coverage in the prior year, the prior year's cost of coverage does not have to be adjusted.
  - Payroll periods that span two calendar years. Employer may treat the coverage as provided in the prior year, subsequent year, or allocate between the two.

What If It Stays? - Medical Loss Ratio Requirements (All Insured Plans)

- Effective as of January 1, 2011, health insurance issuers offering group or individual health insurance coverage (including coverage provided to a grandfathered health plan) must comply with Medical Loss Ratio (MLR) requirements.
  - Must report to HHS the proportion of premiums spent on medical care.
  - Issuers must spend at least 80% (in the small group market) or 85% (in the large group market) of premium dollars on medical care. States may impose a higher MLR.
  - If an insurer fails to meet these standards, it must provide an annual rebate to each enrollee starting in 2012 (based on 2011 MLRs). (Special rules apply for mini-med and expatriate plans.)
  - HHS is allowed to adjust the MLR standard for a state if it determines that meeting the 80% MLR standard may destabilize the individual market.

What If It Stays? - How to Determine Medical Loss Ratio (All Insured Plans)

- PPACA required the National Association of Insurance Commissioners (NAIC) to develop uniform definitions and methodologies for calculating insurance companies' MLRs. The HHS regulation certified and adopted the recommendations submitted by the NAIC.
- MLR = Total amount spent on medical care divided by the total amount of premium revenues in a year.
  - Medical care – incurred medical claims and amounts spent to improve health care quality.
  - Premium revenues – amounts received as premiums, minus the issuer's federal and state taxes and licensing and regulatory fees.
- MLRs are calculated based on aggregated market data in each state and not upon a particular policy's experience.

What If It Stays? - Rebates (All Insured Plans)

- Recipients - Rebates are provided to *enrollees* - the subscriber (e.g., employee), policyholder (e.g., employer) and/or government entity that paid the premium for health care coverage received by an individual during the reporting year.
- Timing - Rebates for a calendar year must be calculated by June 1 following the end of such year, and provided to enrollees no later than August 1. The first rebates will be payable in August 2012.
- Form – An issuer may provide the rebate in the form of a premium credit, lump sum check, refund to a credit card or debit card, or pre-paid debit card provided certain conditions are met (see CCIIO Technical Guidance Q&A #37 for the pre-paid debit card conditions).

What If It Stays? - Rebate Recipients (All Insured Plans)

- Individual market – Rebates are provided to the individual enrollee.
- Large group and small group markets – Rebates for most group health plans are provided to the policyholder, with protections designed to ensure that subscribers benefit.

What If It Stays? - Rebates to ERISA Plans (All Insured Plans)

- To the extent rebates are considered "plan assets" –
  - Fiduciary responsibility and prohibited transaction provisions apply.
  - They must generally be held in trust.
  - They must not inure to the benefit of any employer.
  - They must be held for the exclusive purpose of providing benefits to participants in the plan.
- A rebate will be a plan asset if a plan has a beneficial interest in the distribution under ordinary notions of property rights.

What If It Stays? - When Are Rebates ERISA Plan Assets? (All Insured Plans)

- If the plan or trust is the policyholder, the rebates are plan assets, *unless there is specific plan or policy language to the contrary.*
- If the employer is the policyholder and the insurance policy or contract, together with other plan documents, clearly provide that rebates belongs to the employer, the rebates are not plan assets and may be retained by the employer.
- If the employer is the policyholder, but the contract or plan documents are ambiguous, other evidence may be used to determine intent – typically, it is the source of the premium payments.
  - If the premiums are paid entirely out of trust assets, the rebates are plan assets.
  - If all or a portion of the premiums are paid by participant contributions, a portion of the rebate is considered plan assets.

What If It Stays? - ERISA Fiduciary Responsibilities (All Insured Plans)

- Fiduciaries must act prudently, solely in the interest of plan participants and beneficiaries, and in accordance with the terms of the plan.
- Fiduciaries must act impartially.
- When a plan provides benefits under multiple policies, fiduciaries should generally allocate or apply the plan's portion of a rebate for the benefit of participants and beneficiaries who are covered by the policy to which the rebate relates.

What If It Stays? - What Can Be Done with Rebates (All Insured Plans)

- The portion of the rebate that is considered plan assets can be:
  - Distributed to participants.
  - Applied toward future participant premium payments (i.e., premium payment holidays).
  - Applied toward benefit enhancements.

(The DOL guidance does not specifically address using the rebates for plan administrative expenses.)

What If It Stays? - What Can Be Done with Rebates (All Insured Plans)

- Fiduciaries may weigh the costs to the plan and the ultimate plan benefit along with competing interests of plan participants, in deciding what to do with the rebate.
  - If the cost of distributing shares of a rebate to former participants approximates the amount of the proceeds, the fiduciary may choose to allocate the rebate to current participants.
  - If distributing payments are not cost effective because the amounts are de minimis or would give rise to tax consequences, the fiduciary may use the rebate for other purposes, including participant premium payment holidays or benefit enhancements.

What If It Stays? - ERISA Trust Requirements (All Insured Plans)

- To the extent rebates are plan assets, they should be held in trust.
  - Plan sponsors can avoid the need for a trust by directing insurers to apply the rebate toward future participant contributions or benefit enhancements.
  - The DOL will not assert a violation of ERISA's trust requirement against plan sponsors who are already relying on ERISA Technical Release 92-01 as long as the rebate is used to pay premiums or the amount is refunded to participants within three months of receipt of the rebate.

What If It Stays? - Technical Release 92-01 (All Insured Plans)

- The DOL will not enforce the trust requirement:
  - If the sole reason a plan would be subject to trust requirements is the receipt of participant contributions to a cafeteria plan.
  - If the sole reason an insured plan would be subject to the trust requirements is the receipt of participant contributions provided the following requirements are met: (1) benefits are paid exclusively through an insurance policy; (2) premiums are paid directly by the employer to the insurer as soon as possible (but no later than three months); and (3) insurance refunds must be refunded to participants within three months of receipt.

What If It Stays? - Rebates to State and Local Government Plans (All Insured Plans)

- Rebates may be provided to the policyholder.
- Policyholder must use the amount of the rebate that is proportionate to the premiums paid by subscribers in one of the following ways:
  - Reduce subscribers' portion of premiums in subsequent policy year for all subscribers covered under the option for which the rebate applies (or for all subscribers covered under any option).
  - Provide a cash refund to subscribers enrolled in the option, at the time the rebate is received, for which the issuer is providing the rebate.
- The premium reduction or cash refund can be: (1) divided evenly; (2) divided based on each subscriber's actual contributions; or (3) apportioned in a manner that reasonably reflects each subscriber's contribution to the premium.

What If It Stays? - Rebates to Church Plans Exempt from ERISA (All Insured Plans)

- Rebates may be provided in one of the following ways:
  - Paid to the policyholder *only if* the issuer receives a written assurance from the policyholder that the rebates will be used to reduce premiums or provide refunds to subscribers.
  - If no written assurance is received, distributed to subscribers by dividing the entire rebate in equal amounts to all subscribers, regardless of how much each subscriber actually paid toward premiums.

What If It Stays? - Rebates to Terminated Plans (All Insured Plans)

- If the issuer *cannot* locate the policyholder, the issuer must distribute the rebate directly to subscribers.
  - Divide the entire rebate, including the amount that is proportionate to the policyholder's premiums, in equal amounts to all subscribers, regardless of how much each subscriber actually paid toward premiums.
- If the issuer *can* locate the policyholder of an ERISA plan, the policyholder must comply with ERISA, including looking to the plan document to determine how assets are to be allocated upon termination. If the plan document is silent, the policyholder may need to determine if it is cost effective to distribute the rebate to former participants.

What If It Stays? – Federal Tax Consequences to Employees (All Insured Plans)

- If employees pay premiums on a pre-tax basis, an MLR rebate is generally subject to federal income and employment tax, regardless as to whether the rebate is in the form of a premium reduction or a cash distribution.
- If employees pay premiums on an after-tax basis, an MLR rebate is generally not subject to federal income and employment tax, regardless as to whether the rebate is in the form of a premium reduction or a cash distribution, with one exception.
  - If the employer is only providing the rebate to those employees who participated in the group health plan *both* in the year the premiums being rebated were paid and the year the MLR rebates are paid and an employee deducted the prior premium payments on his/her Form 1040 in the year the premiums were paid, the MLR rebate is taxable to the extent the employee received a tax benefit from the deduction (but it is not subject to employment taxes).

What If It Stays? - Rebate Notice (All Insured Plans)

- Insurers must provide a notice to the policyholder and subscribers, at the time a rebate is provided, that provides an explanation of the rebate, its calculation, and how the rebate will be handled.
- Insurers who meet or exceed MLR standards must also provide a one-time notice for the 2011 reporting year with the first plan document that the insurer provides to enrollees on or after July 1, 2012.

Snell & Wilmer

Health Care Reform in 2013

What If It Stays? - Tax on Medicare Retiree Drug Subsidies

- Effective for tax years beginning on or after January 1, 2013, employers will no longer be able to deduct Medicare Part D drug subsidies paid to employers with retiree medical programs that provide prescription drug coverage.

What If It Stays? - Health FSA Limit

- Health care reform added a $2,500 limit on salary reduction contributions to health flexible spending arrangements ("health FSAs").
- Prior to health care reform, there was no limit on health FSA contributions.
- On May 30, 2012 the IRS issued Notice 2012-40 which provides guidance on a number of issues.

What If It Stays? - Health FSA Limit

- The plan year
  - The term "taxable year" used in Section 125(i) of the Code refers to the plan year of the cafeteria plan.
  - The $2,500 limit does not apply for plan years that begin before January 1, 2013.
  - The limit will be indexed for cost-of-living adjustments for plan years beginning after December 31, 2013.
  - In the case of a short plan year, the limit must be prorated.
  - Be careful about changing plan years to delay application of the limit – if no valid business purpose, the plan year remains the old plan year.

What If It Stays? - Health FSA Limit

- Application of the limit
  - The limit applies on an employee-by-employee basis, regardless of the number of individuals whose medical expenses are reimbursable under the employee's health FSA.
  - Each spouse may elect to make $2,500 contribution each plan year even if they participate in the same health FSA sponsored by the same employer.

What If It Stays? - Health FSA Limit

- Controlled group rules
  - All employers that are treated as a single employer under Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the $2,500 limit.
  - If an employee participates in multiple cafeteria plans offering health FSAs maintained by members of a controlled group or affiliated service group, the employee's total health FSA salary reduction contributions under all of the cafeteria plans are limited to $2,500 (as indexed for inflation).
  - An employee employed by two or more employers that are not members of the same controlled group may elect up to $2,500 (as indexed for inflation) under each employer's health FSA.

What If It Stays? - Health FSA Limit

- Salary reduction contributions
  - The $2,500 limit applies only to salary reduction contributions and not to employer non-elective contributions, sometimes called flex credits.
  - For example, if an employer contributes a $500 flex credit to an employee's health FSA for the plan year, the employee may still elect to make salary reduction contributions of $2,500 to a health FSA for that plan year.
  - If an employer provides flex credits that employees may elect to receive as cash or as a taxable benefit, those flex credits are treated as salary reduction contributions.
  - The limit does not apply to dependent care, adoption care, or premium payments, health savings accounts or health reimbursement arrangements.

What If It Stays? - Health FSA Limit

- Application of grace periods
  - If a plan provides for a grace period (which can be no longer than two months and 15 days) for a plan year, unused salary reduction contributions to the health FSA for the plan year that are carried over into the grace period do not count against the $2,500 limit applicable for the subsequent plan year.

What If It Stays? - Health FSA Limit

- Plan amendments
  - A cafeteria plan offering a health FSA must be amended to set forth the $2,500 limit, or a lower limit.
  - Cafeteria plan amendments must normally be effective only prospectively.
  - An amendment reflecting the $2,500 (or lower) limit must be adopted on or before December 31, 2014.
  - It may be made effective retroactively, provided that the cafeteria plan operates in accordance with the requirements of Code Section 125(i) in the interim.

What If It Stays? - Health FSA Limit

- Excess contributions
  - A cafeteria plan that fails to comply with the limit will lose its tax-advantaged status.
  - The Notice provides relief where employees are erroneously allowed to exceed the limit, if the excess contributions result from a reasonable mistake by the employer and are refunded to affected employees and reported as wages by a specified date.

What If It Stays? - Health FSA Limit

- The use-it-or-lose-it rule
  - IRS and Treasury are considering whether the rule should be modified.

What If It Stays? – Increase Restricted Annual Limit

- For plan years beginning before January 1, 2014 restricted annual limits on essential health benefits are permissible, as determined by HHS.
- The interim final regulations adopt a three-year phased approach for restricted annual limits, under which the annual limits may be no less than the following:
  - (1) $750,000 for plan years beginning on or after September 23, 2010 but before September 23, 2011;
  - (2) $1.25 million for plan years beginning on or after September 23, 2011 but before September 23,2012; and
  - (3) $2 million for plan years beginning on or after September 23, 2012 but before January 1, 2014.

What If It Stays? – 2014 Employer Penalties

- Beginning January 1, 2014, an "applicable large employer," generally, one that employed an average of at least 50 full-time employees during the preceding calendar year,
  - not offering coverage for all its full-time employees,
  - offering minimum essential coverage that is unaffordable, or
  - offering minimum essential coverage that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60%,

  will have to pay a penalty if any full-time employee is certified as having purchased health insurance through a state exchange with respect to which a tax credit, or cost-sharing reduction, is allowed or paid to the employee.

What If It Stays? – 2014 Employer Penalties

- Only one more year to go before rules take effect.
- Employers need to start focusing on the employer penalties now.
- If thinking about not offering coverage, need to understand the penalties.
  - Careful consideration and detailed analysis should be undertaken now.
- Rumblings that Congress may increase employer penalties.

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What If It Goes?

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What If It Goes?

- Do not have to comply with any of the above changes.
- Need to think about which changes to keep, and which to unwind.
- If keep some, consider whether to shift cost to employees.
- Employee relations issues.
- Plan amendments.
- When will changes take effect?
- 60 day SMM rule.
- Not a lot of time to make changes in advance of next plan year.

What If It Goes?

- Don't have to worry about grandfathered plan status.
  - Remove grandfathered plan notice from plan documents and summaries.
- No more small business tax credit.
- $5 billion retiree medical reinsurance program – not clear what will happen.
  - Employers who applied might not receive expected payments.
  - Could claw back payments already made.

What If It Goes?

- Don't have to, but may, allow reimbursement of over-the-counter medications without a prescription under a health FSA or similar plan.
- Ability to offer increased wellness incentives will go away. In a recent survey of employers this was the provision of health care reform that employers would most want reinstated.

What If It Goes? - Coverage For Children To Age 26

- This is probably the most popular change.
- Can revert to prior rules.
  - Reduce age, require financial dependence, require children to be unmarried, require full-time student status, etc.
- If continue to allow coverage to age 26, special tax rule deeming children to be dependents will no longer apply because it was part of health care reform.
  - If these kids continue to be covered, will need to impute income if not a tax dependent for health care purposes.
- Might have to impute income for coverage already provided to such kids.
- If keep this coverage, might charge more for it.

What If It Goes? – Preexisting Condition Exclusion For Children

- May add back pre-existing condition exclusion for children (and adults if made in advance of the 2014 effective date).
- Must comply with HIPAA pre-existing condition rules.
- Difficult to justify adding back.

What If It Goes? – Annual and Lifetime Limits

- May add back some or all annual and lifetime limits on benefits.
- Some employers terminated HRAs because of the annual limit rules.

What If It Goes? – Preventive Services

- Non-grandfathered plans had to cover a specific list of preventive services without any cost-sharing.
  - No copayments, coinsurance or deductibles.
- May decide not to cover some or all of the preventive services.
- In addition, or alternatively, may subject them to cost sharing.

What If It Goes? - Choice of Health Care Professional

- Health care reform required non-grandfathered plans to:
  - Allow participants to choose any willing participating provider as their primary care provider;
  - Allow children to designate a pediatrician as their primary care provider; and
  - Allow women to access in-network OB/GYN without a referral or prior authorization.
- May undo some or all of these changes.

What If It Goes? – Emergency Services

- Health care reform required non-grandfathered plans to:
  - Cover out-of-network emergency services without prior authorization and at same copayment and coinsurance rates as in-network providers; and
  - Equalize rates paid to out-of-network and in-network providers.
- May undo some of all of these changes.

What If It Goes? – Ban on Rescission of Coverage

- Health care reform prohibits retroactive termination of coverage except due to fraud or intentional misrepresentative of a material fact.
- Required 30 days advance notice of such retroactive termination.
- Most employers will probably revert to pre-health care reform rule to make plans easier to administer.

What If It Goes? – Nondiscrimination Rules For Insured Plans

- The new nondiscrimination rules for non-grandfathered insured plans are not currently being enforced by the agencies.
- Before the agencies indicated they would not enforce these rules until regulations were issued, some employers terminated discriminatory executive health benefits.

What If It Goes? – Expanded Claim and Appeal Rules

- Health care reform required non-grandfathered plans to comply with additional claim and appeal rules.
- The most obvious one was the addition of an external review procedure.
- Most employers will probably revert to pre- health care reform rules to make plans easier to administer.
- Department of Labor previously indicated that it intended to change the claims procedures regulations to incorporate some of the changes health care reform made to internal appeal procedures.

What If It Goes? - $2,500 Cap on Health FSAs

- Although not yet effective, some employers have amended their plans in anticipation of it taking effect.
- Consider whether to go back to higher limit.
- Amendment must be effective prospectively.

What If It Goes? - Tax on Medicare Retiree Drug Subsidies

- Health care reform eliminated the deduction for Medicare Part D drug subsidies.
- Although not effective until 2013, some employers took a charge against earnings related to the anticipated elimination of the deduction.
- Employers will need to determine whether and when to change their financial statements to reflect that deduction again exists.

What If It Goes? – Some Insurance Companies Not Changing

- On June 11, 2012 three major health insurers announced that they will continue abiding with many of the health care reform rules, regardless of how the Supreme Court rules.
- UnitedHealthcare and Humana said they will continue to offer:
  - preventive health care without copayments;
  - dependent coverage to age 26;
  - elimination of lifetime coverage limits;
  - no rescissions of coverage except for fraud or intentional misrepresentation of material fact; and
  - review of appeals by independent review organizations.
- If an insurer keeps certain provisions, an employer may not be able to unwind them.

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