Health Care Reform Path to Compliance

One thing's certain, change is constant as employers and employees navigate through the twists and turns of health benefits coverage.

WHITE HOUSE DIRECTION

2012
Internal Claims Review and External Review of Appeals processes must be in place (only applies to non-grandfathered plans)
Jan. 1

2012
Women's preventive care services must be covered without cost sharing (non-grandfathered plans)
Aug. 1

2012
Employers with insured plans may be eligible for rebates under minimum medical loss ratio (MLR) requirements
Aug. 1

2012
Summary of Benefits and Coverage (SBC) and Uniform Glossary requirements take effect for open enrollments
Sept. 23

2013
Medicare withholding tax (for those making more than $200k single or $250k family) will increase from 1.45% to 2.35%
Jan. 1

2013
Health Flexible Spending Accounts (FSAs) are limited to $2,500
Jan. 1

2013
Health & Human Services (HHS) evaluates each state's health insurance exchange and may step in to establish and run the state's exchange
Jan. 1

2013
Employer must report health care costs on each employee's W-2 (if more than 250 W-2s issued)
Jan. 31

2013
Employers need to communicate with employees about the future availability of a health insurance exchange in their state
Mar. 1

2013
Insured and self-funded plans will pay $1 per member to fund comparative effectiveness research of medical treatments. (applies to 2012 plan year; increases to $2 for 2013 plan year)
July 31

EMPLOYER HEALTH BENEFITS

HEALTH INSURANCE EXCHANGES

2013
Group health plans must certify they are compliant with HHS rules on electronic transactions between health providers and health plans
Dec. 31

2014
Individuals must buy health coverage or pay a tax (starts at the greater of $95 per person or 1% of household income)
Jan. 1

2014
Employer Shared Responsibility (Pay or Play) rules, FTE Definition and 90-day limit on eligibility waiting periods take effect
Jan. 1

2014
Expanded Medicaid; Small group insurance market reforms (guaranteed issue & renewability); No limits on pre-existing conditions for adults; No annual benefit limits; Cover costs of clinical trials
Jan. 1

2014
Wellness rewards or incentives may increase in 2014 from 20% to 30% of the cost for single coverage
Jan. 1

WELLNESS PROGRAMS

2014
Employers pay quarterly fees for Transitional Reinsurance Program
Jan. 15

2016
States to form Health Care Choice Compacts to offer purchase of insurance across state lines
Jan. 1

2017
Employers with >100 employees can purchase coverage through health insurance exchange
Jan. 1

2018
40% excise tax levied on "Cadillac Plans"
Jan. 1

20??
Uncertain effective date for auto-enrollment provision and non-discrimination rules for insured plans

The following pages provide specifics of each change mentioned above.
Findley Davies can assist plan sponsors on their compliance journey.
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2012-2018

Health Care Reform Path to Compliance

This timeline is intended to cover the highlights of the Patient Protection and Affordable Care Act (PPACA) as it relates to employers and employees. Although PPACA was signed into law on 3/23/2010, this timeline focuses on the aftermath of the Supreme Court of the United States' decision rendered on 6/28/2012. This timeline does not address fundamental changes impacting Medicare, Medicaid, the health care delivery system, insurers, or the states.

2012

2012
Internal Claims Review and External Review of Appeals processes must be in place (only applies to non-grandfathered plans)
Jan. 1

1. Internal Claims Review and External Review of Appeals processes were required to be in place by 1/1/2012. However, self-funded employers must have contracted with three (up from two) Independent Review Organizations (IROs) by 7/1/2012.
   - Self-funded employers using carriers as their medical claims administrator will likely have piggy-backed on the external review arrangements the carriers made for their insured plans.
   - Employers using TPAs may have had to make their own arrangements with IROs.

2012
Women's preventive care services must be covered without cost sharing (non-grandfathered plans)
Aug. 1

2. For plan years beginning on or after 8/1/2012 (i.e. 1/1/2013 for a calendar year plan) a comprehensive set of women's preventive care services must be covered without cost sharing.
   - Applies to non-grandfathered plans.
   - Required services include contraception (including Plan B drug) and sterilization.
   - On 1/20/2012 HHS ruled that nonprofit employers who, based on religious beliefs, do not provide contraceptive coverage in their health plans, will have until 8/1/2013 to comply. However, they must sign a temporary enforcement safe harbor certification form.
   - On 2/10/2012 the White House announced insurers would be required to directly pay for contraceptives and sterilization demanded by members covered by health plans sponsored by religious employers that do not offer coverage for these services. Self-funded religious employers are not exempt from the HHS mandate to cover these services which are deemed by the religious employer as "objectionable."

2012
Employers with insured plans may be eligible for rebates under minimum medical loss ratio (MLR) requirements
Aug. 1

3. Beginning 8/1/2012 insured employers may be eligible for rebates under minimum medical loss ratio (MLR) requirements.
   - Does **not** apply to self-funded health plans or to stop loss insurance contracts.
   - Large (> 100 employees) group insurers must spend at least 85% of premiums on claims and activities to improve health care quality; this MLR threshold for the individual and small group markets is 80%.
   - No exception under the MLR requirements for broker commissions; must be counted as part of the carrier's administration/overhead (legislation has been proposed to exclude commissions).
   - Questions persist on whether insured HSA plans will meet MLR requirements, because payments from the HSA don't count as claims under current guidance.
   - If the plan is insured, subject to ERISA, and the carrier did not meet the applicable MLR threshold, then the rebates would constitute plan assets; as such, the employer, as policyholder and fiduciary, would need to comply with ERISA rules on how to allocate the rebates.
     – DOL's Employee Benefits Security Administration suggests using the rebates for plan purposes, such as a premium holiday.

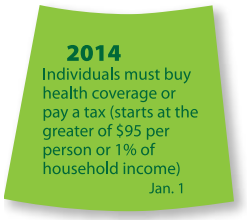
2012
Summary of Benefits and Coverage (SBC) and Uniform Glossary requirements take effect for open enrollments
Sept. 23

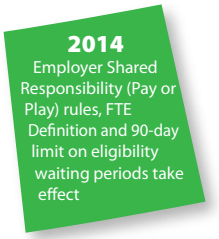
4. Summary of Benefits and Coverage (SBC) and Uniform Glossary requirements take effect for Open Enrollments beginning on or after 9/23/2012.
   - Both insurers and self-funded health plan sponsors must provide a:
     – SBC that includes standardized health plan comparison tools known as "coverage examples;" and
     – Uniform Glossary of health coverage and medical terms.
   - If Plan Year is a calendar year, do not have to provide SBCs for both 2012 and 2013.
     – Do not have to provide separate SBCs by coverage tier, i.e. one for Single coverage and another for Family coverage.
   - 60-day advance notice of material modifications to the plan also takes effect.
   - $1,000 per enrollee penalty applies for intentional or willful non-compliance.
     – "Flexibility Standard" exists for the first year of applicability; so long as plans use their best efforts to comply with the requirements, no penalty will be issued.
   - Must be provided by:
     – The first day of the first open enrollment period beginning on or after September 23, 2012 for participants who are enrolling or reenrolling in coverage through an open enrollment period by; and
     – By the first day of the first plan year beginning on or after September 23, 2012 for participants who are enrolling in coverage other than through an open enrollment period (e.g. new hires or other newly eligible participants).
   - Do not need to be provided by Health Reimbursement Arrangements (HRAs) or Health Flexible Spending Accounts (Health FSAs) if such arrangements are integrated with major medical plans.
   - Do not need to be provided by Dental or Vision plans that are considered limited scope or unbundled from Medical/Rx benefits, Health Savings Accounts (HSAs), or by Health FSAs that are considered HIPAA "excepted benefits."
   - Will need to be provided by other plans considered ERISA "group health plans" (e.g. non-integrated HRAs, non-integrated Health FSAs that are not considered HIPAA accepted benefits, and certain EAPs and wellness plans).

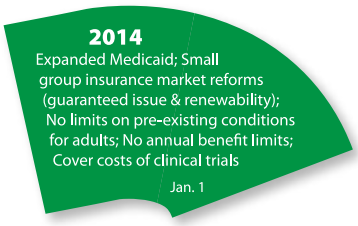
2013

1. Effective 1/1/2013 Medicare withholding tax will increase from 1.45% to 2.35%.
   - Applies to employment income in excess of $250,000 if married, or $200,000 if single.
   - Medicare tax on self-employment income will increase from 2.9% to 3.8%.
   - 3.8% Medicare tax imposed on net investment income for taxpayers with modified adjusted gross income over $250,000 if married, or $200,000 if single.
2. Effective 1/1/2013 Health FSAs are limited to $2,500 (subject to annual indexing for inflation).
   - Limit applies only to employee salary deferrals and not to employer non-elective FSA contributions.
   - An employee covered under a qualified HDHP with an HSA can use the HSA for qualified medical expenses; see definition under IRC 213.
   - IRS has said cafeteria plan documents do not have to be amended immediately, but just before the end of the 2014 calendar year.
3. On 1/1/2013 HHS will evaluate each state's progress in establishing its health insurance exchange. If progress is deemed insufficient, HHS can step in to establish and run the state's exchange effective 1/1/2014.
   - The exchange applies to the individual and small group markets (< 100 employees) initially; employers > 100 employees can join exchange in 2017.
   - It's too early to know which carriers will participate in each state's exchange, which plans will be offered and how much exchange-based coverage will cost (due to no PECs, guaranteed issue, community rating and a weak individual mandate).
4. For W-2s to be issued in January 2013 (i.e. 2012 Tax Year), employers issuing more than 250 W-2s will be required to report the aggregate cost of employer-sponsored health care coverage on their employees' W-2s.
   - This does **not** mean the value of health coverage will become taxable income;
   - Does not apply to Health FSAs if contributions only occur through salary reduction (i.e. IRC 125 pre-tax elections); and
   - Does not include Dental and/or Vision coverage that is considered limited scope or unbundled from Medical/Rx benefits; and
   - Does not include any amounts contributed to a HSA (but continue reporting on HSAs in box 12 using code W); and
   - Does not include costs under an EAP, wellness program, or on-site medical clinic if the employer does not charge a premium for that coverage under COBRA.
5. On 3/1/2013 employers will need to provide their employees notice about the future availability of a health insurance exchange in their state.
6. By 7/31/2013 insured and self-funded plans will pay $1/member to fund comparative effectiveness research of medical treatments by the new non-profit Patient Centered Outcomes Research Institute.
   - This requirement took effect 1/1/2012 for calendar year plans.
   - Employers will use revised IRS Form 720 to remit the fees.
   - Fees for plan years beginning 1/1/2013 will be $2/member.
7. By 12/31/2013 group health plans must certify they are in compliance with HHS rules on electronic transactions between health providers and health plans.

2014







1. Effective 1/1/2014 U.S. citizens and legal residents are required to purchase minimum essential health coverage or pay an annual individual responsibility tax. The per person tax is the greater of:
   - 2014: $95 or 1% of household income (AGI plus tax exempt interest and foreign-earned income for all persons in the household) in excess of the threshold amount required to file a federal income tax return ($9,500 for a single person or $19,000 for married persons filing jointly in 2012)
   - 2015: $325 or 2% of household income
   - 2016: $695 or 2.5% of household income

   The per person tax is reduced by 50% for each person under age 18. Families would be capped at $2,250. After 2016, the dollar amounts would be indexed to inflation.

   Note: It is our understanding the IRS cannot enforce the individual tax via lien and can withhold the tax only from income tax refunds or Social Security benefits.

2. Effective 1/1/2014 Employer Shared Responsibility (i.e. Pay or Play) rules take effect.
   - An employer with more than 50 full-time equivalent employees (FTEs) must offer **all** of its FTEs minimum essential health coverage; otherwise, if at least one FTE receives a federal subsidy to buy coverage through the exchange, then the employer must pay an excise tax calculated as follows: # of actual full-time employees (minus 30) x $^{1}/_{12}$ of $2,000 for each month that such coverage is not offered.
     – Note: A FTE is defined as an employee who works on average at least 30 hours/week. On 8/31/2012 the IRS issued guidance on safe harbor methods employers may use to identify FTEs; see footnotes on page 6 for details.
   - An employer with more than 50 FTEs that offers essential coverage deemed "unaffordable", causing at least one FTE to receive a federal subsidy to buy coverage through the exchange, must pay an excise tax calculated as follows: # FTEs who receive a premium subsidy x $^{1}/_{12}$ of $3,000 for each month that such coverage is "unaffordable."
   - Coverage is "unaffordable" if:
     – The employee's required premium/contribution for self-only coverage exceeds 9.5% of the employee's W-2 income; or
     – The employer's share of covered expenses is less than 60%.
   - Premium subsidies or credits are available to any employee whose household income is at least 100% of the Federal Poverty Level (FPL) but less than 400% of FPL.

3. Other requirements effective 1/1/2014:
   - Medicaid expanded to people under age 65 with incomes up to 133% FPL unless the state opts out; Ohio is one of many states considering whether to opt out of expanded Medicaid.
   - Guaranteed issue, renewability, and rating rules take effect for the individual and small group markets.
   - Employer-sponsored plans cannot impose annual benefit limits or pre-existing condition limits on adults.
   - Employers cannot use an eligibility waiting period in excess of 90 days (or face a fine of $600/FTE).
   - Employers must file a "Quality of Health Care Report" with HHS.
     – Initially required for plan years beginning after 3/23/2012.
     – Intended to report on activities relating to quality, safety, health promotion and case management.
   - Non-grandfathered plans must cover routine costs and services in connection with a clinical trial.

4. Employee wellness rewards can be increased from 20% to 30% of the cost for single coverage.
   - The Secretary of HHS may permit rewards of up to 50% if "appropriate."
5. Effective 1/1/2014 state-based Transitional Reinsurance Programs are established.
   - Both insured and self-funded health plans will be assessed fees to fund the program during the three-year period 2014-2016.
   - Intended to reinsure high cost claimants enrolled for individual coverage in and outside the health insurance exchange.
   - Fees for 2014 are estimated to range from $61 to $105/member and are to be paid quarterly.
   - States can charge additional fees to reinsure their individual, small and large group insurance markets.
   - If a state does not establish the reinsurance program, HHS will operate the program.

2016

States may form Health Care Choice Compacts to allow for the purchase of individual health insurance across state lines.

2017

Employers with more than 100 employees can purchase coverage through the health insurance exchange.

2018

A 40% excise tax is levied on "Cadillac Plans."

- Tax is assessed on the annual value of plans exceeding $10,200/individual or $27,500/family
- These thresholds are to be adjusted for inflation

20??

Recent comments from DOL/HHS/Treasury indicate the auto-enrollment provision may not be ready for 2014.

- When PPACA was enacted on 3/23/2010 large employers with at least 200 employees were to begin auto-enrolling new employees in the employer's health plan, but provide an opt-out provision.
- Guidance was never issued and the effective date was pushed back to 2014.
- Perhaps this provision will be dropped, similar to the CLASS Act, or repealed like the "free choice voucher."

Insured health plans will not be able to discriminate in favor of highly compensated individuals.

- Rules were to have taken effect in 2011, but guidance was delayed.
- Rules are expected to be similar to non-discrimination requirements for self-funded plans under IRC § 105(h).

Footnotes

On August 21, 2012 the IRS issued guidance on how to determine if an employee is a "full-time" employee for purposes of complying with the employer shared responsibility (aka "pay or play") rules that take effect in 2014. The guidance is summarized below:

1. To determine if an on-going employee is a FTE, the employer may use a "look-back/stability period safe harbor" of not less than 3 but no more than 12 months.
   - If the on-going employee meets the FTE definition during the look-back or "standard measurement period" then he/she must be treated as a FTE during the subsequent "stability period" regardless of the hours worked in the stability period.
   - Although the stability period must be at least 6 months, for practical purposes, employers will likely set their standard measurement and stability periods at equal lengths.
2. If a new employee is reasonably expected, as of his/her date of hire, to work full-time, and the employee is offered health benefits during his/her first 3 months of employment, the penalty/tax will not apply.
   - For plan years beginning after December 31, 2013, both grandfathered and non-grandfathered plans cannot impose eligibility waiting periods greater than 90 days.
   - New employees can be subject to a different measurement period called an "initial measurement period."
3. If, on the date of hire, the employer cannot determine whether a new employee is reasonably expected to work on average at least 30 hours/week, he/she is considered a "variable hour employee."
   - If the variable hour employee does not meet the FTE definition during the initial measurement period, then he/she is deemed not to be a FTE during the following stability period that must not be more than one month longer than the initial measurement period.
     – During the stability period, the employer will not be subject to the pay or play penalty.
4. The IRS recognized employers need time between the measurement period and the subsequent stability period to identify, notify, and enroll FTEs. Therefore, an "administrative period" of up to 90 days may be used.
   - The administrative period begins before the standard measurement period ends and before the associated stability period begins.
   - Ongoing employees who are eligible for coverage based on a prior measurement period must be offered coverage during the administrative period.
5. The employer may use different measurement and stability periods for different employee classifications, such as collectively bargained and non-collectively bargained employees, or salaried and hourly employees.
6. The IRS proposed a method of transitioning a new employee to an on-going employee.
   - The employer must test the new employee at the end of the initial measurement period and after the first standard measurement period during which the employee is employed for the duration, even if there is an overlap between the initial and standard measurement periods.
7. The IRS said employers may use reasonable good faith interpretation of the term "seasonal employee" to include retail employees employed during the holiday season or agricultural workers.
8. The IRS indicated the employer could rely on this guidance through 2014. The IRS also said the guidance applies to measurement and stability periods that begin in 2013 or 2014. This means if an employer with significant numbers of part-time employees is concerned about covering in 2014 only those employees intended to classify as full-time and reducing any possible penalty, then the earliest a measurement period could commerce is January 1, 2013.

For additional information, refer to Findley Davies' Overview of IRS Guidelines on Defining FTEs Client Advisory Bulletin, http://tinyurl.com/8stuuh7