Health Care Reform:
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July 2012

On June 28, 2012, the U.S. Supreme Court issued one of its most noteworthy opinions in recent history and upheld nearly all of the Patient Protection and Affordable Care Act (also known as Health Care Reform). While there may be legislative challenges to Health Care Reform, particularly after the November election, the constitutionality of Health Care Reform is now settled. Assuming Health Care Reform is not repealed or significantly revised by Congress, the purpose of this bulletin is to summarize the key Health Care Reform changes affecting employers now and in the near future, and to discuss how employers may want to approach health benefit planning when the employer “pay or play” penalty takes effect in 2014.

1. Past Compliance Activities Weren’t Wasted Efforts

Steps employers have already taken to comply with Health Care Reform won’t need to be unwound as a result of the Court’s decision. Employees will be pleased that their older dependent children will continue to be eligible for health coverage until age 26 and that the prohibition regarding lifetime limits on the dollar value of essential health benefits will continue to apply. Other insurance market reforms, such as the restrictions regarding annual limits on the dollar value of essential health benefits and the ban on pre-existing condition exclusions must be fully implemented by 2014. Employers should make sure those latter changes are on their “to do” list.

2. Additional Plan Changes Will Be Required in the Future

Employers must amend their plans for additional changes taking effect in the near future.

- Contraceptives  Non-grandfathered health plans must offer contraceptive drugs and devices to female participants on a first dollar basis with no participant cost-sharing effective as of the first day of the plan year beginning on or after August 1, 2012. An exception is available for religious employers.

- Medical FSA Cap  Employee pre-tax contributions to a medical flexible spending account (FSA) will be capped at $2,500 per participant per year. The IRS recently issued guidance to clarify that this is a plan year vs. calendar year limit and begins to apply as of the first day of the first plan year beginning on or after January 1, 2013. The limit applies on an employee-by-employee basis so for married couples where both spouses are working and are eligible for an FSA, each spouse may elect to contribute up to the maximum. Employers have until December 31, 2014 to amend their Section 125 plans for the new limit as long as the plan is operated in compliance with the new limit as of the effective date.

- Waiting Period  Beginning in 2014, health plans may not impose a waiting period of longer than 90 days for newly eligible employees.
• **Cost-Sharing Limits**  Beginning in 2014, non-grandfathered health plans must comply with the maximum out-of-pocket limits which apply to high deductible health plans offered in conjunction with a health savings account. Also beginning in 2014, the deductible under a non-grandfathered health plan may not exceed $2,000 for single coverage and $4,000 for coverage with dependents. There is uncertainty as to whether the deductible restriction applies to all non-grandfathered health plans or only non-grandfathered health plans in the small group market.

• **Automatic Enrollment**  Employers with more than 200 full-time employees must automatically enroll newly-eligible full-time workers and continue enrollment of current employees in their health plans. Health Care Reform did not specify an effective date for this requirement. Guidance has been issued indicating that the automatic enrollment provisions will not apply until regulations are issued and that regulations will not be issued in time for a 2014 effective date.

3. **Don’t Forget About the Nondiscrimination Rules**

Self-funded group health plans have been subject to nondiscrimination rules for many years. Those rules prohibit discrimination in favor of highly compensated individuals with regard to eligibility and benefits. Historically, fully-insured group health plans have not been subject to nondiscrimination rules. That distinction changed under Health Care Reform. Now fully-insured, non-grandfathered group health plans will be subject to similar nondiscrimination rules to the rules for self-funded plans. In December 2010, the Internal Revenue Service (IRS) announced that it is drafting regulations to implement this new requirement and that it will not require fully-insured, non-grandfathered group health plans to comply with this provision until plan years beginning after a certain period of time following the issuance of regulations. So while the new rules may not apply to a fully-insured, non-grandfathered health plan as of the first day of the next plan year, there is no doubt that regulations will be issued in the future and this will be an important requirement for employers to address.

4. **New Participant Notices Must Be Provided**

Several participant notices were required when the insurance market reforms initially took effect. For example, employees were required to be notified of a health plan’s amended definition of dependent child and the opportunity for older children to enroll. If an employer’s health plan is grandfathered, a notice of grandfathered status must continue to be included in all plan materials. New participant notices must also be provided.

• **Summary of Benefits and Coverage**  The most significant new participant notice required under Health Care Reform is the summary of benefits and coverage (SBC). The purpose of the SBC is to provide certain information in a prescribed format to participants in an employer’s health plan so participants can easily compare the information to other plans they may be eligible for, including the coverages which will be offered on state exchanges. The SBC must be provided to participants at open enrollment effective with open enrollment periods beginning on or after September 23, 2012. Further, newly-eligible enrollees must be provided with an SBC effective as of the first day of the first plan year beginning on or after
Employers will be looking to the insurer or third party administrator of the employer’s health plan for assistance in preparing and providing the SBC. The SBC may be provided electronically to employees who work with a computer as a regular part of their jobs, to newly-eligible enrollees and to individuals enrolling online.

- **Notice of Exchange Availability** Beginning in 2013 employers must provide individuals with a notice regarding the availability of the state exchanges which must be in place by 2014, and the premium credits and cost-sharing subsidies available to low income individuals if they enroll in coverage on the exchange.

5. **Employers Must Comply with More Reporting Requirements**

Health Care Reform imposes a steady stream of employer reporting requirements.

- **W-2 Reporting of Health Benefit Costs** Effective for 2012 and later tax years, employers must include the aggregate cost of employer-sponsored health benefits on the W-2 statements issued to employees. This new reporting requirement initially applies to W-2s issued in January 2013. It is not applicable to employers with fewer than 250 individuals to whom the employer must issue a W-2. Since the cost is based upon the coverage tier in which an employee is enrolled and the cost must account for any changes in the employee’s coverage during the year, employers should be developing systems now to track an employee’s health benefit coverage elections so this information can be captured when preparing W-2s in January 2013. The cost is generally based on either the premium charged by the plan’s insurer or the applicable COBRA premium minus the 2% administrative charge. Both the employer’s and the employee’s contribution toward the cost are reported.

- **Quality of Care** Non-grandfathered health plans must submit an annual report to the U.S. Department of Health and Human Services (HHS) addressing whether the plan’s benefits satisfy various criteria relating to cost and quality of care in areas such as case management, discharge planning and wellness. HHS was required to issue regulations by no later than March 23, 2012. The regulations have yet to be issued. The reports will be due as of a date established in the yet-to-be issued regulations.

- **State Exchanges** Beginning in 2013, employers will be required to interact with the state exchanges to verify an employee’s eligibility for employer group health coverage in order to administer the potential financial assistance for low income individuals applying for exchange coverage. Guidance is expected to be issued in 2013.

- **IRS Reporting for Pay or Play** Beginning in 2014, employers with 50 or more full-time employees must report to the IRS whether they offer minimum essential coverage to employees. This information is required in order to administer the pay or play penalty. Regulations are expected to be issued detailing the reporting requirements.

Health Care Reform introduces many new taxes and fees to help finance the legislation. Some of the taxes, for example, the new tax imposed on medical device manufacturers, have an indirect effect on employers and individuals. Other taxes and fees have a direct impact on employers and individuals.

- **Premium Tax for Research** For plan years ending on and after October 1, 2012, a new premium tax will be assessed to finance comparative clinical effectiveness research. For the first plan year the fee is based on the average number of covered lives (employees and dependents) under a health plan multiplied by $1. The multiplier increases to $2 for subsequent plan years and no longer applies for plan years ending after October 1, 2019. In the case of fully-insured plans, the tax is payable by the insurer. In the case of self-funded plans, the tax is payable by the employer. The tax will be reported on IRS Form 720 and paid once per year by July 31. As a result, employers will have until July 31, 2013 to pay the premium tax for the initial year.

- **Medicare Hospital Insurance Payroll Tax** Currently, the Medicare hospital insurance payroll tax for employees is 2.9% (1.45% paid by the employee and 1.45% paid by the employer, with self-employed individuals paying 2.9%). Beginning in 2013, higher income taxpayers with wages in excess of $200,000 (if single) or $250,000 (if married and filing jointly) will be subject to an additional .9% Medicare hospital insurance payroll tax on wages in excess of those thresholds. In addition, these individuals will be subject to a 3.8% tax on their net investment income which includes interest, dividends and royalties. However, net investment income for this purpose does not include distributions from a 401(k) plan or other qualified retirement plans.

- **Cap on Itemized Deductions for Medical Expenses** Currently, taxpayers may deduct unreimbursed medical expenses exceeding 7.5% of their adjusted gross income. The 7.5% threshold is increased to 10% effective for 2013 and later tax years. However, if a taxpayer or his or her spouse is age 65 or older, the threshold continues at 7.5% through 2016.

- **Temporary Reinsurance Program** Health Care Reform establishes a new temporary reinsurance program for insurers in the individual market. The purpose of the program is to transfer risk from insurers in the individual market to the group market over a three-year period beginning in 2014. Approximately $25 billion must be raised to finance the program and it will be collected through a per capita contribution fee assessed against insurers in the case of fully-insured plans and against third party administrators in the case of self-funded health plans.

7. Assistance for Employers

As discussed above, while Health Care Reform imposes many burdens on employers, there are also positive changes in the legislation designed to assist employers. They include the following:
- **Small Employer Tax Credit** Since 2010, certain small employers who provide health coverage to their workers have been eligible for a tax credit. To qualify, the employer must have no more than 25 full-time equivalent employees (FTEs) with average annual wages of less than $50,000 per FTE. For tax years through 2013, the tax credit is up to 35% of the employer’s contribution toward health coverage provided the employer is contributing at least half the cost and the employer’s contribution share is a uniform percentage for each employee. The full credit is available to employers with ten or fewer FTEs with average annual wages of less than $25,000 per FTE. The credit phases out as the size of the employer’s workforce and average annual wages increase. For tax years 2014 and later, the maximum tax credit increases to 50%.

- **Medical Loss Ratios** Employers sponsoring fully-insured group health plans (as opposed to self-funded plans) may be receiving rebates soon pursuant to the medical loss ratio (MLR) rules of Health Care Reform. The purpose of the MLR rules is to require insurers to deliver transparency and value in connection with health insurance policies. Under the rules, insurers must spend a minimum percentage of collected premium dollars on claims as opposed to profits and indirect costs such as administration and marketing. Insurers must report their MLR data for a calendar year to HHS by June 1 of the following year. If the MLR requirements are not satisfied, rebates must be issued by the following August 1. The first year this requirement applies is for 2011 with any rebates to be issued by August 1, 2012. Any MLR rebate will typically be issued to the employer as the policyholder with respect to a fully-insured group health plan. While the rebate may be welcome dollars for the employer, the portion of the rebate attributable to participant (employee) contributions will generally be considered a plan asset under the federal law known as ERISA. The ERISA fiduciary rules require plan assets to be used for the exclusive benefit of participants. The U.S. Department of Labor (DOL) has issued guidance as to permissible methods of applying the portion of any MLR rebates which constitute plan assets. Those methods include cash refunds, using the proceeds to reduce future premiums, and/or using the rebate to enhance benefits.

- **Wellness** Currently, under the HIPAA nondiscrimination rules, employees enrolled in an employer’s health plan may be provided with incentives/penalties to participate in a wellness program based on one or more health status factors. The wellness program must satisfy certain requirements, including a cap on the incentive/penalty; it may not exceed 20% of the cost of coverage under the employer’s health plan. Health Care Reform increases the 20% limit to 30% beginning in 2014. Further, the IRS, DOL and HHS are provided with discretion under Health Care Reform to issue regulations increasing the 30% limit to as high as 50%.

### Health Benefit Planning for 2014

The centerpiece of the Health Care Reform legislation is the establishment of the state exchanges, the individual mandate and the employer “pay or play” penalty -- all which will take effect in 2014. Employers have decisions to make regarding whether they will offer a health plan and if so, what changes will be made to the plan in response to these new rules.
Beginning in 2014, employers with 50 or more full-time employees must offer health coverage to full-time employees and their dependents or pay a $2,000 per full-time employee penalty (disregarding the first 30 full-time employees). If the employer offers a health plan, but has at least one full-time employee who is enrolled in health coverage through a state exchange and the employee is low income and receives the premium credit, the employer must pay a penalty of $3,000 per each such individual. The $3,000 penalty is capped at $2,000 multiplied by all of the employer’s full-time employees (disregarding the first 30), if that amount is less. However, low income individuals who are eligible for employer-provided health coverage can only qualify for the premium credit if the employer’s health coverage isn’t valuable enough or isn’t affordable. The employer’s health plan isn’t valuable enough if it doesn’t provide minimum essential coverage (generally covers at least 60% of the average employee’s eligible expenses). The IRS has issued guidance to help employers determine if their coverage is valuable enough. It is expected that the vast majority of employer health plans will satisfy this requirement. An employer’s health plan isn’t affordable for purposes of the $3,000 penalty if the employee’s premium for single coverage under the lowest cost health option exceeds 9.5% of the employee’s wages for that year (as defined for purposes of Box 1 on Form W-2).

Employers should look at their options --

- Will you discontinue your health plan for all of your employees and pay the $2,000 penalty? If so, will you provide additional compensation or a stipend to assist employees in obtaining coverage on the exchange?

- If you don’t make any changes to your health plan, will there be low income workers who might cause you to incur the $3,000 penalty because your health plan isn’t valuable enough or affordable? If so, will you consider modifying your health plan to avoid the penalty? For example, you could introduce a more modest, low cost option.

Prepare for more guidance

While the Supreme Court has answered the big question, there are many unanswered questions. For example, we still need more guidance to help employers determine who is a full-time employee for purposes of the employer pay or play penalty. The federal government is expected to issue a continual stream of new regulations in the coming months in order to flush out additional details regarding Health Care Reform. Employers need to keep an eye on new developments in order to help determine their best course of action going forward. We will continue to keep you informed as developments unfold. In the meantime, if you have any questions, please contact your Brown & Brown representative.