Health Care Reform Update

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Supreme Court Challenge

The Constitutional challenge to the individual mandate requiring all persons to purchase health insurance or face a penalty was heard by the U.S. Supreme Court March 26-29, 2012. A decision by the Court would likely be rendered by June of 2012. One of the decisions the Court must make is whether or not it can hear the case at all. During the underlying appellate court battle, the Obama administration portrayed the mandate as a tax rather than a penalty, reversing the position it held during Congressional debate over the mandate in 2010. By portraying the mandate as a tax, the administration hoped to invoke a little-known federal law known as the Tax Anti-Injunction Act that prohibits courts from ruling on taxes before they are levied. In the case of the individual mandate, this could delay a court decision until the mandate goes into effect in 2014.

It is expected that the Court will split along Liberal/Conservative lines of 4/4, leaving Justice Kennedy as the anticipated "swing" vote who may decide the matter.

Summary of Benefits and Coverage (SBC)

The Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments) recently published the final rules regarding the summary of benefits and coverage (SBC) provisions of the Affordable Care Act. The SBC creates a new disclosure requirement for employers.

As with many of the provisions of health care reform, the SBC has been delayed. For participants and beneficiaries who enroll or re-enroll through an open enrollment period (including late enrollees and re-enrollees), SBCs must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. Persons who are newly eligible for coverage and special enrollees must receive an SBC by the first day of the 2013 plan year. Under the regulations, there are a number of events that trigger providing an SBC: application/enrollment, first day of coverage (if there have been any changes since enrollment), special enrollment, renewal, or upon request.

The Departments have created an SBC template for employers to use to communicate information regarding group medical plans. Dental and vision plans that are not integral parts of a group medial plan are not required to be included in the SBC. SBCs may be provided in paper or electronic form, including via an Internet posting.

The SBC must not exceed four pages (front and back), be in 12-point font, be presented in "culturally and linguistically" appropriate language, and include the following:

- Uniform definitions of standard insurance terms and medical terms
- A description of coverage and any cost-sharing (including any deductibles, coinsurance, and copayments, but not premiums)
- Any exceptions, reductions, and limitations on coverage
- Renewability and continuation coverage provisions
- Coverage examples (currently only childbirth and diabetes, but up to four more may be added in the future)
- A statement of whether the plan provides minimum essential coverage and has an actuarial value of at least 60 percent (effective 1/1/14)
- A contact number to call and an Internet address for a copy of the policy (and presumably the SPD for self-funded plans)
- If a plan has multiple networks, contact information for obtaining a list of network providers
- If a plan uses a prescription drug formulary, contact information for obtaining information on prescription drug coverage

- An Internet address for obtaining the uniform glossary, a contact number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

W-2 Reporting

Beginning in 2012, employers must report the cost of all applicable employer health care coverage on each employee's Form W-2. Employers who provided more than 250 W-2's in 2011, must provide informational reporting of the aggregate cost of applicable employer sponsored group health plan for the 2012 tax year. Employers who provide fewer than 250 W-2's will not have to report until the 2013 tax year (i.e. delivered in 2014).

It does not apply to dental, vision, or FSA coverage. The amount to include in Box 12 of the Form W-2 is the sum of employer and employee contributions. The most popular method is the "COBRA method" which uses the COBRA premium, without the 2% admin fee. Amounts are reported using the code DD.

Health Plan Participant Fees-the Comparative Effectiveness Fee

Beginning with plan years beginning on or after September 30, 2012, self-funded plan sponsors will be required to pay health plan participant fees. The fee will be due for 7 years beginning in 2012 with the amount increasing over that time. While TPAs may agree to collect and forward the fee, the plan sponsor is ultimately responsible for its payment. The fees will apply to group medical plans, but not "excepted" plans including dental, vision, and FSAs.

Fee for Calendar Year Plans	
2012	$1 x Average Number of Covered Lives
2013	$2 x Average Number of Covered Lives
2014	$2 x Inflation* x Average Number of Covered Lives
2015	$2 x Inflation* x Average Number of Covered Lives
2016	$2 x Inflation* x Average Number of Covered Lives
2017	$2 x Inflation* x Average Number of Covered Lives
2018	$2 x Inflation* x Average Number of Covered Lives
2019 & beyond	No fee
* Fee is adjusted for projected increases in national health expenditures	

Increased Medicare Payroll Tax

Beginning in 2013, there will be new taxes for singles earning >$200,000 and joint filers >$250,000. These include an increase in the Medicare payroll tax to 2.35% (employee portion only) and a new 3.8% surtax on capital gains, dividend, interest and other net investment income. The threshold for itemized deductions for unreimbursed medical expenses increases from 7.5% of adjusted gross income to 10%, but does not apply to persons age 65 and over.

Medical Loss Ratios (MLR)

Fully insured plans will contend with the new Medical Loss Ratio (MLR) rules in 2012. Under MLR, health insurers must publically report the portion of premium dollars spent on health care and quality improvement and other activities in each state they operate. Insurers failing to meet the applicable MLR standard must pay rebates to consumers beginning in 2012.

The Medical Loss Ratio provision of the ACA requires most insurance companies that cover individuals and small businesses to spend at least 80% of their premium income on health care claims and quality improvement, leaving the remaining 20% for administration, marketing, and profit. The MLR threshold is higher for large group plans, which must spend at least 85 percent of premium dollars on health care and quality improvement. The ACA permits adjustments to the MLR requirements in a state if it is determined

by the federal government that the 80% MLR requirement could destabilize the state's individual insurance market. HHS has approved MLR adjustments for very few states including Georgia, Iowa, Kentucky, Maine, Nevada, New Hampshire, and North Carolina. HHS has denied requests from eleven states and territories, including Wisconsin. Rebates must be distributed by August 1st of the year following the reporting period.

Non Calendar Year FSA Contribution Reminder

Plan sponsors must be aware that the 2013 reduction in Flexible Spending Account (FSA) contributions will affect non-calendar-year FSA plans in 2012.

Under the Affordable Care Act, FSA contributions will be limited to $2,500 for tax year 2013. This means that employees will only be able to put $2,500 into their FSAs in 2013, *even if it's split between two separate plan years* . If an employee puts in over $2,500 for their 2012-2013 plan year, they will need to decrease their contributions for the 2013-2014 plan year to avoid violating the tax year contribution limit. Unfortunately, plans are not allowed to reduce contribution amounts mid-year (i.e. in January 2013) to drop the monthly contribution to meet the 2013 tax year limit. The law change does not meet the mid-year change rules found in Treasury Regulation §1.125-4 to allow a mid-year change. While it is possible that the IRS will make an exception if enough employers miss this, it is highly unlikely that the IRS would grant such relief.

Example:
Employer's FSA plan year runs April 1-March 31. Employee A contributes $3,600 for the 2012-2013 plan year, or $300/month. For January, February, and March of 2013, the employee will have already used up $900 of their $2,500 contribution allowance for the 2013 tax year. The employee would only be able to contribute $1,600 during the remaining nine months of the 2013 tax year, or $177.77/month. This would limit the employee's monthly contribution to $177.77 for 2013, which would annualize to $2133.33 for the next plan year.

If elections have already been made for 2012-2013 that exceed $2,500, a correction can be made to reduce contributions in the following year to prevent a violation of the new $2,500 limit.