Health Care Reform:

Practical Implications for Employers – 2014 and Beyond

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Employer Responses to Health Care Reform

- **The Supreme Court Speaks – Affordable Care Act ("ACA") Is Constitutional**
  - Majority opinion upholds the individual mandate and the ACA as a legitimate use of Congress' taxing power.
  - Court held that new eligibility requirements for Medicaid cannot be imposed on already approved funding amounts.
- **What's Next – How Should Employers Proceed??**
  - Begin preparation for Health Care Reform (HCR) rules that become effective in 2014
    - — Automatic enrollment and 90-day Maximum Waiting Period
    - — Employer Play or Pay Mandate
      - Offer FTEs "qualifying" and "affordable" coverage or pay nondeductible penalties
    - — Individual Mandate
      - Everyone must have "minimum essential coverage" or pay a penalty
    - — Individual Subsidies

Employer Responses to Health Care Reform

- Health Insurance Exchanges
  - —subsidized and unsubsidized coverage
- Insurer fee
- Cost-sharing limitations
- Reporting of Health Insurance Coverage
- Cadillac Tax (2018)
  - —Employer-based coverage should not exceed certain premium values
- Women's Preventive Care
  - —First dollar coverage requirement

Employer Responses to Health Care Reform

- **Analyze Various Options Available to Employers Under HCR**
  - Retain current health care design
    - Determine whether current health plans have “minimum essential coverage” under “play or pay” rules
    - Determine whether current health plans are “affordable” under HCR
    - Determine whether any plans are “discriminatory”
- **Consider Whether to Change or Eliminate Coverage and Send Employees to Health Insurance Exchanges**
  - Depends on employer size as to when Exchanges are available
  - Calculate penalty costs – analyze financial goals
  - Consider employee relations impact and impact on total compensation goals strategic goals
  - Balance financial and strategic goals
  - If employer eliminates coverage, will it make employees whole?

Employer Responses to Health Care Reform

- **Consider Consequences of Using Exchanges for Some Employees and Not Others**
  - Impact of current self-funded and cafeteria plan nondiscrimination rules
  - Impact of new nondiscrimination rules for insured plans under HCR
- **Consider Consequences of Adopting a Self-Funded Option**
- **Emphasize Prevention Strategies by Adopting Wellness Programs**
  - Be sure to analyze ERISA, HIPAA and ADA implications
- **Revisit Cost-Saving Design Strategies**
  - Consider adoption of higher cost-sharing plans that comply with HCR

Health Care Reform – 2014 Automatic Enrollment

- **All Large Employers (More Than 200 Employees) That Offer a "Health Benefits Plan" and Are Subject to the Federal Fair Labor Standards Act Are Required to Automatically Enroll New Full-time Employees (FTEs) in the Plan, Subject to Any Waiting Period Authorized by Law**
- **DOL Has Regulatory Jurisdiction Over the Auto-Enrollment Rule**
  - Employers do not have to comply until guidance is released
  - DOL announced that the effective date of the auto-enroll requirement is deferred until guidance is issued and that guidance will not be ready to take effect by 2014 (IRS Notice 2012-17 Q&A-1)
  - Requirement: Enroll new full-time employees in a health benefits plan offered by the employer

Health Care Reform – 2014 Automatic Enrollment

- **Who Is a "New Full-Time Employee"?**
  - Automatic enrollment of newly-hired employees who are full time?
    - Full-time employee does not appear to be same as for "play or pay" (*i.e.*, 30 hours/week)
  - Automatic enrollment of an employee who moves from part time to full time?
  - What about employees with irregular schedules or temporary employees?
  - Will employer be permitted to define its "full-time" class, for counting the +200 employee rule?
- **What Is a "Health Benefits Plan"?**

Health Care Reform – 2014 Automatic Enrollment

- **In Which Plan Do Employees Have to Be Automatically Enrolled – Can Employer Choose?**
  - Least costly?
  - Most comprehensive coverage?
  - Nondiscrimination issues
  - Must it provide “minimum essential coverage”?
  - Must it be “qualifying coverage” for “play or pay” purposes (*i.e.*, minimum essential coverage with minimum value)?
  - What about dependents?
  - Will there be a requirement to subsidize the coverage to same extent as for other employees who have enrolled on their own?

Health Care Reform – 2014 Automatic Enrollment

- **"Adequate Notice" of Auto-Enrollment, and Opt-Out Right**
  - Content of notice?
  - When and how provided?
  - Notice to enrolled family members?
- **Opt-Out Opportunity**
  - Can both employee and enrolled family members opt out?
  - How much time for opt-out opportunity?
  - Refund of deductions taken while employee enrolled?
  - Does opt-out give rise to COBRA rights?
  - What if employee uses coverage during enrolled period?
  - Cafeteria Plan Implications

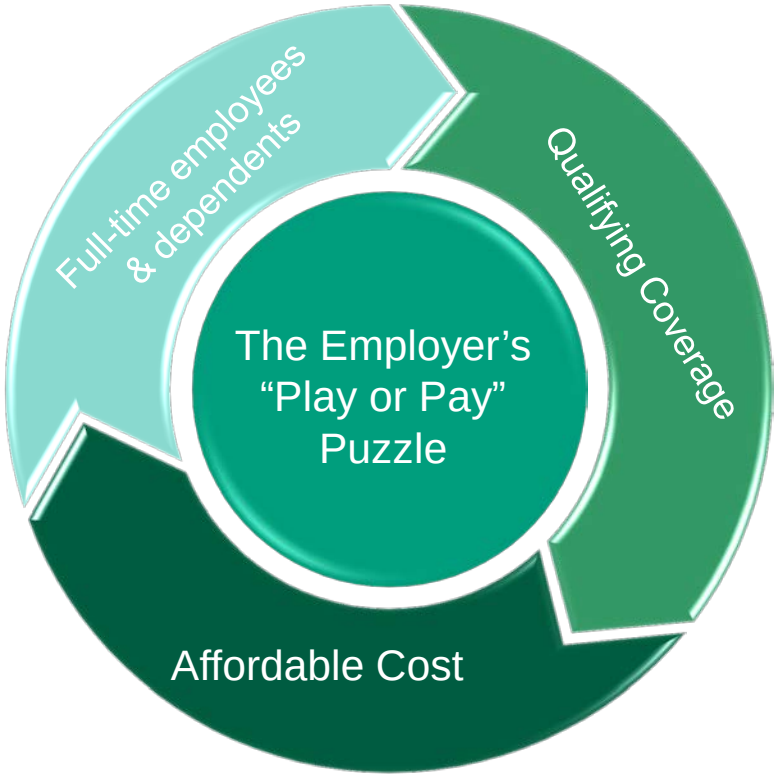
Health Care Reform – 2014 Automatic Enrollment

- **Changing Options**
  - May employees opt-out of automatically enrolled option into another option?
  - Administrative burden on employers
- **90-Day Maximum Waiting Period**
  - Waiting period, once eligible, can't exceed 90 days – Plan mandate
  - Employers may wish to have waiting period run concurrently with opt-out period

Health Care Reform – 2014
90-Day Maximum Waiting Period

- **Good News**
  - The 90-day waiting period will apply only to employees whom the employer treats as "eligible" for coverage under the employer's plan (IRS Notices 2012-59 and 2012-17) (Q&A – 6 & 7)
  - 90-day clock begins when employee becomes eligible
  - Other eligibility conditions are generally permissible unless designed to circumvent the 90-day waiting period limitation
- **What About "Hours of Service" Prerequisites to Eligibility, *i.e.*, 30 Hours or Full-Time Status?**
  - Notice 2012-59 addresses application of 90-day waiting period to variable-hour/seasonal employees where plan eligibility is conditioned on hours
  - Plan may take a reasonable period of time to determine whether employee meets plan's eligibility condition
    - Employer can use measurement periods allowed for full-time employee determination for variable-hour employees under play or pay

Health Care Reform – 2014 Employer Play or Pay



Offer . . .

- Full-Time Employees (and their dependents) . . .
  - —FTE = 30+ hours per week
- Qualifying Coverage . . .
  - —"Minimal essential coverage" that satisfies a "minimum value" requirement
- At an Affordable Cost
  - —Not more than 9.5% of W-2 pay (affordability safe harbor) for employee-only coverage

. . . or pay penalties . . .

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Health Care Reform – 2014
Employer Play or Pay
Determination of Full-Time Employees

- **Who Are the "Full-Time Employees" Who Must Receive the Offer of "Qualifying" and "Affordable" Coverage, in Order for the Employer to Avoid the Penalties?**
  - A full-time employee is a common law employee working an average of at least 30 hours per week or 130 hours/month.
  - Recent new guidance on how to determine whether employees are full-time employees for play or pay purposes. (Notices 2012-58 and 2011-36)
  - Employees may rely on safe harbor to comply through January 1, 2015.
    - Safe harbors apply to classification of workers differently
      - new full-time employees at date of hire
      - ongoing employees
      - new variable-hour employees
      - new seasonal employees
  - "Ongoing employees" are employees who have been employed for at least one standard measurement period. Rules are promised on how to treat changes in employment status.
  - Variable-hour employees are employees whose full-time status is unknown at date of hire or period of employment is reasonably expected to be of limited duration under the facts and circumstances .
  - Guidance does not define the term "seasonal employees" for play or pay purposes so employers may use a reasonable good faith interpretation for play or pay at least through 2014.

Health Care Reform – 2014
Employer Play or Pay
Determination of Full-Time Employees

- **General Safe-Harbor Principles**
  - Determination of full-time status is based on average hours worked over measurement period
  - Employers may select a standard measurement period (for ongoing employees) of between 3 and 12 months and apply those results to employees for a subsequent stability period of same duration (but at least 6 months) for play or pay.
    - For new variable-hour/seasonal employees, employers may use an "initial measurement period" and may need to retest during standard measurement period if not initially found to be full-time.
  - Safe harbors only protect employers who are offering "minimum essential coverage".
- **New 90-day Administrative Period Safe Harbor**
  - Employer can have up to 90 days between measurement and stability periods to determine who is a full-time employee.

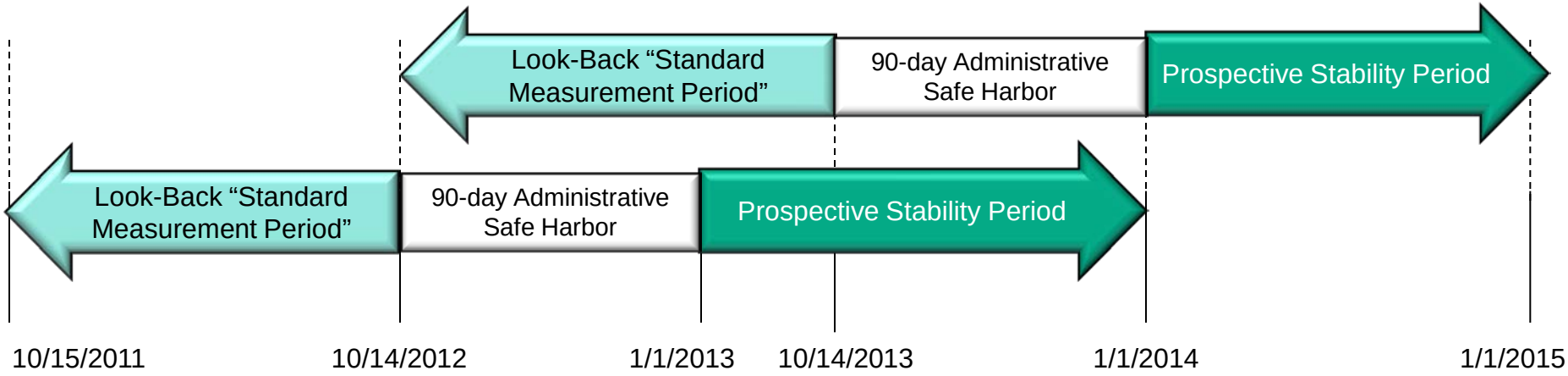
Health Care Reform – 2014
Employer Play or Pay
Determination of Full-Time Employees

Chart Summarizing Different Employee Classifications and Safe Harbors

Employee Classification	Definition	Safe Harbor Determination of FTE	90-day Administrator Safe Harbor	Comments
New FTE	• Employee reasonably expected to work F/T at date of hire • Employer can impose 90-day waiting period	N/A	N/A	
Ongoing Employee	• Have been employed by employer for at least one "standard measurement period."	• Standard measurement and stability periods of between 3 and 12 months • If FTE during standard measurement period, deemed FTE during stability period	• Up to 90 days between standard measurement and stability periods	• Rules on treatment of changes of employment status are promised
New "Variable-Hour" Employee	• Definition applies a facts and circumstances test • FTE status unknown at hire date • Limited duration employee	Same as ongoing-employee safe harbor EXCEPT •Each new employee has his own "initial measurement period." •If found not to be FTE, must be retested as on-going employee	Same as ongoing – employee safe harbor EXCEPT •Employee determined to be FTE must enter plan no later than first day of 13th month following hire date	• Safe harbor may be helpful to retail, hospital or staffing industries.
New Seasonal Employee	• Not defined for play or pay • Employees may use a reasonable good faith interpretation	• Same as new variable-hour employee	• Same as new variable-hour employee	• Safe harbor may be helpful to retail, hospital or staffing industries.

Health Care Reform – 2014
Employer Play or Pay
Determination of Full-Time Employees

- Below is an illustration of the safe harbor that applies to the determination of full-time status for ongoing employees and new variable-hour/seasonal employees
  - There are additional requirements for new variable-hour/seasonal employees. If determined to be full-time during "initial measurement period," must enter the plan no later than 1st day of 13th month following employee's hire date.
  - New variable-hour/seasonal employees have an "initial measurement period" that begins on hire date.
  - If determined not to be full-time during "initial measurement period" must be re-tested as an ongoing employee using "standard measurement period."



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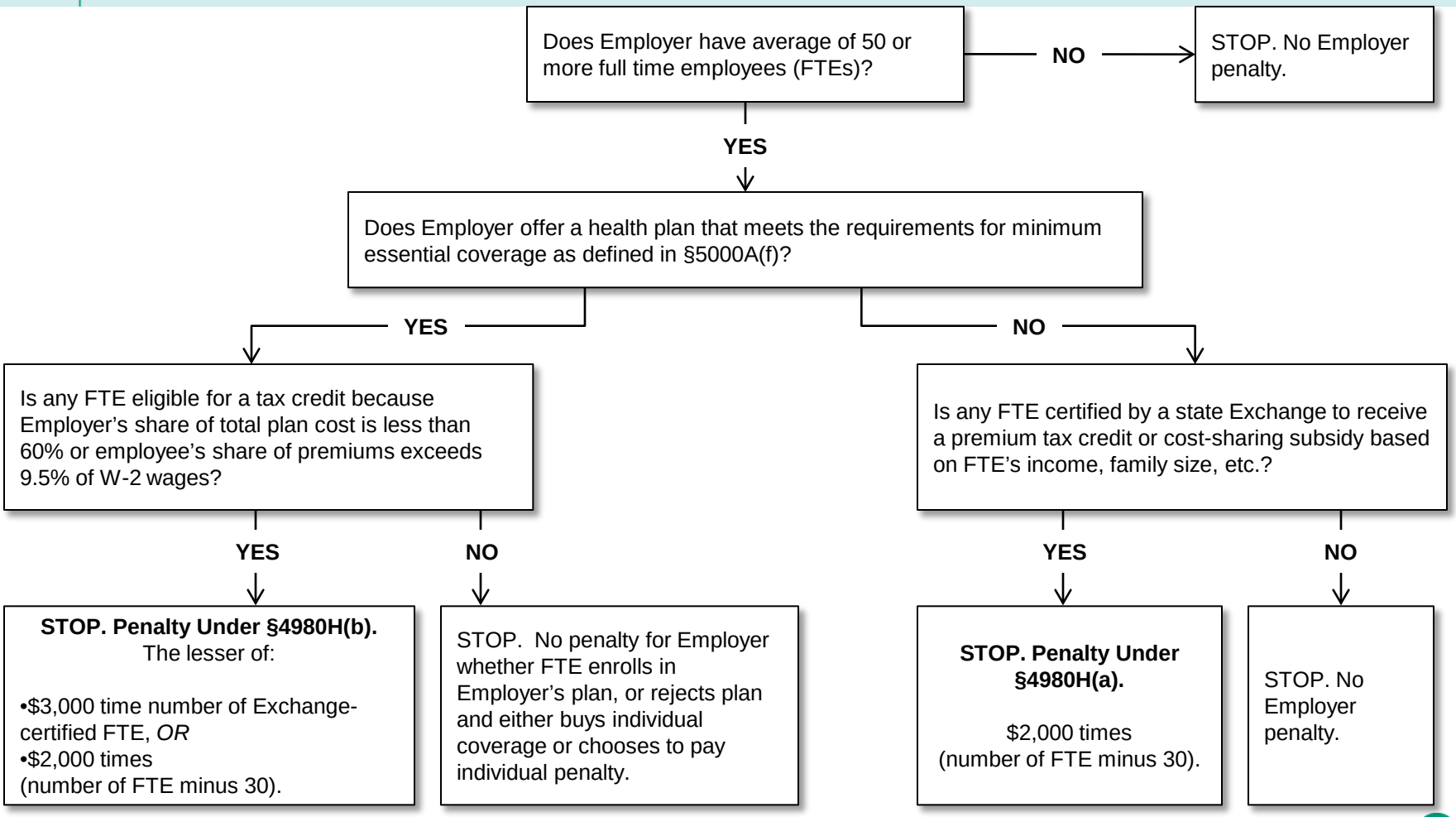
Health Care Reform – 2014 Employer Play or Pay "Qualifying Coverage"

- **What Is "Qualifying Coverage"?**
  - Qualifying Coverage is "minimum essential coverage" that satisfies a "minimum value" requirement.
- **What Is "Minimum Essential Coverage"?**
  - Minimum essential coverage includes health insurance coverage offered in the individual market (such as through a QHP), an employer-sponsored plan, or government-sponsored coverage such as Medicare or Medicaid.
- **As Distinguished From "Essential Health Benefits Package," Which Includes 10 Benefit Categories Similar to What Is Typically Provided Under an Employer Plan.**
  - — Qualified Health Plans in an Exchange must offer "essential health benefits."
- **Must Satisfy "Minimum Value" Requirement**
  - Plan's share of the total allowed cost of benefits is at least 60%
- **Must Be "Affordable" – Not More Than 9.5% of Employees' W-2 Wages (as reported in Box 1) Instead of Household Income. (Notice 2012-17)**

Health Care Reform – 2014 Employer Play or Pay Determination of Penalty



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Health Care Reform – 2014 Nondiscrimination Rules in HCR

- **Applies Nondiscrimination Rules Currently Applicable to Self-Funded Plans to Insured Plans**
  - Health plan must pass eligibility and benefits test (Code section 105(h))
- **Consequence of Noncompliance Is an Excise Tax For Plan/Plan Sponsor Not Taxation of HCE Benefits or Civil Money Penalty or Civil Suit**
  - Excise tax is $100 for each day in the noncompliance period
  - Civil money penalties apply to non-federal governmental group health plans
  - Civil action can compel the plan to provide nondiscriminatory benefits
  - Does not apply to grandfathered plans
  - Regulators have asked for comments in 2010 and 2011 and compliance is not required until after regulations have been issued
    - Regulators have stated that “guidance will not apply until plan years beginning a specified period after issuance”.

Health Care Reform – 2014 Individual Mandate

- **Beginning in 2014, Individual Taxpayers Will Have Shared Responsibility With Employers to Obtain Minimum Essential Coverage**
- **Individuals Required to Have Coverage or Pay Penalty**
- **Penalty Payment Is the Greater of a "Flat Dollar Amount" or "Percentage of Income" Amount**
- **Capped at the National Average of the Annual Cost of a Bronze-Level Health Insurance Plan Offered Through the Exchanges**

Health Care Reform – 2014 Individual Subsidies

- **Premium Assistance Tax Credits**
  - Income between 100% and 400% of federal poverty line
- **Cost-Sharing Subsidies**
  - Income up to 250% of federal poverty line
- **Proposed IRS Regulations**
  - Would permit disclosure of income to HHS
  - Credit would be paid in advance to insurer of Qualified Health Plan, thereby reducing out-of-pocket premiums.

Health Care Reform – 2014
Health Insurance Exchanges

- **Effective January 1, 2014, HCR Requires Each State to Establish One or More Health Insurance Exchanges Through Which Individuals and Small Employers Can Purchase Insurance Through Their State of Residence**
- **Exchanges Called "American Health Benefit Exchanges"**
- **Exchanges Will:**
  - Certify Qualified Health Plans (QHPs)
  - Determine eligibility for enrollment in QHPs
  - Determine eligibility for premium tax credits
  - Perform customer service
- **Only "Small Employers" Can Offer Coverage Through an Exchange to Their Employees in 2014**
  - Fewer than 100 employees
  - Before 2016, state may modify definition to fewer than 50

Health Care Reform – 2014
Health Insurance Exchanges

- **Large Employers May Offer Coverage to Their Employees Through an Exchange Beginning in 2017**
- **Final Regulations Issued in March of 2012**
  - Exchange needs approval from HHS no later than 1/1/13 BUT
  - HHS will give a conditional approval if State is not ready for 2013 but is “advanced” in its preparation
  - States not ready for 2014 can apply to operate in 2015 or later years
  - Effective Date is fluid – difficult for employers
- **What Is a QHP?**
  - Must offer an “essential health benefits” package
  - Must be offered by a licensed insurer in good standing
  - Insurer of any QHP must offer at least one “silver” level and at least one “gold” level QHP in each Exchange

Health Care Reform – 2014
Health Insurance Exchanges

- **"Essential Health Benefits" Package**
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance abuse disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care

Health Care Reform – 2014
Health Insurance Exchanges

- Offer coverage equal in scope to "typical" employer-sponsored plans. Secretary of HHS is to determine the scope of coverage
- Must limit cost-sharing

➢ **Plan Years Beginning in 2014**

- Coverage cannot exceed maximum out-of-pocket expense limits for high-deductible health plans for taxable years beginning in 2014 (max. for 2014 not currently available, but 2010 and 2011, max. is $5,950 for self-only and $11,900 for family coverage

➢ **Plan Years Following 2014**

- Self-only: increased by a multiple of "premium adjusted percentage"
  - premium adjusted percentage for a calendar year refers to the percentage by which the average per capita premium for health insurance in the U.S. for the preceding calendar year exceeds the average per capita premium for 2013
  - Other than self-only: twice the amount for self-only coverage

Health Care Reform – 2014
Health Insurance Exchanges

- **Four Prescribed Coverage Levels Vary Based on the Percentage of Full Actuarial Value of Benefits the Plan Is Designed to Provide:**
  - Bronze – designed to provide benefits actuarially equivalent to 60% of full value;
  - Silver – designed to provide benefits actuarially equivalent to 70% of full value;
  - Gold – designed to provide benefits actuarially equivalent to 80% of full value; and
  - Platinum – designed to provide benefits actuarially equivalent to 90% of full value.
- **Example:**
  - A silver plan's actuarial value of 70% means the plan would be expected to pay, on average, 70% of expenses for essential health benefits, and covered individuals, on average, would be expected to pay the remaining 30% in the form of deductibles, co-payments, and co-insurance.

Health Care Reform – 2013-2014 Health Insurance Exchanges

- **Notice of Exchange**
  - Provided no later than March 31, 2013, but unsure of this effective date because exchanges may not yet be established
  - Applies to employers subject to the FLSA (very broad)
  - Must provide information relating to:
    - Existence of Exchange
    - Services provided by Exchange
    - How to contact Exchange
    - Eligibility for premium tax credit or cost-sharing reduction
    - Consequences of purchasing QHP through Exchange
      - May lose employer contribution toward the cost of employer-provided coverage
      - All or a portion of employer contributions to employer-provided coverage may be excludable for federal income tax purposes

Health Care Reform – 2014 Reporting Requirements

- **Reporting Minimum Essential Coverage to IRS**
  - Applies to coverage provided on/after January 1, 2014
- **Requires Every Health Insurance Issuer, Employers who Self Insure, Government Agency and any other Entity that Provides Minimum Essential Coverage to file Annual Returns Reporting Information for each individual for whom "minimum essential coverage" is provided.**
  - Name, address and telephone number of primary insured and each person covered
  - Dates each individual was covered
  - Whether coverage is a QHP in an Exchange
  - Amounts of any tax credits or cost-sharing reductions if plan is a QHP for each covered individual
  - Insured employer plans must report name, address and EIN of plan sponsor, portion of premium paid by employer and any other information IRS may need to administer tax credits.
  - Filer of information return
  - Must give each individual listed as return information reported to Service

Health Care Reform – 2014 Reporting Requirements

- **Effective 2014, "Large" Employers Defined in the Same Way as Defined for "Play or Pay" Must File a Return That Reports Terms and Conditions of Coverage Provided to its FTEs**
  - Service asked for comments on coordinating this disclosure with the W-2. (IRS Notice 2012-32 and Notice 2012-33)
  - Employer's name, date and EIN
  - Certification of whether employer offers employees opportunity to enroll in minimum essential coverage
  - Number of full-time employees for each month in the calendar year
  - Name, address and TIN of each full-time employee and the months during which employee covered under employer-sponsored plan

Health Care Reform – 2012 & 2013 W-2 Reporting Requirements

- **W-2 Reporting Requirement for Disclosure of Cost of Coverage Under Employer-Sponsored Group Health Plan**
  - 2012 compliance (for 2011 tax year) was optional
  - Notice 2012-9 says that compliance is optional for small employers for 2012 tax year
  - Transition relief – for employers who file fewer than 250 Forms W-2
- **Purpose of Disclosure Is to Provide Employees With Useful & Comparable Consumer Information on the Cost of Their Health Care Coverage**

Health Care Reform – 2014 - 2018 Premium and “Cadillac” Taxes

- **Premium Tax Designed to Generate $8B in 2014 to $14B by 2018 From Fully Insured Plans**
  - Does not apply to self-insured plans
- **“Cadillac Tax” is an Excise Tax Payable Beginning in 2018 on High-Value Employer Plans (Cadillac Plans) With an Aggregate Value That Exceeds Certain Thresholds**
  - Annual premiums exceeding $10,200 for individuals or $27,500 for a family in 2018
  - Levies a 40% nondeductible tax

Health Care Reform – 2014
Examples of the Impact of Health Care Reform

Type of Midsize or Large Employer	Most Relevant HCR Provisions	Why Provision is Relevant
• **Firm that is self-insured that offers varying levels of coverage to all its workers**	**Affordability Tests**	If an employee's premiums cost 9.5% or more of their income or the health plan does not cover 60% of costs, the employee is eligible for exchange subsidies and the firm is penalized $3,000 per worker receiving a subsidy
	Excise Tax	If the cost of the employer health plan exceeds $10,200 for single coverage or $27,500 for family coverage, the cost of the plan beyond these caps will be taxed at 40% beginning in 2018
• **Firm that does not offer coverage to any of its workers**	**"Play or Pay" Rules**	Since the employer does not offer any coverage, it will be have to pay a penalty of $2,000 for each employee, beyond the first 30 employees.
• **Firm that is fully insured offers coverage to its senior staff but not to low wage workers who work less than 35 hours per week**	**Nondiscrimination Rules**	Since the firm offers coverage only to its senior employees, it may face discrimination penalties of $100 per employee per day not offered coverage.
	Excise Tax	If the cost of the employer health plan exceeds $10,200 for single coverage or $27,500 for family coverage, the cost of the plan beyond these caps will be taxed at 40% beginning in 2018.
• **Firm that is fully insured offers coverage to full time workers but not to seasonal workers who work 8 months per year**	**"Play or Pay" Rules**	Since the seasonal workers work more than 120 days per year, the firm will have to pay a prorated penalty of $1,200 per worker, beyond the first 30 workers.
	Nondiscrimination Rules	Since the firm offers coverage only to its full-time employees, it may face nondiscrimination penalties of $100 per employee per day not offered coverage.
	Excise Tax	If the cost of the employer health plan exceeds $10,200 for single coverage or $27,500 for family coverage, the cost of the plan beyond these caps will be taxed at 40% beginning in 2018.

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Health Care Reform – 2014 Litigation Risks

- **Plan Design Mandates – Nondiscrimination Risks**
  - Participants could file suit under ERISA to enjoin employer or compel employer to comply
  - In the *Amara* case, Supreme Court expanded types of equitable remedies that are available under ERISA.
- **Internal and External Claim Procedures – Noncompliance Risks**
  - Nongrandfathered plans must comply with new internal claim procedures and adopt an external review procedure
  - Failure of the plan to comply results in claimant being deemed to have exhausted administrative remedies and can immediately file suit
  - This calls into question whether benefit claim will be judged under the preferable "abuse of discretion" standard

Health Care Reform – 2014 Litigation Risks

- **Summaries of Benefits and Coverage (SBC) – Noncompliance Risks**
  - Failure to comply with the detailed SBC rules could result in allegations by employees that the plan administrator breached its fiduciary duties under ERISA by providing misleading disclosures
    - Either due to omissions or materially misleading information
    - Under *Amara* case, relief could include reformation, equitable estoppel and surcharge
- **Nondiscrimination Rules under the Internal Revenue Code – Noncompliance Risks**
  - Employees could bring ERISA suit to enjoin any noncompliant act or obtain equitable relief
  - Even though the regulators have delayed the application of these rules, this nonenforcement period is not binding on private litigants under ERISA.

Health Care Reform - 2014 Litigation Risks

- **"Play or Pay" Requirement**
  - These rules apply to common-law employees
  - Increases risk for employers who misclassify employees as independent contractors and other nonemployees
  - Misclassification could lead to inadvertent violation of "play or pay" requirements and attendant penalties
- **Risk Mitigation Strategies**
  - Treat health plan compliance as you treat qualified plan compliance
  - Appoint an individual who is responsible for ensuring compliance
  - Request legal counsel to review SBCs to ensure compliance
  - Create a system to regularly audit the plan and its operations
  - Conduct periodic audits of benefit coverage to ensure accuracy of information contained in the SBC and timely receipt by employees and beneficiaries
  - Work with legal counsel to review worker classification policies

Questions?

- **Questions?**

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