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Volume 35 | Issue 44 | July 11, 2012

What the Supreme Court's Health Care Ruling Means for Employers

Now that the Supreme Court has upheld the constitutionality of the health care reform law, employers that sponsor group health plans must focus on complying not only with currently effective mandates, but also with the mandates that will become effective within the next few years. While some of these mandates are relatively straightforward, compliance with other requirements will require financial analysis, coordination with third parties and strategic planning. Employers should approach implementation of the mandates in light of their particular financial priorities, employee population and plan design. This article briefly describes the Supreme Court's ruling, reviews many of the near-term and long-term requirements facing employers, and comments on the political outlook of health reform in the United States.

Background

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, the ACA) were enacted in March 2010. Legal challenges to various provisions of the ACA were immediate and numerous. Most of the lawsuits focused on the constitutionality of the "individual mandate" provision of the ACA which, with limited exception, will require most individuals to maintain a minimum level of health coverage beginning in 2014 or pay a "shared responsibility penalty" to the federal government. Two federal Courts of Appeals, the 6th Circuit and the D.C. Circuit, upheld the individual mandate. A third court, the 11th Circuit, held the individual mandate to be unconstitutional and finding that it was not severable from the rest of the ACA, struck down the law in its entirety. A fourth court, the 4th Circuit, ruled that the Anti-Injunction Act (AIA), which precludes actions challenging a tax until it has been assessed and paid, barred consideration of the constitutionality of the individual mandate.

An additional attack on the ACA came from the attorneys general of 26 states, who challenged a provision of the law that authorized the Secretary of Health and Human Services (HHS) to withhold all federal Medicaid funds – including those for existing programs – from states that did not agree to expand Medicaid eligibility to nearly all individuals under age 65 whose household incomes do not exceed 133% of the Federal Poverty Level (FPL). The 11th Circuit upheld the constitutionality of that provision.

On November 14, 2011, the Supreme Court (Court) agreed to consider appeals arising from the rulings of the 11th Circuit. The Court heard three days of oral arguments in late March, 2012 that addressed whether:

- The AIA barred the Court from considering the constitutionality of the individual mandate until 2015, when individuals who did not have health coverage would first be required to pay the shared responsibility penalty;
- The individual mandate is a constitutional exercise of Congressional power to regulate interstate commerce and/or to impose and collect taxes;
- The remainder of the health care reform law must be invalidated if the Court found the individual mandate to be unconstitutional; and
- Congress exceeded its constitutional authority under the Spending Clause of the Constitution by requiring states to expand Medicaid eligibility as a condition of receiving federal Medicaid funding.

The Court issued its decision on June 28, 2012, upholding the constitutionality of the individual mandate, but limiting the Medicaid expansion.

Supreme Court Decision

Under federal law, Congress generally has only those powers enumerated in Article 1, Section 8 of the Constitution including the power to regulate commerce among the states (the "Commerce Clause"), to lay and collect taxes (the "Taxing Clause") and to use funds for the general welfare (the "Spending Clause"). In addition, the "Necessary and Proper Clause" included in that Section gives Congress the power to make laws that further the exercise of an enumerated power. For the individual mandate and Medicaid expansion provisions to survive constitutional challenge, a majority of the Court had to find that, in enacting these provisions, Congress did not exceed its powers under one of those clauses.

Application of the AIA. Before the Court could rule on the constitutionality of the individual mandate, it had to determine whether consideration of that issue was barred by the AIA. The Court held that, although the shared responsibility penalty resembles a tax, Congress's decision to label the mandate a "penalty" rather than a "tax" is sufficient to determine that the AIA does not apply. Therefore, the Court could hear the merits of the case.

Constitutionality of the Individual Mandate. The majority of the Court found that Congress does not have the power under the Commerce Clause to mandate that an individual purchase health insurance or pay a penalty. The Court reasoned that although Congress can regulate activities affecting interstate commerce, it cannot regulate "inactivity" – i.e., it cannot force uninsured individuals to purchase health insurance coverage. The Court also found that the Necessary and Proper Clause of the Constitution does not confer on Congress the power to require the purchase of insurance.

Surprising some observers, Chief Justice Roberts found that Congress has the power under the Taxing Clause to impose a tax on individuals who do not maintain the minimum level of required coverage.

Justices Ginsburg, Sotomayer, Breyer and Kagan joined with Chief Justice Roberts to uphold the constitutionality of the individual mandate on this basis.

Constitutionality of Medicaid Expansion. Seven of the nine Justices found that conditioning a state's receipt of *all* Medicaid program funds on its implementation of the Medicaid eligibility expansion was unduly coercive and exceeded Congress's power under the Spending Clause. However, the Court was split on whether this should invalidate other provisions of the expansion or of the ACA. Three of the Justices who held the conditioning of funds unconstitutional (Chief Justice Roberts, and Justices Breyer and Kagan) found that the constitutional issue could be remedied if the Secretary of the Department of Health and Human Services was barred from withholding existing program funds from states that choose not to expand Medicaid eligibility. In this way, states would have the choice between expanding Medicaid eligibility and accepting additional federal funds or maintaining their current eligibility rules and current Medicaid funding. When joined by the two Justices who had found the conditioning of funds constitutional, a majority of Court upheld the Medicaid expansion**.**

Impact on Plan Sponsors

Because a significant legislative change or repeal of the ACA in the near future is unlikely (see Political Outlook below), plan sponsors that adopted a “wait-and-see” approach to ACA compliance pending the Supreme Court’s decision must resume their ACA compliance and 2014 health plan strategy efforts. While the ACA affects many different entities (such as health care providers, insurers, states, and drug and medical device manufacturers), the following sections of this FYI focus on its near-term and long-term implications for group health plans. At the end of this FYI is a timeline of relevant mandates and their corresponding effective dates.

Near-Term Implications

Plan sponsors should move forward to address the more immediate compliance requirements that are effective in 2012 and 2013.

Summary of Benefits and Coverage (SBC)

The most pressing issue for most plan sponsors is to ensure that SBCs are prepared for open enrollment this fall. SBCs must first be provided in connection with open enrollment periods that begin on or after September 23, 2012. Participants and beneficiaries who enroll in coverage other than through an open enrollment period (e.g., new hires or HIPAA special enrollees), must be provided SBCs beginning on the first day of the first plan year that commences on or after September 23, 2012 (January 1, 2013 for calendar year plans). (See our May 22, 2012 For Your Information.)

INSIGHT

The responsibility of complying with this mandate ultimately rests with the plan sponsor. Sponsors of insured plans should confirm that the insurer is furnishing SBCs in a timely manner and take action if it is not. Sponsors of self-funded plans are legally liable for providing

SBCs, even if they contract with a third party – such as a claims administrator – to prepare and distribute them. Preparation of SBCs may be difficult for plans in which coverage for services such as prescription drugs or mental health benefits has been carved out with a specialty vendor. In those cases, the plan sponsor may need to prepare or coordinate SBCs, incorporating the necessary details.

Form W-2 Reporting

Employers should be tracking each employee's applicable employer-sponsored coverage during 2012 so they can calculate and report the aggregate cost of that coverage on the 2012 Form W-2 that they will furnish to employees in January 2013. Generally, the aggregate cost of coverage is the premium that would be charged for that coverage under COBRA without the 2% administrative fee. Applicable employer-sponsored coverage includes medical coverage and, if the employer charges a COBRA premium for them, employee assistance programs, on-site medical clinics and wellness programs. It does not include stand-alone dental and vision plans, health flexible spending accounts (health FSAs) funded solely through salary reduction contributions, health reimbursement arrangements (HRAs) and health savings accounts. (See our January 11, 2012 For Your Information.)

Internal and External Appeals

Nongrandfathered plans already should be in compliance with all of the internal and external claims review requirements, including those related to providing notices in a culturally and linguistically appropriate manner. Effective July 1, 2012, nongrandfathered self-funded plans must have contracts with at least three independent review organizations and rotate assignments among them in order to qualify for the non-enforcement safe harbor announced in 2011. (See our August 4, 2011 For Your Information.)

$2,500 Annual Limit on Salary Reduction Contributions to Health FSAs

Effective for plan years beginning on and after January 1, 2013, plan sponsors may not permit employees to contribute more than $2,500 to their health FSAs through salary reduction. Non-elective employer contributions are not counted towards this limit. Flex credits that an employee can elect to contribute to a health FSA also are not taken into account unless the employee has the option of receiving them as cash. Although plan documents do not need to be amended to reflect the new limit until December 31, 2014, plans must be operated in accordance with the new rules. (See our June 8, 2012 For Your Information.)

Loss of Deduction Related to Retiree Drug Subsidy (RDS)

Currently, plan sponsors who participate in the RDS program can deduct the full amount of their qualifying prescription drug expenses, even though they also receive non-taxable RDS payments with respect to those expenses. Effective for taxable years beginning in 2013, the amount of prescription drug expenses that a plan sponsor can deduct will be reduced by the amount of RDS payments

received. Thus, plan sponsors should consider expediting the receipt of RDS payments before the end of 2012 to maximize the tax benefit before it ends in 2013.

INSIGHT

Although it is clear that the new tax treatment becomes effective in 2013, there are conflicting views on whether it applies to RDS payments received with respect to prescription drug expenses that were paid or funded prior to 2013. Plan sponsors should discuss this tax treatment with their advisors. The loss of this tax benefit has also increased the interest of many plan sponsors in implementing an Employer Group Waiver Plan (EGWP) to provide prescription drug benefits to Medicare retirees. Recent regulatory guidance has eliminated the need to implement the "Wrap" portion of what is commonly called an "EGWP+Wrap" program, to maximize the financial benefits of this approach. This change further enhances the benefits of the EGWP approach for providing prescription drug benefits.

Medical Loss Ratio (MLR) Rebates

Beginning January 1, 2011, the ACA requires that health insurance issuers spend at least 85% of premium dollars received from policies in the large group market (i.e., those that cover more than 50 employees) on a combination of medical care claims and activities to improve health care quality. (The parallel rule for the individual and small group markets requires an 80% expenditure.) Effectively, the MLR provision limits the amount that insurers can spend on administrative expenses, overhead, profit, commissions and other non-claim expenses to 15% of premium dollars received.

Sponsors of insured plans may soon be receiving rebates from those insurance companies that failed to meet the minimum loss ratio standards in a state for 2011. Sponsors of ERISA plans will need to determine the extent to which such rebates may be considered plan assets and, where appropriate, take steps to ensure that they are used in a manner that is consistent with their fiduciary responsibilities under ERISA. Similar rules apply to nonfederal governmental plans and other non-ERISA plans. (See our December 23, 2011 For Your Information.)

INSIGHT

Because satisfaction of the MLR requirements is based on an insurer's entire book of business issued in a state, and not on the MLR for a specific employer's group health plan, some large employers with insured plans may be surprised to receive rebates in 2012.

Women's Preventive Services

For plan years starting on or after August 1, 2012 (2013 for calendar year plans), nongrandfathered plans must provide first-dollar coverage for an expanded list of required women's preventive services when provided in-network. These services include all FDA-approved contraceptive methods and sterilization procedures. (See our August 11, 2011 For Your Information.) Plans sponsored by certain

religious employers are specifically exempted from the requirement to provide first-dollar coverage of contraceptives and there is also currently an enforcement safe harbor for plans that do not currently cover contraceptives because of their sponsors' religious beliefs. (See our April 18, 2012 For Your Information.)

Comparative Effectiveness Fees

Beginning with plan and policy years ending after September 30, 2012, group health plans and health insurers will be assessed a Patient-Centered Outcomes Research Institute (PCORI) fee to fund research to evaluate and compare the health outcomes and clinical effectiveness, risks and benefits of medical treatments, services, procedures and drugs. If a group health plan is insured, the health insurer is responsible for calculating and paying the fee. If the plan is self-insured, the plan sponsor is responsible. For the first plan year to which it applies, the PCORI fee generally is $1 multiplied by the average number of lives covered under the plan (including dependents). Plan sponsors must report and pay the PCORI fee for a plan year by July 31 of the calendar year that immediately follows the year in which the plan year ended. For calendar-year plans, fees will apply to the 2012 plan year and the first PCORI fees must be paid by July 31, 2013. (See our May 9, 2012 For Your Information.)

Waiver of Annual Dollar Limits

Plans that have received a waiver from the restricted annual dollar limits on essential health benefits from the Department of Health and Human Services (HHS) must provide an annual notice informing participants about the waiver and the plan's annual dollar limits as part of any informational materials and in the Summary Plan Description. The plan must also provide certain information to HHS at the end of each calendar year. (See our July 19, 2011 For Your Information.) Similar notice requirements apply to stand-alone HRAs that qualified for a class exemption from the restricted annual dollar limits.

INSIGHT

Stand-alone HRAs that cover only retirees, only reimburse HIPAA-excepted expenses (e.g., dental and vision expense) or that never have a balance that exceeds $500 are not subject to the restrictions on annual dollar limits.

New Taxes in 2013

Employers also need to be aware of the following new taxes that will go into effect in 2013:

- Increase in employee portion of the Medicare hospital insurance tax for certain high income employees. The Medicare hospital insurance tax will become two-tiered. The 1.45% Medicare tax rate will apply to wages up to and including $200,000 for single taxpayers/$250,000 for married taxpayers filing jointly and a rate of 2.35% will apply to wages above $200,000/$250,000 respectively.
- A new 3.8% Medicare tax will apply to net investment income (e.g., interest, dividends, capital gains, etc.) of taxpayers who make more than the above income thresholds. Although

distributions from qualified plans are not included within the term "net investment income," employers that maintain nonqualified plans should consult with their tax advisors.

- A new 2.3% excise tax on medical device manufacturers. This tax likely will be passed on to plan sponsors through higher claim costs.

Exchange Notice

The ACA requires employers to provide their employees with a written notice about the Exchanges by no later than March 1, 2013. New employees must be furnished the notice at the time of hire. The notice must contain the following:

- Information about the existence of the Exchange, including a description of the Exchange services and how an employee may contact the Exchange
- If the employer's share of the cost of coverage is less than 60 percent, a statement that the employee may be eligible for premium tax credits and cost-sharing reductions if purchasing coverage through the Exchange
- If the employee purchases coverage through the Exchange, a statement that the employee will lose the employer contributions and that employer contributions are excludable from income tax.

No guidance has been issued on this notice requirement. It is unclear whether the government will be able to provide employers with adequate information to prepare and distribute notices by the March 1, 2013 deadline.

INSIGHT

This requirement could be very onerous if plan sponsors must tailor the notice to each state Exchange.

Early Retiree Reinsurance Program (ERRP)

Plan sponsors participating in the ERRP program need complete documentation on the proper use of the ERRP funds – either to offset increases in plan costs or to share with plan participants. The Centers for Medicare and Medicaid Services (CMS) has hired a "program integrity contractor" to conduct audits of ERRP plan sponsors to "verify compliance with program rules, including eligibility of early retirees, validity of claims submitted, and use of program funds." (See our February 24, 2012 For Your Information.) In addition, plan sponsors must continue to provide new plan enrollees with the required form notice that informs participants that the plan sponsor may use any reimbursements it receives through ERRP either to reduce or offset increases in participant cost-sharing or to reduce or offset increases in its own costs for maintaining health coverage. (See our October 5, 2010 For Your Information.)

Long-Term Implications

Plan sponsors must make certain that their group health plans comply with the following ACA mandates. In many instances, additional guidance will be needed to establish specific compliance requirements.

Required for Plan Years Beginning on or after January 1, 2014

No Annual Dollar Limits on Essential Health Benefits. Sponsors of group health plans that currently impose permissible annual dollar limits on essential health benefits (i.e., $2 million for plan years beginning on or after September 23, 2012 but before January 1, 2014) will have to eliminate those limits. In addition, the waivers that plans with lower limits received from HHS and the class exemption for stand-alone HRAs will expire.

Also, for 2014, employers that currently impose annual or lifetime dollar limits on benefits that they believe are not "essential health benefits" (EHB), such as bariatric surgery or infertility treatments, will have to ensure that their plan's definition of EHB is authorized by HHS. (See our December 22, 2011 For Your Information.)

INSIGHT

Plan sponsors should begin developing a strategy for offering benefits to employees currently covered under plans for which a waiver has been obtained. See Long-Term Strategies below. In addition, sponsors of stand-alone HRAs will need to decide whether to integrate the HRAs into their group health plans, limit reimbursements to excepted benefits, or to terminate them.

No Preexisting Condition Exclusions for Any Enrollee. Sponsors of group health plans that currently impose a pre-existing condition exclusion on enrollees age 19 and older will have to eliminate that exclusion.

Coverage of Children up to Age 26 Even if Eligible for Other Health Coverage. Grandfathered plans will have to make coverage available to children under age 26 even if they are eligible for coverage through their own employer.

No Waiting Periods in Excess of 90 Days. Sponsors of plans that currently require otherwise eligible employees to wait more than 90 days to enroll will have to shorten those waiting periods to no more than 90 days. This includes plans that currently provide that coverage begins on the first day of the month following 90 days of employment.

Coverage for Individuals Participating in Approved Clinical Trials. Nongrandfathered plans will be required to cover routine patient costs incurred in connection with approved clinical trials. "Routine patient costs" include items and services typically provided under the plan for a participant not enrolled in a clinical trial and do not include the investigational item, device or service itself.

Limits on Deductibles and Out-of-Pocket Maximums. Nongrandfathered plans will not be able to impose an annual deductible of more than $2,000 for an individual and $4,000 for any other coverage tier. In addition, they are prohibited from having out-of-pocket maximums that exceed the limits imposed on high deductible health plans that are compatible with health savings accounts.

INSIGHT

Although some commentators contend that these limits only apply to nongrandfathered plans offered through the Exchanges and not to employer-sponsored plans, the Department of Labor has informally indicated that the limits apply to all nongrandfathered group health plans, including self-insured plans. Additional guidance would be helpful.

No Discrimination Against Providers Acting within the Scope of their Licenses. Nongrandfathered plans will be prohibited from discriminating against health care providers acting within the scope of their licenses when providing services covered by the plan.

Auto-Enrollment of Full-Time Employees. Following the issuance of regulations, employers with at least 200 employees will be required to automatically enroll full-time employees into one of their health plans following the completion of any applicable waiting period. The Department of Labor has indicated that these regulations may not be issued prior to 2014.

Required in 2015

Annual Reporting of Availability of "Minimum Essential Coverage" to IRS and Statements to Full-Time Employees. In 2015, employers subject to the shared responsibility penalties (see below) and certain other employers that offer "minimum essential coverage" will be required to submit a report to the Internal Revenue Service that contains information about the coverage provided or made available to their full-time employees in 2014. In addition, by January 31, 2015, the employers will have to provide a written statement to each full-time employee whose name appears on the report to the IRS regarding that coverage. The information will be used for purposes of administering the individual mandate and the shared responsibility penalties. This annual reporting/disclosure requirement will also apply for subsequent years.

Effective in 2018

Excise Tax on High-Cost Employer Plans ("Cadillac Tax"). Beginning in 2018, an excise tax will be imposed on the aggregate value of employer-sponsored health coverage that exceeds certain thresholds. The tax will be equal to 40% of the aggregate value in excess of $10,200 for individual coverage and $27,500 for family coverage. These thresholds are subject to adjustment and there are also higher adjustments for certain retirees and individuals in high risk professions.

In the case of an insured plan, the tax will be assessed on the insurer providing the coverage. In the case of a self-insured plan, the tax will be assessed on the third-party administrator or on the employer if the plan is self-administered.

Long-Term Strategies

Availability of Exchange Coverage

The most significant long term strategy issue for plan sponsors is to determine the extent to which they will consider the availability of health coverage through the Exchanges when fashioning their active and retiree medical offerings. Beginning in 2014, the Exchanges will be the health insurance marketplace where individuals and small employers (i.e., generally employers with 100 or fewer employees) will be able to purchase coverage. Although large employers (i.e., those more than 100 employees) will not be able to sponsor a plan through an Exchange initially, their employees and retirees can purchase coverage through an Exchange even if eligible for employer-sponsored coverage. Starting in 2017, the ACA permits (but does not require) states to open up Exchanges to large employers.

States have the option of establishing their own Exchanges and/or coordinating with each other to establish regional Exchanges. The federal government has provided states with flexibility in establishing, coordinating and running Exchanges. In order to be ready for open enrollment, these Exchanges must be operational by the fall of 2013. HHS will certify state Exchange readiness by January 1, 2013. If a state is not certified or has indicated that it either will not be ready or will not establish an Exchange, the federal government will step in to implement and run the Exchange.

INSIGHT

As of the date of this FYI, less than a third of the states have enacted legislation to establish their Exchanges. While the federal government is committed to establishing an Exchange in each state that fails to do so, it is possible the task will not be completed by 2014 and instead will be implemented over two or more years. This potential delay could complicate a benefit strategy that utilizes the Exchanges.

Federal Assistance for Employees and Retirees Purchasing Exchange Coverage

Lower-income individuals who buy coverage through an Exchange may be eligible for federal subsidies in the form of a premium tax credit and/or cost-sharing assistance. A premium tax credit, which decreases as income increases, will be provided to individuals with income from 100% to 400% of FPL while cost-sharing assistance is available to those individuals with income less than 250% of FPL. Individuals eligible for employer-sponsored coverage are not eligible for these federal subsidies unless the employer-sponsored is deemed "unaffordable" (i.e., the employee contribution for “employee-only coverage” exceeds 9.5% of the individual’s household income) or if the employer plan does not provide "minimum value" (i.e., have an actuarial value of at least 60%).

INSIGHT

For 2012, 400% of FPL is $44,680 for a single person and $92,200 for a family of four. This means that employees who have income up to those levels could potentially qualify for the

premium tax credit. Thus, a significant portion of many employers' workforces may be eligible for federal assistance. The mechanics of how the credit is determined for each employee is fairly complicated, but can be modeled to determine the impact on the employer's workforce.

Exchanges and the "Shared Responsibility" Penalties

Beginning in 2014, large employers (i.e., employers that employed an average of at least 50 full-time employees on business days during the preceding calendar year) may be subject to one of two "shared responsibility" penalties. An employer that fails to offer health coverage to its full-time employees and their dependents may be subject to a nondeductible "play OR pay" penalty if any full-time employee (generally, an employee who works on average at least 30 hours per week) enrolls for coverage through an Exchange and qualifies for the premium tax credit or reduced cost-sharing. The maximum annual "play OR pay" penalty is $2,000 for each full-time employee of the employer, disregarding the first 30.

Large employers that offer health coverage to their full-time employees and their dependents will potentially be subject to a nondeductible "play AND pay penalty" if at least one full-time employee enrolls in Exchange coverage and qualifies for a premium tax credit or reduced cost-sharing because the coverage fails to provide minimum value or is unaffordable. For purposes of the penalty, coverage is considered unaffordable only if the required employee contribution for employee-only coverage exceeds 9.5% of the employee's Form W-2 wages. The maximum annual "play AND pay" penalty is $3,000 for each full-time employee who enrolls in Exchange coverage and qualifies for the premium tax credit or reduced cost-sharing, subject to the maximum penalty that could be imposed if no coverage had been offered.

INSIGHT

Neither of the shared responsibility penalties apply when a retiree or part-time employee enrolls in Exchange coverage and qualifies for the premium tax credit or reduced cost-sharing.

Employer Strategies

There are generally three possible health care strategies that employers should consider for 2014 and later:

- Drop employer-sponsored health care coverage
- Drop employer-sponsored health care coverage and subsidize Exchange coverage
- Continue employer-sponsored health care coverage

The approach an employer takes could vary for different segments of its workforce or business operations, depending on the flexibility allowed in final regulations. Any adopted strategy needs to reflect the employer's overall benefit philosophy and maintain its ability to attract and retain a productive workforce.

Drop Coverage

One strategy an employer can consider is to stop offering employer-sponsored health care coverage for all employees and retirees and let them purchase coverage through the Exchanges. Large employers could be subject to the "play OR pay" penalty, as described above. Alternatively, an employer could utilize different strategies for different segments of its workforce – offering coverage to some, but not all, employees. Employers should be aware of potential nondiscrimination implications (for both insured and self-insured group health plans) as well as the shared responsibility penalties. In some cases, it could be more economically advantageous for an employer to pay the penalties.

INSIGHT

It is currently unclear how the "play OR pay" penalty applies when an employer offers health coverage to only a portion of its workforce. For example, some employers in the retail industry currently offer health coverage to corporate and home office employees, but offer limited or no coverage to employees in the retail stores. If the employer wants to continue that strategy in 2014, regulatory guidance is needed to clarify whether the $2,000 penalty applies only with respect to those full-time employees who are not offered coverage, or if it applies to all employees, including those who are offered employer-sponsored coverage. This will be a critical issue for some industries.

Subsidize Exchange Coverage

Employers who discontinue offering health coverage may want to provide additional compensation to employees to offset the loss of those benefits. However, determining how to appropriately compensate employees will be difficult since not only will the cost of Exchange coverage vary by demographic factors such as age, family size and location, but subsidies provided through the Exchange will also vary significantly. Higher income employees will not be eligible for the Exchange subsidies. An increase in compensation will also be taxable income for the employee, which will reduce the value of the compensation. An employer may be able to use health reimbursement arrangements or premium reimbursement arrangements to provide tax-favored funds to purchase Exchange coverage, but additional regulatory guidance is needed regarding the use of these accounts in 2014 and later.

Continue Employer-Sponsored Coverage

An employer's third option is to continue to offer health coverage to its employees. This will require the employer to make any required modifications to its group health plans and plan administration to comply with the ACA requirements that are effective in 2014 and later. Employers that offer coverage only to "full-time employees," and define "full-time" work as more than 30 hours a week, will need to determine whether they are excluding some employees who will be considered full-time for purposes of the shared responsibility penalties. Similarly, employers with large part-time populations will need to track work hours carefully or realign work schedules to avoid potential penalties.

INSIGHT

Employers that continue coverage should determine if their plans will satisfy the affordability and minimum value requirements, and estimate the potential impact of any penalties. Employers with a low-income workforce may even want to consider making their plans "unaffordable" to encourage employees to enroll in Exchange coverage. That could be a "win-win" strategy for the employer and the lower income employees.

Pre-Medicare Retiree Coverage

Few large employers are expected to drop active medical coverage in 2014 or in the years immediately following 2014. However, that is not the case with retiree coverage. Since neither the "play OR pay" nor the "play AND pay" penalties apply with respect to retirees, employers will be less reluctant to utilize the Exchanges to address two key issues that face pre-Medicare retirees without employer-sponsored coverage – access to coverage and affordable coverage options.

The state Exchanges will provide access to coverage to all pre-Medicare retirees on a guaranteed issue basis - with no limitations based on pre-existing health conditions. The affordability issue will be addressed in several ways:

- Exchanges are expected to have a wide range of plan offerings and premium levels, with coverage levels from bronze (covering approximately 60% of health care expenses), to platinum (90% of expenses).
- Health plans offered in the Exchanges will be required to use "community rating." They will not be allowed to use health status in setting rates, and they will also be limited to charging older enrollees no more than three times what the younger enrollees are charged. These limitations on setting premiums effectively means that younger enrollees will help subsidize the cost of older enrollees, helping to lower the cost for early retirees.
- Finally, because retirees typically have lower income levels than active employees, they will be much more likely to qualify for the premium tax credit and cost-sharing reductions discussed previously. This may significantly reduce the cost of their coverage.

An employer may also be able to provide retirees with assistance to purchase coverage in a tax-effective manner using health reimbursement arrangements or premium reimbursement accounts.

INSIGHT

Many employers are already moving their Medicare-eligible retirees to Medicare exchanges, which are similar in concept to the health care reform Exchanges. The wide availability in almost all states of individual Medicare Supplement and Medicare Advantage plans provides Medicare retirees with access to affordable coverage that may meet the needs of individual retirees better than a single employer-sponsored Medicare retiree plan. In addition, the

expanded Medicare prescription drug coverage provided through health care reform further limits the need for employer-sponsored coverage. Many large employers are implementing a Medicare exchange through which their retirees can purchase individual coverage. The Xerox "My Medicare Advocate" service is an example of this type of Medicare Exchange, providing Medicare-eligible retirees with access to a call center and web portal, with modeling tools, to help them select the best Medicare plan to meet their individual needs. With the availability of ACA Exchange coverage for pre-Medicare retirees, it is anticipated that many employers will also move their pre-Medicare retirees to Exchange programs starting in 2014.

Expansion of Medicaid

The ACA significantly expands Medicaid eligibility in 2014 to most individuals under age 65 with incomes below 138% of FPL. (Although the law refers to 133%, a five percent income disregard makes the effective rate 138%.) Under the ACA, the federal government will fund 100% of the expanded Medicaid eligibility for 2014 through 2016, and at least 90% of the cost in future years. As discussed in the *Decision* section above, the Court ruled that that states had to be given the option of rejecting the expanded Medicaid eligibility while still continuing to receive current federal Medicaid funding. Thus, some states may decide not to make Medicaid available to the larger group of individuals.

INSIGHT

This decision could have an impact on employer-sponsored plans with low-income workforces. Under the ACA, individuals eligible for Medicaid are not eligible for premium tax credits or cost-sharing subsidies and the shared responsibility penalties do not apply with respect to employees who qualify for Medicaid. If a state does not adopt expanded Medicaid eligibility, employees with income between 100% and 138% of FPL in that state could enroll in an Exchange plan and receive a premium tax credit or cost-sharing subsidy, thus potentially subjecting the employer to a shared responsibility penalty. Employers will also need to track Medicaid eligibility requirements by state, as the standards and qualified income levels could vary by state. Employers should monitor those states in which they have a significant workforce to determine whether they have decided to expand Medicaid eligibility. The governors of Florida, Louisiana, Texas and Wisconsin have stated that their states will not adopt the expansion.

Political Outlook

The ACA will continue to be the law of the land absent a significant shift in the political landscape. Prior to the November election, regulators will continue to issue and finalize guidance, perhaps at an accelerated pace. The Supreme Court's ruling also makes it likely that regulators will tackle some of the more controversial regulatory guidance resulting from the law, such as mandated contraceptive coverage or the shared responsibility penalties. However, such guidance may result in more litigation.

For example, several Catholic dioceses and schools have already filed lawsuits, arguing that the law's contraception coverage mandate violates the Constitution's First Amendment.

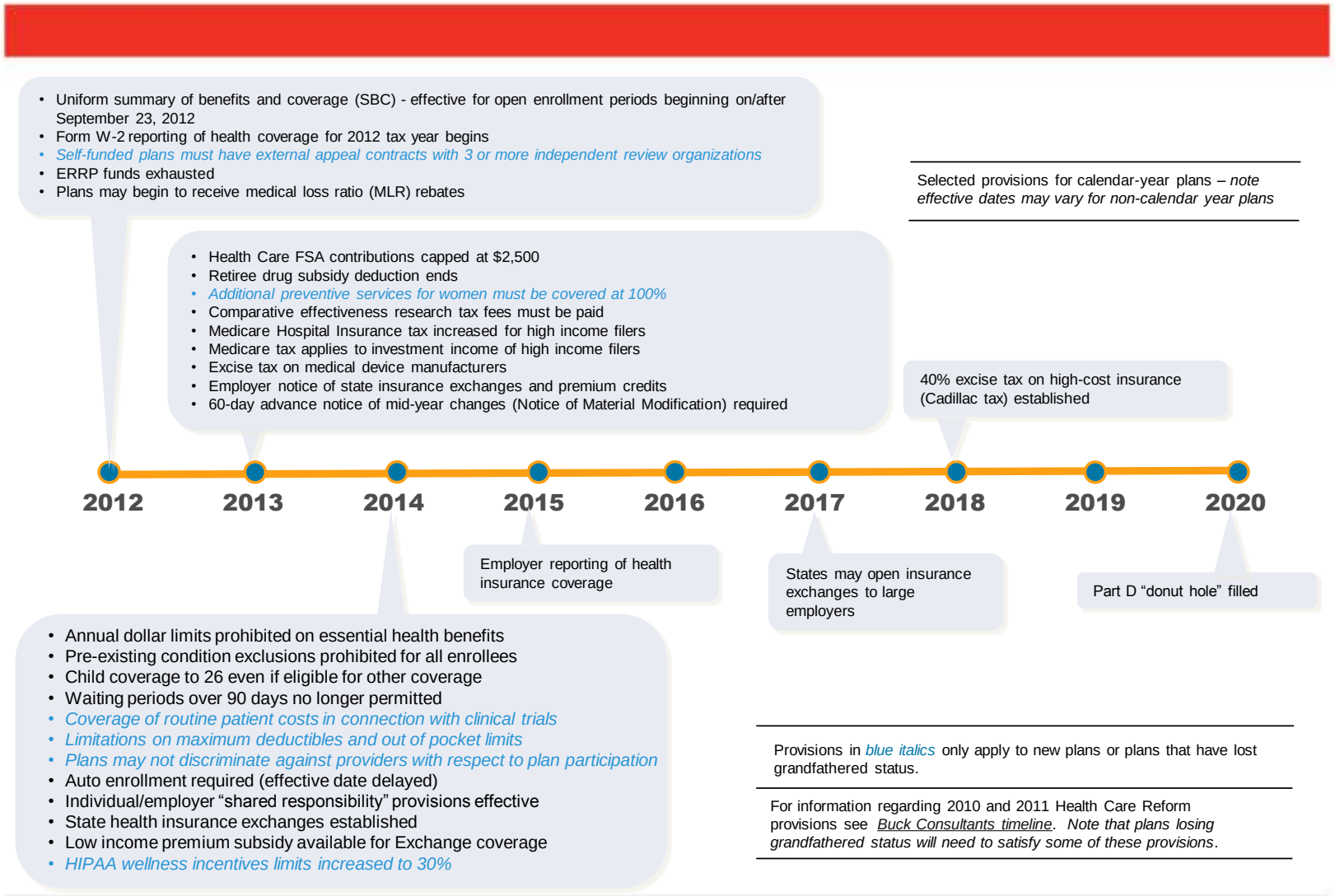
Simultaneously, Republicans may try to repeal all or parts of the law through legislative means in Congress or to create barriers to implementation by slowing down funding. Gaining enough support in the currently Democratic controlled Senate to make any changes to the law has proven difficult for Republicans in the past and seems unlikely unless the American public clamors for immediate change. That said, the Republicans in the House of Representatives are expected to pass a largely symbolic bill to repeal the law. While the bill has no chance of becoming law – because President Obama would veto it if it ever reached him – those Republican efforts may help pave the political way for future efforts.

Time will tell if the Republican Party will make the repeal of the ACA a centerpiece of the 2012 electoral campaign. However, the most likely course for repeal through political means is for Mitt Romney to win the White House. His success at achieving repeal will depend on the final make-up of Congress, support from conservative Democrats and Congressional voting procedures such as reconciliation and filibuster. Even if Mr. Romney is unsuccessful at Congressional repeal, he would likely replace many of the officials leading the regulatory agencies responsible for implementing the law. This leadership shift could change the current tide of regulatory guidance.

Conclusion

While the political outlook of the health care reform law continues to evolve, the Supreme Court's recent ruling means that employers must focus on implementing upcoming group health plan mandates. While specific implementation will depend on each employer's particular situation, group health plan design, and yet-to-be-issued regulatory guidance, there is little doubt that many of the mandates will require detailed financial analysis, coordination with third parties and strategic planning with trusted advisors and legal counsel. Given this complexity, employers are well advised to begin this process sooner rather than later.

Health Care Reform Timeline – 2012 and Beyond



Selected provisions for calendar-year plans – *note effective dates may vary for non-calendar year plans*

Provisions in *blue italics* only apply to new plans or plans that have lost grandfathered status.

For information regarding 2010 and 2011 Health Care Reform provisions see *Buck Consultants timeline*. *Note that plans losing grandfathered status will need to satisfy some of these provisions*.

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Rev. 7/6/2012