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For your information

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Addressing Employer Questions about Health Care Reform

On July 11, 2012, Buck Consultants presented a national Webinar on health care reform. Buck's experts discussed the Supreme Court's ruling, provided an analysis of many of the near-term and long-term requirements facing employers, and offered comments on the political outlook for health care reform in the United States. Due to time constraints, the presenters could not answer all of the questions participants raised. This *For Your Information* answers many of those questions, including questions about the summary of benefits and coverage, Form W-2 reporting requirements, the medical loss ratio, the preventive services mandate, the high-cost-plan tax, the employer shared-responsibility penalty, and insured plan nondiscrimination rules. In addition, during the Webinar, participants were polled to obtain insight into what they are thinking about certain aspects of health care reform. The findings are summarized in the appendix.

Summary of Benefits and Coverage

Insured and self-funded group health plans will have to give participants and beneficiaries a uniform summary of benefits and coverage (SBC) describing available plan options. For details, see our May 22, 2012 *For Your Information*. The primary purpose of the SBC is to enable participants to easily compare coverage options and better understand their benefits. Final regulations delayed implementation of this disclosure requirement:

- *Participants who enroll or reenroll through an open enrollment period***.** The SBC requirement applies as of the first day of the first open enrollment period that begins on or after September 23, 2012.
- *Participants who enroll other than through an open enrollment period.* The SBC requirement applies as of the first day of the first plan year that begins on or after September 23, 2012. For calendar year plans, that means January 1, 2013.

Question: *Is the SBC the employer's responsibility or the carrier's responsibility?*

Answer: For self-insured plans, employers (or plan administrators) are responsible for supplying SBCs to participants and beneficiaries. For insured plans, insurers are responsible for supplying SBCs. However, both the insurer and the plan administrator must provide the SBC to participants and

beneficiaries. The regulations permit the obligation to be satisfied with respect to both entities if *either* the insurer or the plan administrator timely provides the SBC.

Question: *When were the SBC effective dates first announced?*

Answer: Final regulations specifying the effective dates were issued on February 14, 2012.

Question: *Our 2012 open enrollment period begins on September 1 for an October 1 plan year. Do we have to distribute an SBC before open enrollment?*

Answer: No. Because your open enrollment period begins before September 23, 2012, you do not have to distribute SBCs during your 2012 open enrollment period. However, keep in mind that you have obligations regarding those who don't enroll through open enrollment, such as new hires, as of October 1, 2012.

Question: *For cafeteria plan change-in-status qualifying events, does the employer have to distribute a hard copy of the SBC to affected individuals? If it does, does just having the SBC available on the intranet suffice or would the employer have to send participants a link to the intranet site?*

Answer: The answer depends on whether the individual is already enrolled. For those who are eligible for the plan but not yet enrolled, SBCs can be provided electronically as long as the SBCs are readily accessible. The plan must advise the individuals in paper form (such as a postcard) or by email how to obtain the SBC.

For those already covered, the regulations only permit electronic distribution if the Department of Labor (DOL) requirements for electronic distribution are satisfied. This means that SBCs generally could be distributed electronically only to eligible individuals whose access to the sponsor's electronic information system is an integral part of their employment duties. For others – such as COBRA enrollees, retirees, and employees who don't have regular access to the sponsor's system – prior consent to the electronic distribution would have to be obtained. However, under a DOL electronic distribution safe harbor, SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online request for an SBC. Individuals must still be able to obtain a paper copy on request.

Question: We have multiple HMOs in multiple areas and we send the same general open enrollment materials to everyone. We have no way to identify and segregate service areas, but it's pointless to send Buffalo HMO information to eligible individuals in New York City. If the SBCs have to go to all eligible individuals, can't we just direct them to our public website and post the SBCs there instead?

Answer: If you can satisfy the requirements for electronic distribution of SBCs (discussed in the prior question), then providing multiple SBCs will generally not be a problem. However, if you must distribute hard copies of the SBCs and you cannot determine which options are available to each eligible individual, then you may have to distribute all SBCs to all eligible individuals.

Question: SBCs can be delivered by mail or electronically. What about hand-delivery?

Answer: SBCs can be hand-delivered as long as the SBC distribution requirements are satisfied.

Question: Do the SBC requirements apply to retiree-only plans?

Answer: An SBC does not have to be provided for retiree-only plans that qualify as an "excepted benefit" under HIPAA. This same rule applies to stand-alone HIPAA-excepted dental and vision plans.

Question: *Where can I get the government-provided SBC template?*

Answer: The SBC template is available on the Department of Health and Human Services (HHS) Center for Consumer Information & Insurance Oversight (CCIIO) website.

Question: *Can you explain the material modifications requirement?*

Answer: A group health plan or issuer must notify participants of any material modification of information contained in the most recent SBC at least 60 days before the modification takes effect if it occurs other than during open enrollment. A modification is considered material if an average plan participant would consider it to be an important change in covered benefits or other terms of coverage, such as benefit enhancements or reductions.

Question: *Are there any exemptions for translated SBCs if all employees are required to speak English?*

Answer: No. On request, an SBC must be provided in a non-English language to those who reside in counties identified by the Census Bureau as having 10% or more of their population literate only in the same non-English language. In those locations, all SBCs must state, in the applicable foreign language, that non-English services and translated SBCs are available.

Form W-2 Reporting

Employers must report the aggregate cost of "applicable employer-sponsored" group health plan coverage on Form W-2 for taxable years beginning on or after January 1, 2012. For more detail, see our January 11, 2012 *For Your Information*.

Question: *What if you are self-funded? What do you report on the W-2?*

Answer: Employers that sponsor self-funded plans are to determine aggregate cost under rules similar to those for determining the "applicable premium" under COBRA continuation coverage (without the 2% administration fee). COBRA requires the employer to calculate the premium using either an actuarial method or a past cost method. Until further government guidance is released, employers must make that calculation in good faith using a reasonable interpretation of the Internal Revenue Code (Code). Fully insured plans use the premium charged by the carrier.

Question: *Does the amount reported on the W-2 include employee contributions?*

Answer: Yes. The aggregate reportable cost of applicable employer-sponsored coverage includes amounts paid by both the employer and the employee, whether the employee's contributions are made on a pre-tax or a post-tax basis.

Question: *Do we have to include the cost of coverage on a retiree's Form W-2?*

Answer: Health coverage reporting on Form W-2 isn't necessary if a Form W-2 isn't otherwise required. In the case of a retiree, if no reportable income is received from the employer, then the Form W-2 reporting requirement would not apply. But if a retiree has group health plan coverage during the year and also has reportable income – such as a severance plan or retiree life insurance – you must report the coverage on that retiree's Form W-2.

Medical Loss Ratio (MLR)

Beginning January 1, 2011, health insurance issuers must spend at least 85% of the premium dollars they receive from policies in large group market (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 market requires an 80% expenditure.) Effectively, the medical loss ratio (MLR) provision limits the amount that insurers can spend on administration, overhead, profit, commissions, and other non-claim expenses. Satisfaction of the MLR requirements is determined for the insurer separately in each state where the insurer issues policies and separately for each of three market segments in the state: individual, small group, and large group. An insurer must provide rebates to policyholders and enrollees if the insurer fails to meet the MLR standards in a state for the prior year. Insurers have an August 1, 2012 deadline to provide the rebates. For more information, see our December 23, 2011 *For Your Information*.

Question: *What was the MLR requirement before the ACA?*

Answer: Prior to the ACA there were no federal MLR requirements. However, some states (such as New York) had enacted laws with similar requirements.

Question: *Do employers have to do anything to prepare for this requirement?*

Answer: Employers will want to coordinate with insurers to determine if rebates will be paid and establish a process for sharing any rebates with employees. Employers should also be aware that insurers have to send a notice of the rebates directly to plan participants and be prepared to answer questions or distribute employee communications to supplement the notice.

Preventive Services

Non-grandfathered group health plans have to provide, at a minimum and without cost-sharing (e.g., copayments, coinsurance, deductibles), in-network coverage for various preventive care services, including additional preventive care and screenings targeted to the unique needs of women. Starting with the first plan year that begins on or after August 1, 2012, most non-grandfathered plans must cover

additional women's preventive services when furnished by an in-network provider. For more information, see our August 11, 2011 *For Your Information*.

Question: *Why are HIV testing and domestic violence considered "unique" needs of women?*

Answer: The Institutes of Medicine (IOM) was tasked by HHS with making recommendations on specific preventive measures for women, and the IOM included HIV testing and domestic violence in its coverage recommendations. The full IOM report is available.

Question: We are currently exempt from state insurance mandates, such as those pertaining to infertility treatment, because we are a self-funded group health plan subject only to the federal ERISA law. Will this change under health care reform?

Answer: Self-funded plans will continue to be exempt from state insurance mandates under the ACA. However, self-funded plans will be subject to the various ACA group health plan mandates, such as preventive care requirements that may affect the coverage options offered to participants. In addition, a state's definition of essential health benefits could affect self-funded plans because of the ACA prohibition of annual and lifetime dollar limits on essential health benefits.

Excise Tax (Cadillac Tax)

Effective for tax years beginning in 2018, group health plans will be subject to an excise tax of 40% of the value of the coverage that exceeds $10,200 for self-only coverage and $27,500 for family coverage. Higher limits ($11,850/$30,950) apply for certain high-risk professions and retirees ages 55 through 64. The limit may also be higher for higher-than-average age and/or percentage of female participants. Starting in 2019, these amounts will be indexed based on the Consumer Price Index – Urban plus 1%. For years 2020 and beyond, the Consumer Price Index – Urban will be used. The value of coverage does not include HIPAA-excepted benefits such as dental and vision coverage that is offered separately from medical coverage, but does include health care flexible spending accounts.

Question: *Are the $10,200 and $27,500 limits adjusted based upon what region of the country you are in?*

Answer: No. The same values apply in all regions of the country.

Question: *How can wellness plans mitigate the liability associated with the Cadillac tax?*

Answer: A wellness program can be very effective in helping to control long-term health care costs of group health plans. Because the Cadillac tax is not effective until 2018, wellness programs implemented now can help reduce future costs and mitigate the need for plan design changes to potentially avoid the Cadillac tax.

Question: *How does this tax work for retiree plans? Can we carve out the retiree cost from the active cost in a self-funded plan for the Cadillac calculation?*

Answer: The Cadillac tax works the same for retiree plans as for active employee plans except that higher limits apply to pre-Medicare retirees. However, in some cases the tax liability can be reduced by combining pre-Medicare retirees and Medicare retirees and using the lower limits.

Question: *Does the excise tax affect our retiree medical liabilities?*

Answer: It depends. If the Cadillac tax will apply to your retiree medical plans in 2018 or later, the tax impact could result in an increase in current retiree medical liabilities under FASB and GASB accounting.

Shared-Responsibility Definition of Full-Time Employees

Starting in 2014, employers must provide full-time employees and their dependents affordable health coverage with a minimum value. Employers that don't offer that coverage may face financial penalties. Regulators outlined several approaches to determining whether an individual is a full-time employee for purposes of the shared-responsibility penalty.

Question: *What is the definition of a "full-time" employee?*

Answer: Full-time employees are defined as employees working 30 or more hours a week. Additional government guidance is needed on how hours will be measured in determining the 30 hours.

Question: *Does "employee" include statutory employees who receive a W-2?*

Answer: Regulators are considering using existing law to define who is an employee for shared-responsibility purposes. Similarly, existing DOL rules might be used to determine if seasonal workers are employees.

Affordability and Minimum Value Requirements

Beginning in 2014, individuals can purchase individual health insurance coverage through the Affordable Insurance Exchanges. To make that coverage more affordable for certain populations, the ACA created a refundable health insurance premium tax credit that will subsidize the cost of exchange coverage. Generally, the premium tax credit will be available only to individuals:

- Whose household income for a taxable year is between 100% and 400% of the federal poverty level for the taxpayer's family size
- Who are not eligible for other "minimum essential coverage"
- If married, file joint federal income tax returns
- Who are not in jail
- Who are lawfully present in the U.S.
- Who is not another person's tax dependent

- Who is not enrolled in a catastrophic exchange plan.

Minimum essential coverage for purposes of the premium tax credit does not include employer-sponsored coverage that is "unaffordable" or that "fails to provide minimum value." Coverage is considered "unaffordable" if the required employee contribution toward the cost of self-only coverage exceeds 9.5% of the employee's household income. Coverage "fails to provide minimum value" if it fails to pay at least 60% of the total allowed cost of benefits provided under the plan. Employers that offer coverage that is deemed to be unaffordable or fails to provide minimum value will be charged with a shared-responsibility penalty for each full-time employee who receives the premium tax credit. For more information, see our June 18, 2012 *For Your Information*.

Question: *What is the dollar amount of the Federal Poverty Level (FPL)?*

Answer: The FPL is a function of family size and household income. For the 48 contiguous states and the District of Columbia, the 2012 FPL is $11,170 for a single person and $23,050 for a family of four. Therefore, 400% of the FPL is $44,680 for a single person and $92,200 for a family of four.

Question: *Please further explain the 60% minimum-value test.*

Answer: Minimum value will be based on actuarial value. Actuarial value is a measure of the percentage of expected health care costs a health plan will cover across an average population. For example, if a health plan is expected to reimburse, on average, 60% of the eligible expenses covered under the plan, the actuarial value of that plan is 60%. The individuals covered under the plan would pay the remaining 40% through plan features such as deductibles, copayments, and coinsurance. Regulators stated that guidance will be issued on the determination of minimum value for employer-sponsored plans. This guidance will enable employers to determine whether they may be subject to the penalty for providing coverage that does not satisfy minimum-value requirements. For more information, see our March 9, 2012 *For Your Information*.

Question: *What if I have multiple plans that are affordable (employee contribution is less than 9.5%), but an employee enrolls in a higher-cost plan with employee contributions that exceed 9.5% for that employee? Is my plan considered affordable?*

Answer: Yes. In fact, all of your plans are considered affordable as long as at least one plan satisfies the affordability requirement.

Question: *Is there a safe harbor option for employers regarding household income?*

Answer: Yes. The IRS proposed a safe harbor that provides that for purposes of the shared-responsibility penalty only, the affordability of an employer's coverage would be measured with reference to an employee's wages from that employer. Wages for this purpose would be the total amount of wages required to be reported in Box 1 of Form W-2. However, an employee's eligibility for the premium tax credit would continue to be based on the affordability of employer-sponsored coverage relative to his or her household income. For more information, see our September 20, 2011 *For Your Information*.

Question: *What are exchanges under the ACA?*

Answer: Beginning in 2014, 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 with 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 they are 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 provided states with flexibility in establishing, coordinating, and running exchanges. 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 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.

Nondiscrimination Requirements

Self-insured employer-provided health plans may not discriminate with respect to benefits or eligibility in favor of highly compensated individuals. This nondiscrimination rule did not apply to fully insured plans prior to the ACA. However, the ACA eliminates this distinction by making fully insured, non-grandfathered health plans subject to similar nondiscrimination rules. Although the IRS has delayed the application of this nondiscrimination requirement for fully insured group health plans until it issues regulations, the new requirement seriously affects the future of certain discriminatory plans, such as fully insured executive medical programs. For more information, see our January 5, 2011 *For Your Information*.

Question: *How will nondiscrimination testing be performed for fully insured plans?*

Answer: The nondiscrimination rules that will apply to fully insured plans will be similar to the rules governing self-insured plans under Code Section 105(h). However, additional regulatory guidance describing the specific testing requirements is expected.

Appendix: Poll Pinpoints Employer Concerns after Supreme Court Health Care Reform Ruling

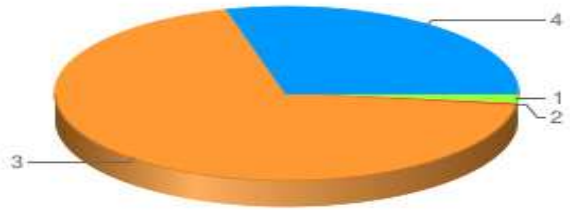
During the July 11, 2012 Buck Consultants Webinar, participants were polled to obtain insight into what they are thinking about certain aspects of health care reform. Of the more than 525 participants (mainly employer clients), approximately 370 responded to each poll question.

Most notably, when asked what approach they anticipate taking with respect to active employee health care coverage in 2014-2015, only about 2% said that they intend to drop employer-sponsored coverage; almost 70% of those responding said that they will continue to offer employer-sponsored coverage.

Question: What approach do you currently anticipate taking with active employee coverage in period 2014-2015?

Summary:

No	Choice	Percentage
1	Drop employer-sponsored health care coverage	1.9%
2	Drop employer coverage and subsidize Exchange coverage	0.3%
3	Continue employer-sponsored health care coverage	68.7%
4	Still considering options	29.1%

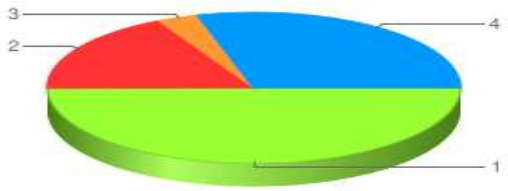


Although the political future of health care reform remains unclear, when asked whether the November elections will affect their health care benefit strategy, almost half of the respondents said that they are moving forward with their current strategy without regard to the election.

Question: Will the upcoming November elections affect your organization's health care benefit strategy?

Summary:

No	Choice	Percentage
1	No, we are moving ahead with our current strategy	49.9%
2	Yes, we are planning to implement only short-term requirements effective this year	17.5%
3	Yes, we aren't implementing anything until after the election is over	3.2%
4	Don't know yet	29.4%

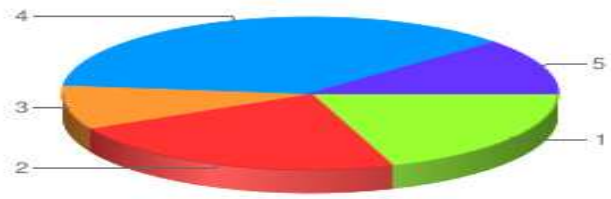


When asked which health care reform requirement listed in the poll concerns them the most, respondents ranked the tax on high-cost plans (the "Cadillac" tax) first. This is somewhat surprising given that the tax is not effective until 2018. The employer shared-responsibility penalty ranked second, suggesting that employers are already beginning to think about 2014 strategies that will help them avoid the penalty.

Question: Which of the following ACA rules concerns your organization the most?

Summary:

No	Choice	Percentage
1	Summary of Benefits and Coverage (SBC)	19.6%
2	Employer shared responsibility penalty	22.9%
3	Form W-2 reporting	9.3%
4	The high cost plan tax (Cadillac tax)	36.5%
5	Automatic enrollment	11.7%



Although this poll was not based on a statistically valid sample of U.S. employers, it may give employers some insight into other organizations' perspectives as they attempt to deal with the myriad decisions facing them as they consider their employee benefit strategy.