McGraw Wentworth

REFORM Update

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This *Reform Update* reviews the following health care reform act provisions:

- Federal Limit on Medical Flexible Spending Accounts (FSAs)
- Loss of Tax-Favored Status of Retiree Drug Subsidy (RDS)
- Quality Information Reporting Requirements
- Tax to Fund Comparative Effectiveness Studies
- Health Insurer Executive Compensation Limits
- Medicare Payroll Tax Increase for High Incomes

Because the effective dates for many of these provisions are a few years down the road, it is very likely additional guidance will be issued along the way to clarify specific requirements.

## Federal Limit on Medical Flexible Spending Accounts (FSAs)

Effective January 1, 2013, the government will limit the amount of money an employee can set aside in a medical FSA. Currently, employers set the maximum amount. According to the 2010 McGraw Wentworth Mid-Market Group Benefits Survey, the median annual limit employers have been allowing is $3,500.

Many employers will need to reduce their annual limits when this aspect of health care reform becomes effective. The details of this change include:

- The change applies only to funds the employee deposits in the account. If an employer funds a portion of an employee's FSA with a non-elective contribution (meaning the employee has no other option but to take the funds as a deposit to the medical FSA), that employer-funded amount does not count toward the $2,500 limit.
- The $2,500 limit applies only to the individual employee. If the employee's spouse works at an organization that offers employees a medical FSA, the spouse could set aside up to $2,500 as well. If an employee and spouse work for the same organization, the employer can allow each to set aside $2,500, providing each one is eligible under the plan.
- The $2,500 limit will be adjusted annually according to the consumer price index. Unfortunately, the inflation rate for medical expenses is often higher than the inflation rate in other areas of the economy. If that remains the case, the value of the annual limit erodes over time because medical costs increase at a higher rate than the annual consumer price index increases.

Certainly, employers expect more IRS guidance on this newly imposed annual limit. Employers with non-calendar plan years are hoping for temporary guidance to help them make the change during their plan year. However, if the IRS does not issue this guidance, the plan can always adopt the $2,500 limit early to alleviate any concerns.

## Loss of Tax-Favored Status of Retiree Drug Subsidy (RDS)

As of January 1, 2013, corporations will have to pay tax on the retiree drug subsidies they receive from the government. Currently those subsidies are tax-free. The subsidies were meant to encourage employers to continue offering their Medicare-eligible retirees creditable prescription drug coverage (coverage as good as or better than Medicare Part D's standard benefit). This change will diminish the value of the retiree drug subsidy for organizations that must pay corporate taxes. It will not affect organizations that are not required to pay taxes.

Employers may wish to reconsider how they offer prescription drug benefits to their Medicare-eligible retirees. Following are two options:

1. An employer, if permitted and not locked in by a union agreement, could simply drop retiree prescription drug coverage. Many Medicare Part D plans are now available for retirees to purchase on their own. Typically, employers taking this route will set aside tax-favored funds in an HRA to help retirees pay Part D plan premiums.
2. An Employer Group Waiver Plan (EGWP) may also be feasible. Put simply, an employer purchases a prescription drug plan from a government-certified vendor. The vendor submits the claims directly to the government, and the government reimburses the plan in the same way it helps fund other prescription drug plans. This option may be more cost effective than the RDS (once your organization loses tax-favored status on the reimbursements).

Employers losing tax relief on retiree drug subsidies have time to investigate alternatives.

## Quality Information Reporting Requirements

Health care reform established a new quality reporting requirement for group health plans and health insurance issuers. The Secretary of the Department of Health and Human Services will issue regulations on the specifics of these requirements no later than March 23, 2012.

Group health plans and health insurance issuers must meet the reporting requirements. These requirements apply to plan benefits and provider reimbursement structures that:

- Improve health outcomes through quality reporting, effective case management, care coordination, chronic condition management, medication compliance initiatives, and medical homes.
- Prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional.

- Improve patient safety and reduce medical errors through the appropriate use of the best clinical practices, evidence-based medicine and health information technology under the plan.
- Implement wellness and health promotion strategies.

While these topics are wide-ranging, the reporting will collect relevant data to determine effective strategies health plans can use to improve health and quality of care.

More details of the new reporting requirement include:

- The report will be submitted to the DHHS and distributed to covered employees annually.
- The report must be available to enrolled employees at open enrollment.
- The Secretary of the DHHS will make the report public through a website.
- Regulations will include penalties for non-compliance; no penalties are directly stated in the health reform acts.
- The Secretary of the DHHS can make exceptions for group health plans that offer comprehensive wellness and prevention programs.

For a wellness or prevention program to qualify, the program cannot require participants to disclose:

- They have or are storing legal firearms or ammunition in their homes.
- They have, use, or store a legal firearm.

This reporting requirement should be interesting. Employers will need more specific information, but the government is hoping the reports will provide useful information on successful ways to manage cost, improve health or improve quality of care. Hopefully, this data will help the government in its long-term quest to improve the quality and reduce the cost of health care.

**Tax to Fund Comparative Effectiveness Studies**

The Health Care Reform Act also establishes the Patient-Centered Outcomes Research Institute. This new agency will conduct studies comparing the effectiveness of various treatments. It will be funded partially through fees from insurance carriers and employer group health plans. Insurance carriers will pay the fee for fully insured plans, and employers will pay the fee for self-funded plans. The fee will be calculated as follows:

- For each policy year ending after September 30, 2012, (and ending in 2013), the fee will be $1 each for the average number of lives the policy covers.
- For plan years ending after the fiscal year 2013, the fee will be $2 each for the average number of lives the policy covers.
- The fee ceases after September 30, 2019.

Excepted benefits under HIPAA are not subject to this fee. This means if you have dental or vision coverage that is separate from your health plan or your organization allows independent elections of this coverage, the fee will not apply for those plans.

For now, no details on the mechanics of reporting average enrollment or paying this fee have been released. Certainly, more regulations are expected.

The Patient-Centered Outcomes Research Institute will establish national priorities for research. It will fund comparative studies to help health insurance plans, patients, clinicians, purchasers and policy-makers make informed decisions. By researching data and publishing research results, the Institute will advance the quality and relevance of evidence on the most effective way to prevent, treat, monitor and manage diseases, disorders, and other health conditions. It will look at disease incidence across the country and analyze chronic conditions, gaps in evidence on clinical outcomes, and differences in medical approaches, care delivery and outcomes. It will also look for new methods that can improve patient health, well-being and the quality of care.

To qualify for funding, research projects will need to meet strict requirements. In addition, if the Institute funds a research study, it will post the results on the Internet.

These studies will provide valuable information for patients and providers. Hopefully, they will result in more effective, quality care with lower long-term costs.

**Health Insurer Executive Compensation Limits**

The Health Reform Act amended Section 162(m) of the Internal Revenue Code. Under the new amendment, health insurance companies must pay corporate taxes on executive salaries that exceed $500,000 a year. This change applies to taxable years beginning after December 31, 2012.

This provision does not explicitly limit executive pay. However, once this provision goes into effect, the health insurance carrier will not be able to deduct compensation over $500,000 as a business expense.

While this won't affect employers directly, it may affect health insurance carriers' ability to pay top-dollar for talent.

**Medicare Payroll Tax Increase for High Incomes**

Currently, employees pay Medicare Part A hospital insurance as part of FICA (1.45% of covered wages). Effective January 1, 2013, the Medicare tax increases to 2.35% on earnings **that exceed** the following thresholds:

- $200,000 (individuals)
- $250,000 (married filing jointly)
- $125,000 (married filing separately)

Employers must withhold 2.35% on any earnings that exceed $200,000. If an employee's earnings do not exceed $200,000, the employer continues to withhold the 1.45%. If the employee is married and filing jointly and the combined income exceeds $250,000, at tax time, the IRS will collect the additional 0.9% tax for the Medicare Part A increase only on the amount of combined earnings that exceeds $250,000.

Anyone whose income exceeds the above thresholds will also be charged an additional 3.8% tax on net investment income (for example, dividends or interest). This additional tax will be used to help fund Medicare Part A.

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The next issue of our *Reform Update* will address the latest guidance on claim appeals, new Q & A's and also new guidance on extending Section 105(h) non-discrimination rules to fully insured plans.