McGraw Wentworth

REFORM Update

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Our *Reform Updates* continue to address the key elements of health care reform that will affect employers in the coming years. In this issue, we will first review two new developments: new questions and answers posted on the DOL's website, and the delayed effective date for W-2 reporting.

Next, we will review the following key provisions included in health care reform:

- Increase in the threshold to deduct medical expenses
- Employer notice requirement regarding the availability of the Exchange
- Additional health plan requirements:
  - Prohibition of pre-existing condition limitations
  - Limit on length of new hire waiting period
  - Change to HIPAA non-discrimination rules
- Employer requirement to provide coverage documentation
- "Cadillac" Tax

These provisions of health care reform have future effective dates. At this point, employers have only the broad provisions of the health care reform statute as guidance. However, additional regulations are expected in the coming years that will provide more details to assist employers with compliance.

New Q & As

The Department of Labor continues to issue questions and answers to help employers and health plans properly implement the first wave of health reform requirements. The new questions and answers can be found at http://www.dol.gov/ebsa/faqs/faq-aca2.html. The issues addressed include:

- The impact of grandfathering when an employer restructures their contribution tiers. An employer that moves more than five percentage points of cost to employees from the cost sharing arrangement on March 23, 2010 would lose grandfathered status. The DOL provides an example of an employer who, on March 23, 2010, had a single/family contribution structure. If that employer changed contribution tiers to single, employee plus one, employee plus two and employee plus three or more, the family contribution percent on March 23 would need to be compared to the employee plus one, employee plus two and employee plus three or more contribution tiers. The single contribution would continue to be compared to the single contribution tier. When comparing the contribution percentages, if any category is more than 5% higher than the March 23rd contribution percent, the plan would lose grandfathered status.

If the plan adds new coverage tiers without eliminating or modifying previous coverage tiers, and the new coverage tiers cover individuals who were previously not covered under the plan, this change would not prompt a loss of grandfathered status. For example, if a plan with an employee-only coverage tier added a family coverage tier, this would not prompt the loss of grandfathered status.

- How wellness incentives may impact the grandfathered status of the health plan. Health plans can continue to offer incentives for wellness by providing premium discounts or enhanced benefits to reward healthy behaviors, using quality providers or incorporating evidence-based treatments. This is permitted providing these wellness initiatives comply with any applicable non-discrimination rules (HIPAA, state law or any other Federal law). However, these penalties or benefit differentials need to be taken into consideration in determining if the plan maintains grandfathered status. Unfortunately, the DOL did not provide any examples to assist employers in determining how to evaluate wellness incentives in terms of requirements to maintain grandfathered status.
- The practical implication of coverage rescissions. The guidance on coverage rescissions very broadly defines a rescission as a "termination of coverage with retroactive effect". The question discusses retroactive terminations of coverage in the normal course of business. The DOL notes the example provided in the rescission guidance: due to an administrative error a plan covered an employee who should have lost eligibility when dropping to part-time status, but coverage was continued with both the employee and employer making contributions. Once the employer discovered the error, coverage could only be terminated prospectively, not back to the date the employee started working part-time.

  Carriers have taken this broad interpretation and many are instituting prospective termination only policies, which is impractical due to the time it takes to process employment terminations. The government will not consider a retroactive termination of coverage a rescission if the employer discontinued taking contributions for the health plan after the termination of employment.

It appears the government will continue to post Q & As to assist with health care reform compliance.

Delay for W-2 Reporting

The IRS issued Notice 2010-69 recently that will basically delay the requirement to report the value of employer-sponsored group health coverage on employees' W-2s. Initially, the requirement applied to W-2s issued for 2011. The IRS Notice 2010-69 states the reporting requirement will not be mandatory for 2011. Employers can comply with the requirement voluntarily, but they are not required to. While it is not directly addressed, the W-2 reporting requirement will likely apply to 2012 W-2s.

The IRS issued the delay because employers had so many questions relating to this requirement. In addition, payroll vendors expressed concern over their ability to modify software to allow for the W-2 reporting.

The Notice does confirm the IRS intends to issue additional guidance to clarify this new requirement. In addition, they have also released a draft of the revised W-2. The draft of the new W-2 can be found at http://www.irs.gov/newsroom/article/0,,id=228881,00.html.

Increase in the Threshold to Deduct Medical Expenses

Effective January 1, 2013, the threshold to submit an itemized tax deduction for medical expenses will increase to 10% of adjusted gross income. This change will impact individuals who take an itemized tax deduction for medical expenses. Currently, medical expenses must exceed 7.5% of adjusted gross income in order to be deducted. As of January 1, 2013 that threshold increases to 10%.

This increase will have a delayed effective date for older taxpayers. The increase to 10% for the years 2013, 2014, 2015, and 2016 will not apply if a taxpayer or a taxpayer's spouse has attained age 65 by the close of the tax year. By January 1, 2017, the increase will impact all taxpayers.

Most individuals do not incur enough medical expenses during the year to exceed 7.5% of their adjusted gross income. This is one of the reasons employees embrace medical flexible spending accounts. By participating in the spending accounts, individuals can set aside money annually on a pre-tax basis to pay for eligible medical expenses.

This increase in threshold does not affect employers directly. However, many employers discuss this threshold when communicating the value of medical flexible spending accounts. If your communication materials include this information, it should be updated in 2013 to reflect the increase.

Employer Notice Requirement Regarding the Availability of the Exchange

The Fair Labor Standards Act was amended by health care reform to include an employer notice requirement regarding coverage options. Regulations will need to be issued to provide much of the details, but the health care reform acts contain a summary of the requirement. Employers will be required to provide each employee at the time of hire (or, with respect to current employees, no later than March 1, 2013) a written notice that:

- Informs the employee of the existence of the Exchange, including a description of the services provided by the Exchange and how an employee can contact the Exchange for assistance.
- Advises the employee that if the employer's plan share of the total allowed cost is less than 60% of such cost, that employee *may be* eligible for a premium tax credit and possibly a cost sharing reduction if the employee purchases coverage through the Exchange.
- Educates employees that if they choose to purchase a qualified health plan through the Exchange and the employer does not offer a free choice voucher, the employer contribution for coverage may be lost.

Future regulations will likely expand the information that needs to be provided in this notice. The health care reform acts did not include details or requirements for the delivery process. The government will likely release a model notice employers can use in order to create a compliant notice.

Additional Health Plan Requirements

Health care reform also includes a second wave of changes that will impact health plans in the future. The following plan changes will be required the first day of the first plan year on or after January 1, 2014:

- Prohibition of pre-existing condition limitations: Health plans will no longer be able to apply a pre-existing condition limitation for anyone covered by the plan.
- Limit on length of new hire waiting period: The government will limit the length of the new hire waiting period on group health plans to no longer than 90 days.

The government is likely to issue guidance in the future to assist employers in complying with these requirements.

Another change that may impact employers is a change to HIPAA non-discrimination rules. The health reform acts restate HIPAA non-discrimination rules. Basically, a group health plan or a health insurance carrier cannot establish eligibility rules based on health status-related factors for the employee and any eligible dependents. Health status-related factors include health status, medical conditions, claims experience, receipt of health care, genetic information, evidence of insurability, disability or any health status factor determined appropriate by the Secretary of Health and Human Services.

Special consideration is given to wellness programs, which are programs designed for health promotion or disease prevention. If an employer offers a premium discount, rebate or other reward simply for participating in the wellness plan, the conditions for a qualifying wellness plan do not need to be met. Employers must offer all similarly-situated employees the opportunity to participate in the wellness programs. The following are examples of what the health care reform acts deem as participation-type rewards:

- A program that reimburses all or a portion of the cost for a fitness club membership.
- A diagnostic testing program that provides a reward based on participation in the test, not on any test result.
- A program that encourages use of preventive care related to a health condition through a waiver of copayments or deductibles for the cost of certain items or services related to a health condition (for example, the waiver of office visit copays for prenatal care).
- A program that reimburses an individual for the cost of smoking cessation programs without regard to whether the individual quits smoking.
- A program that rewards individuals for periodically attending health education seminars or presentations.

However, different rules apply if a health plan wants to make a reward like a premium discount or improved benefits contingent upon achievement of a specific health factor. If the reward is to be conditioned upon the achievement of a health factor, HIPAA requires the program meet a number of requirements:

1. The program must be reasonably designed to promote health or prevent disease.
2. The program must give eligible individuals the ability to qualify for the reward at least once each year.
3. The program must offer a reasonable alternative for individuals to achieve the reward if achieving the initial health factor is unreasonably difficult due to a medical condition or deemed medically inadvisable. The plan can require a physician verification that achieving the specific health factor is unreasonably difficult or medically inadvisable in order to qualify for the reasonable alternative.
4. The program must disclose the terms of the plan including the availability of a reasonable alternative to achieve the reward.
5. The amount of the reward is limited to 20% of the value of employee-only coverage. If the wellness requirements are extended to spouse and/or children, then the reward can be equal to 20% of the employee plus one or family rate, depending on which members must achieve the health standards. The amount of the reward will be changed by the health care reform acts in 2014. Plans can increase the amount of the reward to 30% of the single, two person or family rates (whichever rates apply if wellness requirements are extended). The Secretary of Health and Human Services has the ability to increase the amount of the award to 50% in the future.

Health care reform is focused on providing incentives for individuals to maintain or improve their health. The ability to earn a significant financial reward for the achievement of a specific health factor provides a strong incentive for plan participants to improve their health.

Employer Requirement to Provide Coverage Documentation

When the “pay or play” requirements become effective on January 1, 2014, employers will be required to provide documentation of employee coverage. The health care reform acts added this documentation requirement to the Internal Revenue Code. Large employers (with 50 or more full-time employees) will be required to file an annual return that will need to contain, at a minimum, the following information:

- The name, date, and employer identification number of the filing employer.
- A certification as to whether the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored health plan.
- If the employer certifies that they did offer full-time employees and their dependents the opportunity to enroll, the employer must verify:
    - The length of any new hire waiting period that applies to coverage.

  - The months during the calendar year that coverage was available under the plan.
  - The monthly premium for the lowest cost option in each of the enrollment categories under the plan.
  - The employer's share of the total premium or cost of benefits that are provided by the plan.
  - The option for which the employer pays the largest portion of the cost of the plan, and the portion of the cost paid by the employer in each of the enrollment categories under that plan.
- Verification of the number of full-time employees for each month during the calendar year.
- The name, address and tax identification number of each full-time employee for each month during the calendar year and any months during which any such employees or dependents were covered by the health benefits.
- The name, address and phone contact information for the person completing the employer return.

The return will need to be filed on or before January 31st of the year following the calendar year for which the return is applicable.

The health care reform acts also extend the requirement to file this return to governmental entities.

More guidance will be needed to help employers complete this return properly. It is likely this return will incorporate an electronic filing process to expedite data collection; however, no details addressing the submission process were included in the health reform acts.

"Cadillac" Tax

Beginning in 2018, the IRS will levy an excise tax on high cost employer-sponsored health plan coverage. The tax applies if an employee is covered by an employer-sponsored health plan at any time during a taxable period and there is any *excess benefit* with respect to that coverage. A tax equal to 40% of the excess benefit will be imposed.

What is considered an excess benefit? Excess benefits are determined by the cost of the plan. The excess amount is determined by calculating the aggregate cost of employer-sponsored coverage and comparing that to the federally-set applicable dollar limit. In 2018, the annual federal limit is $10,200 for employee-only coverage and $27,500 for family coverage.

More details on this new tax for "Cadillac" benefits:

- The tax will be assessed against the insurance carrier if the group health plan is fully insured. If the plan is self-funded, the tax is assessed against the employer.
- The annual federal limits will be adjusted each year to account for inflationary increases.

- An increased annual limit is allowed for qualified retirees, employees engaged in a high risk profession, or employees employed to repair or install electrical or telecommunication lines.
    - Qualified retiree means any individual who is receiving coverage by virtue of being a retiree, has attained age 55, and is not entitled to benefits or eligible for enrollment under Medicare.
    - Employees employed in high risk professions include law enforcement officers, firefighters, emergency medical technicians, paramedics, first responders, long shore men, construction, mining, agriculture, forestry, and fishing industries. This term would also cover individuals who have retired from these high risk professions.

  The increased limit for qualified retirees and high risk professionals is $11,850 for self-only coverage and $30,950 for family coverage.
- Determination of the cost of coverage will include employee contributions for coverage.
- If the employer plan has an MSA (Medical Savings Accounts) or HSA (Health Savings Account) and the employer makes a contribution to these tax-favored accounts, the employer's contribution should be included in the cost for coverage.
- Governmental plans will also be responsible for this tax if they offer employer-sponsored plans that exceed the annual federal cost limits.

More details will be needed to adopt a process for reporting this potential excise tax. The effective date for this provision is so far in the future (2018), it is likely to change.

The government hopes that by encouraging employers to start cutting back these very rich plans, the added cost-sharing will impact health care utilization. Generally, as cost is shifted to employees, savings come not only from the cost-shift but from a reduction in utilization. If a member has to pay more for various services, it should impact their decision on how necessary health care services may be.

This *Reform Update* completes our initial overview of the key aspects of the health care reform acts that will impact employers. McGraw Wentworth will continue to publish *Reform Updates* whenever new guidance is issued to help clarify many of details still needed to comply with health reform. All current and previous editions are available at www.mcgrawwentworth.com.