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ASHHRA 48th ANNUAL CONFERENCE & EXPOSITION

The Beltway Crystal Ball: Current Outlook for Health Care Reform

September 22, 2012

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Overview

- The Court
- What the heck is going on in Washington?
- What will the elections mean?
- The hazy, cloudy future

Issues Before the Court

- Anti-Injunction Act
- Individual Mandate
- Severability
- Medicaid Expansion

Anti-Injunction Act

- Issue: Does the Anti-Injunction Act preclude resolution?
- Court Rules (9-0): Tax Anti-Injunction Act does not apply – Court can rule on the mandate at this time

Individual Mandate

- Issue: Is the Individual Mandate constitutional?
- Court Rules (5-4): Yes – Under the taxing powers of the Constitution
  - Not constitutional under Commerce Clause or Necessary and Proper Clause
- No need to rule on severability

Medicaid Expansion

- Issue: Are ACA provisions expanding Medicaid to cover those up to 133% FPL constitutional?
- Court Ruling: The federal government cannot withhold all state Medicaid funds when a state refuses to comply with the expansion. Only funds associated with the expansion can be withheld.

Congressional Response

- Use of appropriations process to limit funding for implementation of the law
- Use of the law's provisions as offsets to defund it
- Republican messaging: the largest tax increase on the middle class in history
- Democratic messaging: this law improves everyone's life

The White House Response

- Rapid issuance of regulations/guidance to implement programs and demonstrations
- Promotion of law's benefits with electorate
- Keeping the Democrats in line

Post-Election Scenarios

- (If) Obama – Continue on current track; keep the Congressional AND state Democrats in line
- (If) Romney – Carry out pledge to repeal law; opponents expected to target unpopular and controversial provisions of the law
- Congress – Depends on which party controls the Senate and by how many seats

The 2012 Version of "Romney Care"

- Give states responsibility, flexibility, and resources
- Reform tax code to promote individual ownership of health insurance
- Reform the medical liability system
- Make health care more like a consumer market and less like a government program

Post-Election Scenarios

- Executive Order
- Budget Reconciliation Repeal Strategy – securing 51 votes in the Senate (if Republican majority)
- Repeal and Replace – Republican alternative proposals to reform expected
- Law may play into entitlement reform
- Starve portions of the law of funding
- HHS becomes very flexible
- Don’t issue rules and regulations

The States – Medicaid Expansion

- As a result of the Court decision, states can elect not to expand Medicaid eligibility in 2014 to 133% FPL.
  - The feds will cover 100% of the cost until 2017, phasing down to 90% by 2020. This is still significantly above current federal Medicaid matching rates.
- Lack of Medicaid expansion will leave a segment of the population unable to attain Medicaid coverage or exchange subsidies.
- This would likely drive strong political opposition from consumer advocates and providers.

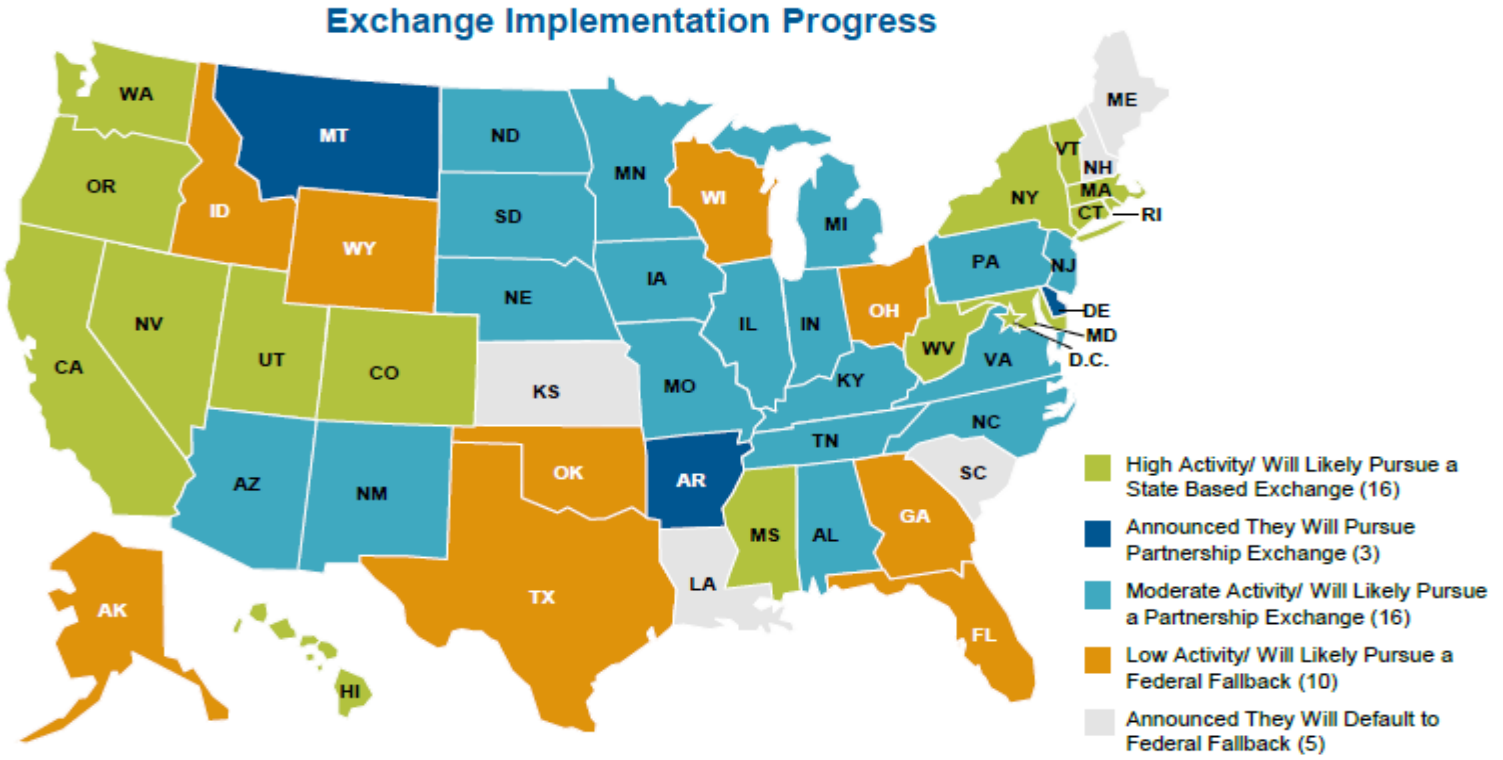
The States – Medicaid Expansion

- Many questions remain
  - Is it really optional now?
  - May states only expand partially?
  - May states opt in now and opt out later?
  - What are the ramifications of not participating?
  - How will states opt in or out? State plan amendments?
- Political fights
- Intense stakeholder lobbying and pressure

The States – Exchanges

- A key part of the ACA
- New competitive marketplaces in which individuals and small businesses can choose among health insurance plans
- ACA authorizes states to establish an exchange
- If states don't, feds will set up an exchange
- Questions around ability of feds to offer subsidies for federal exchange participation
- Premium assistance subsidies available to make sure that individuals and families do not spend more than a certain percentage of their income on health insurance; they come in the form of tax credits.

The States – Exchanges

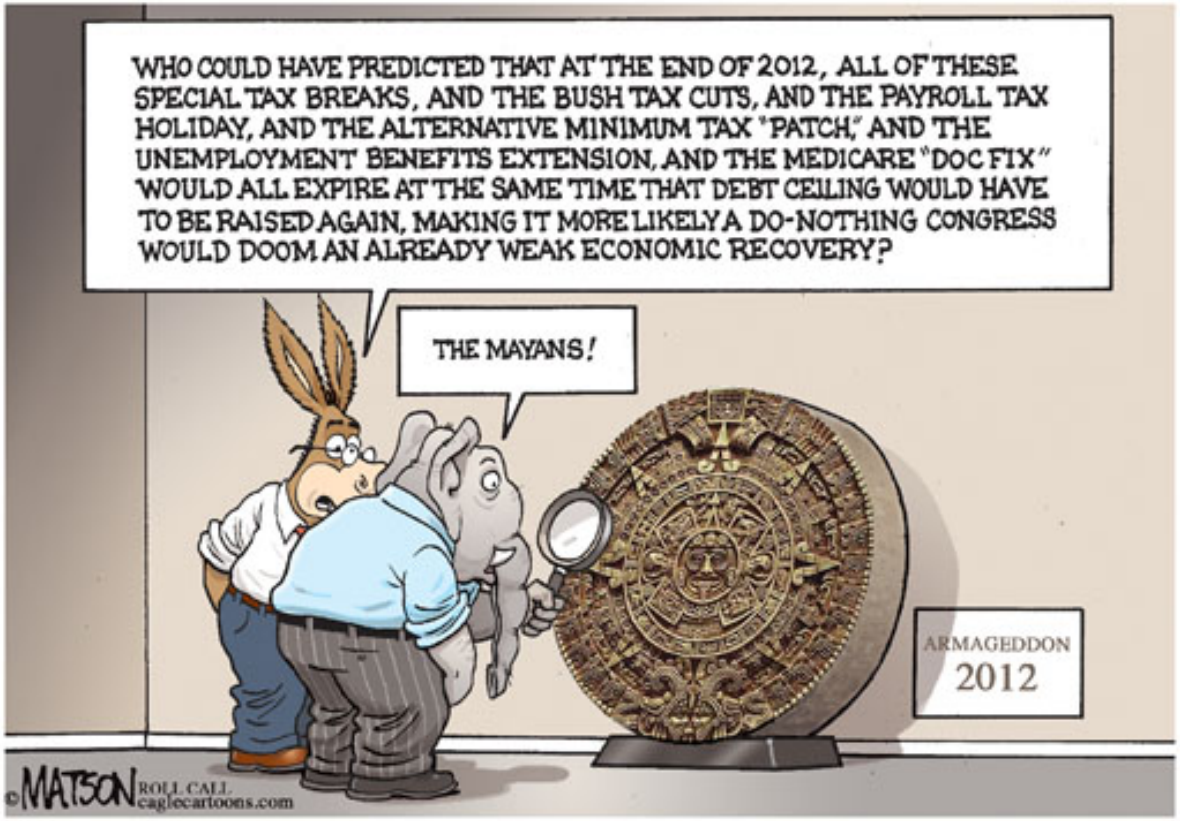


Source: Avalere Health *State Reform Insights*, June 2012; Assessment of exchange type based solely on Avalere analysis of implementation progress to date

The States – Decisions

- Must decide whether to participate in Medicaid expansion and state exchanges – states have much more power
- Timeline tight – even for those who bought in early
- States fear decline of federal funding to support expansion, given federal budget
- State health exchange development mediocre at best – possible implementation delays
- Some Governors have said no
- Many are considering their options
- Must work with state legislatures
- Feds are left with the carrot
  - Can deny other changes to state programs
  - Entice with funding and flexibility
  - Obama administration will not block grant program

The Congress – Post-election Lame Duck



How Does Sequestration Work?

- Budget Control Act of 2011 created the "sequestration"
- January 2, 2013: First automatic cuts, sequestration, of any amount less than $1.2 trillion not enacted by Congress
- Sequestration for Fiscal Years 2013-2021
  - Equal across-the-board spending cuts for defense and non-defense discretionary spending
  - Mandatory programs (e.g., Medicare maximum of 2%)
  - Currently operating under spending caps for Fiscal Year 2012 and Fiscal Year 2013

Sequestration by the Numbers

- Defense – $54.7 billion decrease per year (9% reduction)
- Non-defense – $54.7 billion decrease per year
  - Mandatory cuts – Approximately $16 billion
    - $10.8 billion in Medicare payments in 2013
    - $5.2 billion in cuts to other mandatory programs
  - Non Mandatory cuts – $38.6 billion

Federal Spending: The Bottom Line

- Discretionary vs. Entitlement Spending
- Trade-offs between “devil you know” (2%) vs. “devil you don’t know”
- Health care providers will continue to be “hit” with respect to cuts and “shared sacrifice”
- Legislating in “small bites” – no long-term decisions or actions
- Congress may push sequestration to “another day”

Conclusion

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Strategic Health Care Reform Workshop

September 22, 2012

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The Value Based Purchasing (VBP) Program

- The Patient Protection and Accountable Care Act ("PPACA" or "Health Reform") formalizes the Centers for Medicare & Medicaid Services ("CMS") initiative to tie reimbursement to performance
  - The VBP program transforms the current pay-for-reporting scheme to a pay-for-performance framework
- The VBP program rewards hospitals for quality care, rather than simply reducing reimbursements as a consequence of not reporting on quality measures
  - Hospitals that achieve certain performance standards or improve their performance will be eligible to receive incentive payments beginning in FY 2013

What Providers Are Not Affected by the VBP Program?

- The VBP program will initially apply to all hospitals except for:
  - Psychiatric hospitals
  - Rehabilitation hospitals
  - Hospitals whose inpatients are predominately under 18 years of age
  - Hospitals with an average inpatient length of stay greater than 25 days
  - Certain cancer treatment or research centers
  - Those that are subject to payment reductions relating to the Hospital Inpatient Quality Reporting (IQR) program
  - Those hospitals that are deficient in such a manner that poses immediate jeopardy to the health and safety of patients
  - Those hospitals for which there are not sufficient applicable measures for the performance period, as determined by the Secretary of HHS

Which Providers Are Affected by the VBP Program?

- The VBP program will not immediately apply to other healthcare providers, but PPACA provides for such a program in the future for ambulatory surgery centers, skilled nursing facilities, home health agencies and physicians

VBP Program Measures

- Hospital are NOW in the Performance Period for both Clinical Process and Patient Experience (April 1, 2012 – December 31, 2012)
- The Performance Period for Measures and Dimensions (the Outcome Domain) ended June 30, 2012
- Hospitals' "quality" will be measured by 12 clinical measures and 8 patient care experience measures
- To calculate a hospital's Total Performance Score, CMS has proposed to weight the clinical and patient care measures as follows: 70% to the clinical measures and 30% to the patient care measures

VBP Program Measures

- Clinical measures consist of quality measures most hospitals have been reporting through the Hospital IQR program
  - Specific measures are categorized under the following headings:
    - Acute Myocardial Infarction
    - Heart Failure
    - Pneumonia
    - Healthcare-Associated Infections
    - Surgical Care Improvement

VBP Program Measures

- For FY 2014, CMS has proposed to adopt additional clinical measures, including:
  - Three mortality outcome measures
  - Eight hospital-acquired condition measures
  - Nine Agency for Healthcare Research and Quality measures

VBP Program Measures

- Patient care experience measures are based on patient responses to 27 questions about their recent hospital stay
  - The questions focus on the following subjects:
    - Communications with nurses
    - Communications with physicians
    - Responsiveness with hospital staff
    - Pain management
    - Cleanliness of hospital environment
    - Quietness of hospital environment
    - Communication about medication
    - Communication about discharge information
    - Overall rating of hospital
    - Whether patient would recommend hospital

Potential Financial Impact of VBP Program

- Because PPACA and the VBP incentive payments must be budget neutral, HHS is required to reduce the base operating diagnosis-related group ("DRG") payment to each hospital
- In FY 2013, hospitals will experience a 1% Medicare holdback
- By 2017, up to 2% of a hospital's Medicare reimbursement will be at stake

Potential Financial Impact of VBP Program

- The at-risk reductions in DRG payment and concomitant incentive payments are scheduled as follows:

Fiscal Year	Value-Based Purchasing
2013	1%
2014	1.25%
2015	1.5%
2016	1.75%
2017	2%
2018	2%
2019	2%

Potential Financial Impact of VBP Program

- VBP payment is based on the hospital's Total Performance Score and the total amount of incentive dollars available to be paid to hospitals
- CMS has proposed using a linear regression formula under which those hospitals with higher scores will receive a larger incentive payment than those with lower scores
  - Those with scores less than zero will not receive an incentive payment and will see an overall net loss in reimbursements
  - Those hospitals with lower scores may not recover in incentive payments the total amount lost through the reduction in DRG payments

Potential Employee Relations/Union Vulnerability Issues

- VBP Program:
  - Hospitals will closely scrutinize their patient care environment to maximize their clinical and patient experience scores. Direct care providers are likely to experience some level of change in the work they do, how they do it and how they interact with patients
  - From an employee's perspective, the patient experience measure may seem like an intrusion into their area of expertise or a challenge to their professionalism. Employers should anticipate employee uncertainty, insecurity and/or resistance

Potential Employee Relations/Union Vulnerability Issues

- Loss of Health Coverage:
  - By some estimates, up to 30-40% of employers may choose to forgo providing health coverage, accept the PPACA-provided penalty and shift their workforce's health coverage to state health insurance exchanges
  - Employers that continue to offer health insurance may find it necessary to make significant changes in the health benefits they offer and the employee cost of health insurance
  - This change in health insurance benefits will likely be perceived by employees as a benefit reduction and cause employee resentment and dissatisfaction

Potential Employee Relations/Union Vulnerability Issues

- The HCAHPS Survey
  - Reimbursement will be affected by HCAHPS Survey results. Providers will scrutinize these patient satisfaction data. The expectations for performance by direct care staff will increase measurably
  - On a unit-by-unit basis, registered nurses and other staff will be held accountable for
    - treating patients with courtesy and respect
    - listening carefully to patients
    - explaining things in a way patients can understand

Potential Employee Relations/Union Vulnerability Issues

- On a unit-by-unit basis, registered nurses and other staff will be held accountable for (cont'd)
  - meeting patient expectations on call button responsiveness
  - assisting patients to use bathroom or bedpan
  - controlling patients' pain
  - communicating with patients about medications
  - inquiring about post-discharge need for assistance
  - providing written information about post-discharge symptoms or potential health problems
  - keeping patient rooms and bathrooms clean
  - keeping it quiet at night near patient rooms

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Appendix D

CAHPS® Hospital Survey

(English)

CAHPS® Hospital Survey

SURVEY INSTRUCTIONS

- You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient.
- Answer all the questions by checking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☐ Yes
☑ No → *If No, Go to Question 1*

You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

Please note: Questions 1-22 in this survey are part of a national initiative to measure the quality of care in hospitals. OMB #0938-0981

Please answer the questions in this survey about your stay at the hospital named on the cover. Do not include any other hospital stay in your answers.

YOUR CARE FROM NURSES

1. **During this hospital stay, how often did nurses treat you with courtesy and respect?**
   - 1 ☐ Never
   - 2 ☐ Sometimes
   - 3 ☐ Usually
   - 4 ☐ Always

2. **During this hospital stay, how often did nurses listen carefully to you?**
   - 1 ☐ Never
   - 2 ☐ Sometimes
   - 3 ☐ Usually
   - 4 ☐ Always

3. **During this hospital stay, how often did nurses explain things in a way you could understand?**
   - 1 ☐ Never
   - 2 ☐ Sometimes
   - 3 ☐ Usually
   - 4 ☐ Always

4. **During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?**
   - 1 ☐ Never
   - 2 ☐ Sometimes
   - 3 ☐ Usually
   - 4 ☐ Always
   - 9 ☐ I never pressed the call button

YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with courtesy and respect?

   1 ☐ Never
   2 ☐ Sometimes
   3 ☐ Usually
   4 ☐ Always

6. During this hospital stay, how often did doctors listen carefully to you?

   1 ☐ Never
   2 ☐ Sometimes
   3 ☐ Usually
   4 ☐ Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?

   1 ☐ Never
   2 ☐ Sometimes
   3 ☐ Usually
   4 ☐ Always

THE HOSPITAL ENVIRONMENT

8. During this hospital stay, how often were your room and bathroom kept clean?

   1 ☐ Never
   2 ☐ Sometimes
   3 ☐ Usually
   4 ☐ Always

9. During this hospital stay, how often was the area around your room quiet at night?

   1 ☐ Never
   2 ☐ Sometimes
   3 ☐ Usually
   4 ☐ Always

YOUR EXPERIENCES IN THIS HOSPITAL

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?

    1 ☐ Yes
    2 ☐ No → If No, Go to Question 12

11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

    1 ☐ Never
    2 ☐ Sometimes
    3 ☐ Usually
    4 ☐ Always

12. During this hospital stay, did you need medicine for pain?

    1 ☐ Yes
    2 ☐ No → If No, Go to Question 15

13. During this hospital stay, how often was your pain well controlled?

    1 ☐ Never
    2 ☐ Sometimes
    3 ☐ Usually
    4 ☐ Always

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

    1 ☐ Never
    2 ☐ Sometimes
    3 ☐ Usually
    4 ☐ Always

15. **During this hospital stay, were you given any medicine that you had not taken before?**

[1] ☐ Yes
[2] ☐ No → **If No, Go to Question 18**

16. **Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?**

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

17. **Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?**

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

WHEN YOU LEFT THE HOSPITAL

18. **After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?**

[1] ☐ Own home
[2] ☐ Someone else's home
[3] ☐ Another health facility → **If Another, Go to Question 21**

19. **During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?**

[1] ☐ Yes
[2] ☐ No

20. **During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?**

[1] ☐ Yes
[2] ☐ No

OVERALL RATING OF HOSPITAL

Please answer the following questions about your stay at the hospital named on the cover. Do not include any other hospital stays in your answer.

21. **Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?**

[00] ☐ 0 Worst hospital possible
[01] ☐ 1
[02] ☐ 2
[03] ☐ 3
[04] ☐ 4
[05] ☐ 5
[06] ☐ 6
[07] ☐ 7
[08] ☐ 8
[09] ☐ 9
[10] ☐ 10 Best hospital possible

22. **Would you recommend this hospital to your friends and family?**

- [1] ☐ Definitely no
- [2] ☐ Probably no
- [3] ☐ Probably yes
- [4] ☐ Definitely yes

ABOUT YOU

There are only a few remaining items left.

23. **In general, how would you rate your overall health?**

- [1] ☐ Excellent
- [2] ☐ Very good
- [3] ☐ Good
- [4] ☐ Fair
- [5] ☐ Poor

24. **What is the highest grade or level of school that you have completed?**

- [1] ☐ 8th grade or less
- [2] ☐ Some high school, but did not graduate
- [3] ☐ High school graduate or GED
- [4] ☐ Some college or 2-year degree
- [5] ☐ 4-year college graduate
- [6] ☐ More than 4-year college degree

25. **Are you of Spanish, Hispanic or Latino origin or descent?**

- [1] ☐ No, not Spanish/Hispanic/Latino
- [2] ☐ Yes, Puerto Rican
- [3] ☐ Yes, Mexican, Mexican-American, Chicano
- [4] ☐ Yes, Cuban
- [5] ☐ Yes, other Spanish/Hispanic/Latino

26. **What is your race? Please choose one or more.**

- [1] ☐ White
- [2] ☐ Black or African American
- [3] ☐ Asian
- [4] ☐ Native Hawaiian or other Pacific Islander
- [5] ☐ American Indian or Alaska Native

27. **What language do you mainly speak at home?**

- [1] ☐ English
- [2] ☐ Spanish
- [3] ☐ Some other language (please print): _____

THANK YOU

Please return the completed survey in the postage-paid envelope

Potential Union Vulnerability Issues

- VBP Program
  - Providers will be under substantial pressure to increase efficiency, productivity, quality and patient satisfaction
  - As a result, every covered provider will likely need to make changes in its operations and, in many cases, these changes will be extensive
  - These cascading pressures and demands could manifest in employee dissatisfaction, frustration and/or disengagement
  - These negative employee perceptions can adversely affect the provider's goals on quality and patient satisfaction and can lead to union organizing vulnerability
  - Providers are likely to find it necessary to adjust and/or reduce staffing levels
  - Retirement plan, health insurance and wage increases will be analyzed to determine where and how costs can be controlled

Potential Union Vulnerability Issues

- Assess Union Vulnerability
  - In addition to any dissatisfaction associated with the implementation of new practices per the VBP program or loss of health coverage, providers should determine whether any other factors may contribute to a union-friendly workforce

Other Employee Relations Challenges

- For non-acute cure hospitals, the National Labor Relations Board recent decision in *Specialty Healthcare*. (*Specialty Healthcare and Rehabilitation Center of Mobile*, 357 NLRB No. 83 (2011)) makes it substantially easier for unions to organize employees. The decision allows unions to seek micro-bargaining units, which can lead to more units and smaller units than the NLRB has ever permitted previously.

Other Employee Relations Challenges

- The suspended (for now) NLRB plan to allow “ambush” elections
- The suspended (for now) NLRB requirement that all employers post notices informing employees of their right to unionize

What HR Leaders Should Consider Now:

- Develop a comprehensive employee relations strategy to educate all engaged parties about the impact of Health Care Reform (HCR) on the provider, the patient and employees
  - Senior Leadership and the Board must understand
    - The potential negative impact of HCR on employee engagement and satisfaction
    - The importance of developing a comprehensive strategy to communicate, educate and engage employees regarding HCR and how it will affect the provider, employees' own work responsibilities and their critical roles

What HR Leaders Should Consider Now:

- Employees should understand:
  - The numerous ways in which HCR will affect the provider financially
  - How providers will be held accountable for quality and patient satisfaction
  - How and why HCR will impact providers' expectations and demands of employees, particularly direct care staff

Questions/Comments

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Employee Benefit Issues Under Health Care Reform Following Supreme Court Decision

September 22, 2012

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Supreme Court Decision

- Anti-Injunction Act (9-0) - Tax Anti-Injunction Act does not apply – Court can rule on the mandate at this time
- Individual Mandate (5-4) Upheld under the taxing powers of the constitution (not constitutional under Commerce Clause or Necessary and Proper Clause)
- Severability (no need to rule)
- Medicaid Expansion - The federal government cannot withhold all state Medicaid funds when a state refuses to comply with the expansion. Only funds associated with the expansion can be withheld

Next Steps for Plan Sponsors
2012 - 2014

Next Steps for Plan Sponsors for 2012

- Summary of Benefits and Coverage
- Advance Notice of Material Modification
- W-2 Reporting
- Research Trust Fund Fee
- Medical Loss Ratio Rebates

Next Steps for Plan Sponsors for 2013

- $2,500 limit on participant contributions to Health FSAs
- Notice of Insurance Exchanges
- Increase of the FICA Medicare tax rate

Next Steps for Plan Sponsors for 2014

- Elimination of Excessive Waiting Periods and Pre-Existing Condition Exclusions
- Wellness Rewards
- Employer Shared Responsibility Mandates
- Automatic Enrollment
- Coverage Reporting
- Limitation on Cost Sharing
- Exchanges for Small Employers

Summary of Benefits and Coverage

Background and Purpose of SBC

- Group health plans will be required to provide a “summary of benefits and coverage” (SBC) to participants and beneficiaries
- Affects employers that sponsor group health plans, designated plan administrators and insurers
- Provides participants and beneficiaries clear and understandable information about their plans in uniform, summary format, allowing them to “comparison shop”

Effective Dates

- The first day of the first open enrollment period that begins on or after September 23, 2012
  - A health plan may have to provide its SBC(s) to participants and beneficiaries as early as October or November, 2012
- For mid-year enrollees, the first day of the first plan year that begins on or after September 23, 2012
- The regulations become effective for disclosures by insurers to plans beginning on September 23, 2012

Responsible Parties

- In the case of an insured group health plan
  - Insurers are required to distribute the SBC to the group health plan (i.e., the plan sponsor), and
  - The group health plan and the insurer are both required to distribute the SBC to plan participants and beneficiaries
    - One party's compliance covers all, so consider assigning responsibility
- In the case of a self-insured group health plan, the plan's designated plan administrator is responsible

Plans Subject to SBC Requirements

- SBC is not required for:
  - Stand-alone dental and vision plans,
  - Health flexible spending arrangements (health FSAs) that are "excepted benefits" under HIPAA, and
  - Health savings accounts
- Health reimbursement arrangements (HRAs) are subject to the SBC requirements
- A separate SBC is not required for a non-excepted health FSA or HRA, unless it is a stand-alone plan

Distribution Timing Requirements

- Insurers to Group Health Plans
  - Upon receipt of an application by the plan for health coverage
  - Upon renewal
- Group Health Plans and/or Insurers to Participants and Beneficiaries
  - At enrollment
  - To special enrollees
  - At renewal or reenrollment
  - Upon request
  - Material modification

SBC Content Requirements

- Uniform definitions of standard insurance and medical terms
- Description of the coverage
- Exceptions, reductions, and limitations on coverage
- Cost-sharing provisions
- Renewability and continuation of coverage provisions
- Coverage examples illustrating common benefits scenarios
- Statement that the SBC is only a summary and that the plan or policy controls
- Contact information for questions
- Internet address for obtaining a list of network providers
- Internet address for more information about prescription drug coverage
- Information about the uniform glossary

SBC Content Requirements

- Separate SBC applies to each benefit package option
- May combine coverage tiers (e.g., single, family) in a benefit option's SBC if information is understandable
- If SBC covers multiple coverage tiers, then examples are based on single coverage level

Uniform Glossary Requirements

- Glossary of definitions of insurance, medical, and other terms
- Must be presented in a uniform format and using terminology that is understandable by the average plan participant and beneficiary
- Must make the uniform glossary available upon request within seven business days
- Cannot be modified in any way

SBC Format

- Must be:
  - In a uniform, easy-to-understand format
  - Culturally and linguistically appropriate (i.e., may be required to be translated into a foreign language)
  - No more than four double-sided pages in length
  - In at least 12-point font
- SBC may be provided in combination with an SPD (SBC at beginning)
- Agencies have created an SBC template, which cannot be modified, except in limited circumstances
  - http://www.dol.gov/ebsa/healthreform/index.html

Distribution of SBC

- Distribute a single SBC to a family unless any beneficiary is known to reside at different address
- SBC may be distributed in paper form or, if certain requirements are met, electronically

Electronic Distribution of SBC

- For employees eligible but not enrolled, electronic SBC permitted if:
  - Format is readily accessible
  - SBC is provided in paper upon request
  - If posted on Internet, plan or insurer notifies the individual in paper (e.g., postcard) or email that the documents are available on the Internet, address and that paper form is available upon request
- For employees enrolled, pursuant to DOL's electronic distribution safe harbor
- New safe harbor permits electronic distribution of SBC in connection with online enrollment or re-enrollment

Consequences of Noncompliance

- A penalty of up to $1,000 for each failure to provide an SBC to an individual and/or an excise tax of up to $100 a day, for each affected individual
- No penalties imposed during the first year on plans or insurers that are working diligently and in good faith
- If another party has contractually assumed responsibility to complete or deliver the SBC, the plan or insurer generally is not subject to penalties for SBC failures
  - Must continue to monitor the other party's performance

Advance Notice of Material Modifications

Advance Notice of Material Modifications

- If a plan or insurer makes a mid-year plan change that is a material modification that would affect the SBC content, notice must be provided to enrollees at least 60 days in advance of the effective date of the change

Form W-2 Reporting

W-2 Reporting

- Does the reporting of employer-sponsored group health plan coverage create additional tax?
  - Per the IRS, the reporting is for the employees' information only
  - W-2 Reporting may be basis for assessing Cadillac tax
    - Cadillac 40% excise tax on value of employer-provided coverage which exceed certain thresholds
    - Effective 2018
- W-2 Guidance: IRS Notices 2011-28 and 2012-9

W-2 Reporting

- What must be reported
  - Aggregate cost of applicable employer-sponsored coverage
    - Report Employee and Employer portions
      - Include employee cost regardless if pre-tax or after-tax
    - Report coverage of the employee and any person covered by the plan because of a relationship to the employee
      - Includes dependents and domestic partners
      - Include any portion of cost that is includible in employee's gross income
- Mechanics of Reporting
  - Report cost of coverage on W-2, Box 12 using Code DD

W-2 Reporting

- What must be reported?
  - Coverage **Includes**:
    - Medical Coverage
    - Dental Coverage (if integrated with group health plan)
    - Vision Coverage (if integrated with group health plan)
    - Coverage for EAP, wellness program and on-site medical clinics if the coverage under the program is a group health plan
      - Reporting of cost of EAP, wellness program and on-site medical clinics is NOT required if the employer does not charge a premium with respect to that type of coverage under COBRA

W-2 Reporting

- Who must report?
  - All employers to the extent the employer provides applicable employer sponsored coverage under a group health plan
    - Includes: Government, churches, religious organizations and employers not subject to COBRA continuation coverage
      - Note: Exclusion for certain types of coverage
    - Excludes: Federally Recognized Indian tribal government
    - Transition relief for small employers (filing less than 250 Form W-2)
  - Employees of more than one employer
      - Each employer must report cost of coverage
        - » Exception: Common Paymaster of related employers

W-2 Reporting

- When is the reporting required?
  - Voluntary Early Reporting
    - Employer may but is not required to include cost on Forms W-2 for 2011 (received by employees in 2012)
  - Mandatory Reporting
    - Reporting is mandatory for eligible employers and applies to Form W-2s issued for 2012 (received by employees in 2013)
    - Small employer transition relief for 2012 Forms W-2 (received by employees in 2013)
      - Employers filing less than 250 Form W-2s for the preceding calendar year
      - Not required to report cost of coverage until issuance of additional guidance by IRS

W-2 Reporting

- Mechanics of Reporting
  - Report cost of coverage on W-2, Box 12 using Code DD
  - How to treat terminated employees?
    - Employer may apply any reasonable method
    - Employer has the option to report cost of COBRA coverage or cost of coverage received before termination
    - Must be consistent for all employees terminated during the same plan year
    - If terminated employee requests W-2 before end of calendar year, employer not required to report cost of coverage
      - 2012 transition rule pending additional guidance

W-2 Reporting

- Mechanics of Reporting, cont.
  - Employer is not required to issue Form W-2 to include cost if Form W-2 not otherwise required to be issued
    - Example: Retiree or former employee who received no compensation
  - Cost not required to be reported on Employer's Form W-3

W-2 Reporting

- Employer Sponsored Coverage Does Not Include:
  - Dental and vision coverage (when not integrated with a group health plan)
  - Most HIPAA-excepted benefits (e.g., accident only coverage, workers compensation, specified disease or illness coverage, fixed indemnity coverage)
  - Long-term care coverage
  - Contributions to HSAs and Archer MSA
  - Cost of coverage under HRA
  - Cost of coverage under self-insured group health plan that is not subject to federal continuation coverage (e.g., church plan that is self-insured)
  - Health care FSA deferrals (generally excluded)
    - Exception for employer provided match or flex credits: look at total employee deferral election (premiums & FSA) and compare to total FSA amounts available; if total FSA amount higher, difference reported

W-2 Reporting

- Methods of Calculating Cost
  - COBRA Applicable Premium Method
    - Report cost for a period that equals the COBRA applicable premium for that coverage
  - Premium Charged Method
    - Use this method to determine cost of coverage for employee covered by employer's insured plan
    - Apply premium charged by insurer for employee's coverage

W-2 Reporting

- Methods of Calculating Cost, cont.
  - Modified COBRA premium method
    1. If Employer subsidizes the cost of COBRA coverage: Use a reasonable good faith estimate of the COBRA premium; or,
    2. If the current year COBRA premium is equal to a prior year COBRA rate then Employer can use prior year COBRA rate to report the cost of coverage in the current year.

W-2 Reporting

- Methods of Calculating Cost, cont.
  - Employer must take into account employee changes in coverage
    - Addition or loss of spousal/dependent coverage
    - Cost under the plan decreases or increases
    - Employer may use reasonable method to calculate reportable cost

Patient-Centered Outcomes Research Trust Fund Fee

Patient-Centered Outcomes Research Trust Fund Fee

- PPACA created non-government entity (Patient-Centered Outcomes Research Institute) to review, evaluate and compare clinical effectiveness research (on medical treatments, services, procedures, drugs and other strategies)
- Proposed rules issued April 12th
- Paid for by annual fee charged to insured and self-insured plans for plan years ending on or after October 1, 2012 and before October 1, 2019
  - For calendar year plan, the fee applies for plan years 2012 through 2018
- Fee imposed on issuer (insured plans) and plan sponsor (self-funded plans)

Patient-Centered Outcomes Research Trust Fund Fee

- Includes:
  - Major medical plan
  - Retiree medical plan
- Excludes
  - HRA integrated with self-insured medical plan
  - Excepted benefits under HIPAA (stand-alone dental, vision, certain health flexible spending accounts)
  - Employee assistance program
  - Disease management program or wellness program that does not provide significant benefits in the nature of medical care or treatment

Patient-Centered Outcomes Research Trust Fund Fee

- Calculation Fee equals $2 ($1 for 2012) x average number of covered lives; beginning in 2014, fee increases based on increases in the projected per capita amount of National Health Expenditures

Patient-Centered Outcomes Research Trust Fund Fee

- Mechanics
  - File IRS Form 720 “Quarterly Federal Excise Tax Return” by July 31 of each year for the plan year that ends during the preceding year
    - first filing is due July 31, 2013
    - IRS encourages electronic filing
  - Payment due annually by July 31
  - Must identify “plan sponsor” (as identified in plan document, or if not identified, each employer participating will have to file for its own employees)

Medical Loss Ratio (MLR) Rebates

MLR Requirements

- MLR standards apply to health insurance issuers
  - MLR is the percentage of premiums that insurers spend on medical care; reserves limited percentage for administrative expenses
- Insurers must report to HHS for each plan year an accounting for costs
- In some cases, must provide rebates to policyholders if MLRs are less than
  - 85% in large group market
  - 80% in small group and individual markets
  - Required MLR may be higher in some states

MLR Rebates

- Issuers file reports with HHS by June 1 following the end of a MLR reporting year
- Rebates are provided by August 1
- Rebates are provided to “policyholder”
  - Typically the employer, plan sponsor
  - May be the plan or plan’s trust
- Issuer must send notice to each participant if a rebate is paid

MLR Rebates – ERISA and Tax Implications

- Evaluate whether rebates are plan assets
- If so, fiduciary duty rules apply to treatment of rebates
- Address rebates timely – use within 3 months of receipt to avoid trust and reporting requirements
- Tax consequences may apply

Next Steps - 2013

$2,500 Limit on Participant Contributions to Health FSAs

$2,500 Health FSA Limit

- Effective 1/1/13 Health FSA contributions limited to $2,500 for “any taxable year”
- Applies to participant contributions only, not employer contributions to Health FSA
- Taxable year usually means calendar year, not plan year
- Most plans that began January –June 2012 already amended for $2,500 limit and participant elections have already been made

$2,500 Health FSA Limit

- On 5/30/12 – IRS Notice 2012-40 provided:
  - Taxable year = plan year
  - Limit doesn't apply to plan years that begin before 2013
  - Plan amendments need to be made by 12/31/14
  - Grace period coordination relief
  - Relief for contributions in excess of $2,500 due to "reasonable mistake"

Notice of Insurance Exchanges

Notice of Insurance Exchanges

- Employers must provide to employees a written notice describing the exchanges and employee's potential eligibility for premium credits
- Effective March 1, 2013

Increase of the FICA Medicare Tax Rate

Increase of the FICA Medicare Tax Rate

- The employee portion of the hospital insurance tax part of FICA, currently 1.45% of covered wages, will be increased by 0.9% on wages that exceed $200,000 ($250,000 for married couples filing jointly)

Next Steps - 2014

Elimination of Excessive Waiting Periods and Pre-Existing Condition Exclusions

Elimination of Excessive Waiting Periods and Pre-Existing Condition Exclusions

- Plans cannot have a waiting period for eligibility that exceeds 90 days or impose any pre-existing condition exclusions

Wellness Rewards

Wellness Rewards

- A reward for participation in a wellness program that requires an individual to satisfy a standard related to a health status factor may not exceed 30% (increased from the current 20% maximum) of the cost of employee-only coverage under the health plan

Employer Shared Responsibility Mandates

Employer Shared Responsibility Mandates

- Starting in 2014: Penalties apply to employers with 50 "Full-Time Employees"
  - "No Coverage" Penalty
  - "Unaffordable Coverage" Penalty
- Free Choice Vouchers – ***Eliminated***
- IRS Notice 2011-36: *proposed* approach to determine FTE status
- IRS Notice 2011-73: Potential safe harbor (use **wages paid** by employer (as reported in Box 1 of Form W-2) instead of **household income**)

Employer Shared Responsibility Mandates

- When Do The Penalties Apply?

1. FTE who obtains coverage on the exchange **AND**
2. FTE has *household* income in excess of 100% but not in excess of 400% of FPL **AND**
3. FTE receives either a premium tax credit or cost-sharing assistance **AND**

4A. FTE does not have opportunity to enroll in employer coverage, then "no coverage" penalty applies **OR**

4B. FTE has access to coverage, but has to pay more than 9.5% of *household* income or, if insured, the coverage does not provide a minimum value, then "unaffordable coverage" penalty applies

Employer Shared Responsibility Mandates

- How Much Is the Penalty?
  - "No Coverage" Penalty: ($2000/FTE/year)
    - Based on ALL FTEs (not just those obtaining coverage on the exchange)
    - No penalty for first 30 FTEs or for any non-FTEs
  - "Unaffordable Coverage" Penalty: ($3000/FTE/year)
    - Based only on the number of FTEs who actually receive federal premium assistance
    - Maximum penalty = no coverage penalty amount
- Penalty is assessed on a monthly basis (i.e., for each month any FTE enrolls in and receives a subsidy)

Employer Shared Responsibility Mandates - Who Is a Full-Time Employee?

- One Potential Approach (*Proposed* IRS Guidance - IRS Notice 2011-36):
  - "Common law" employee (no leased employees)
  - Average of 30 hours/week or 130 hours/month (52x30/12 = 130)
  - "Hours of service" – similar to existing DOL guidance
    - Each hour EE paid or entitled to payment for the performance of duties and each hour EE paid or entitled to payment on account of vacation, holiday, illness, etc.
    - If hourly EE, look at actual hours
    - If salaried EE, could apply equivalency (8 hours/day or 40 hours/week)

Employer Shared Responsibility Mandates - Is the Penalty *Really* Assessed Monthly?

- One Potential Approach (*Proposed* IRS Guidance): Look Back/Stability Period
  1. Look at each employee's average hours over a defined measurement period (3-12 months)
  2. Calculate the employee's average hours for that period
  3. Determine whether the employee is full time (i.e., averages 30 hours/week)
  4. Apply that determination for the prospective "stability" period
     - If employee is an FTE during the measurement period, then treated as FTE for the subsequent stability period (at least 6 months; at least as long as the measurement period)
     - If employee is <u>not</u> an FTE, stability period cannot exceed the measurement period

Employer Shared Responsibility Mandates - Recent IRS Notice 2012-17

- In 2011, IRS requested comments on this proposal and alternatives
- IRS intends to issue guidance regarding use of employee's Box 1 Form W-2 wages as safe harbor to determine *household* income
- To determine if **existing** employees are FTEs, IRS still intends to issue guidance on safe harbor approaches (i.e., look back/stability period)

Employer Shared Responsibility Mandates - Recent IRS Notice 2012-17

- To determine if **new** employees are FTEs, IRS intends to issue guidance:
  - Providing for no penalty if coverage is not offered to a new employee during the first 90 days
  - Giving employers the first 3-6 months (depending on the circumstances) to determine if new employees are FTEs
    - If newly-hired employee is reasonably expected to work full-time on an annual basis and does work full-time during first 3 months = FTE after first 3 months
    - If can't determine if newly-hired employee is expected to work full-time annually, then employers will have 3 (and maybe 6) months to make this determination

Employer Shared Responsibility Mandates - Other PPACA Clarifications in IRS Notice 2012-17

- No requirement that any employer offer health coverage to any part-time employee (ok to limit eligibility to just FTEs)
- Small employers won't incur a penalty if they choose not to offer coverage to any employee – but large employers (over 50 FTEs) will
- Still can have coverage waiting period (up to 90 days)

Automatic Enrollment

Automatic Enrollment

- Automatic Enrollment Notice:
  - Applicable for employers with more than 200 full-time employees
  - Employer must automatically enroll new **full-time** employees in one of the available health plans and continue enrollment of **current employees**
  - "Adequate notice" required
  - Must provide opportunity for employee to opt out of any coverage in which auto enrolled
  - In late 2010 – IRS said compliance not required until regulations are issued (expected by 2014)
  - Recent IRS Notice 2012-17 says regulations "will not be ready to take effect by 2014"

Coverage Reporting

Coverage Reporting

- Employers must file an annual return with the government that certifies whether full-time employees have the opportunity to enroll in minimum essential coverage

Limitation on Cost Sharing

Limitation on Cost Sharing

- Deductibles under plans cannot exceed $2,000 (for single coverage) and $4,000 (for family coverage). Plans' annual out-of-pocket requirements (deductible, coinsurance, copayments, etc.) cannot exceed those applicable to health savings accounts in 2014 (currently $5,950 for singles and $11,900 for families).

Exchanges for Small Employers Begin in 2014

Reminders About Grandfathered Plans

Reminders About Grandfathered Plans

- To maintain GF status, limits on plan changes apply
- Plan Sponsors must continue to maintain documents necessary to verify grandfathered plan status
- GF plans must continue to provide a statement in any plan materials that the plan is grandfathered
- GF plans continue to be exempt from certain requirements of the Health Care Reform Law

Questions/Discussion