Health Care Reform:
Not going away anytime soon

John L Fecile, CEBS
Director, Employee Benefits Division
Lyons Companies
Health Care Reform: Not going away anytime soon

June 18, 2012 – Wilmington DE

We are within days of knowing the Supreme Court’s opinion of the various issues placed before it regarding the Patient Protection and Accountable Care Act (PPACA) – national health care reform. But the issues raised by this legislation, the market reforms already forced in to place, and the expectations raised during this debate will not go away with this issuance of the four decisions that are anticipated by the end of this month. Regardless of what the Supreme Court decides, the disruption in the health insurance marketplace will continue.

I. What are we waiting for?

This simple answer is, “We’re waiting to learn the fate of the health care reform effort.” But the truth is more complicated. And ultimately, the fate of reform will be decided in subsequent national elections.

The Supreme Court has four issues impacting PPACA for which we are awaiting a decision.

- Whether the law’s “individual mandate” to purchase coverage is constitutional
- Whether the required Medicaid expansion by the states is constitutional
- If the Federal Anti-Injunction Act, which establishes that entities can’t sue over a tax until it has actually been levied, is applicable in this case.
- If the law’s lack of a “severability clause” means that the whole law is struck down if one portion is found unconstitutional.

The Justices have already cast their secret votes and are writing the majority and minority opinions in the cases. It’s possible that the decisions will be released piecemeal, simultaneously.

These four issues are among eighteen cases that the Justices are expected to rule on by the end of this month. The Court normally releases its opinions on Mondays, and occasionally on Thursdays. The last Monday in June is the 25th, the date this term of the Court is scheduled to end. However, there is a possibility that the release of the opinions will be delayed to the 28th.

Public opinion on the likely results is split. A number of possibilities exist:

- The Court upholds all of PPACA
- The Court finds the individual mandate to be unconstitutional and strikes most or all of the PPACA provisions
- The Court finds the individual mandate to be unconstitutional but severable from the rest of the law and upholds most or all other provisions of PPACA

The question is what the marketplace will look like after the rulings and will any of this change the fundamentals that drove health care reform in the first place.
Health Care Reform: Not going away anytime soon

According to a press release, the International Foundation of Employee Benefit Plans (IFEBP) surveyed plan administrators, trustees and organizational representatives from single-employers/corporations, multi-employer trust funds and public/governmental employers in early May and received more than 1,000 responses. The survey covered a wide range of organizations across the country. An overwhelming majority, 66%, expect the individual mandate will be struck down, but other pieces of reform will remain, while 19% of employers expect the full law will remain intact and 15% of employers expect the full law will be thrown out.

If PPACA is upheld and the current timelines stand, many of the states are not ready to implement exchanges. This is particularly true of those states being led by Republican administrations and/or participating in the numerous lawsuits in front of the Court. To date, only 15 states have established exchanges, three more are planning to establish them, 16 are studying their options, 15 have no significant activity and two have decided not to create exchanges (Arkansas and Louisiana). All four states in our region have received federal grant money to explore their exchange options – Delaware, Pennsylvania, New Jersey, and Maryland. Only Maryland has established an exchange. Delaware, Pennsylvania, and New Jersey are all studying their options. In New Jersey, Governor Christie (R) recently vetoed flawed legislation with the explanation that the state was waiting to hear from the Supreme Court.

According to the IFEBP, over 90% of the firms surveyed are closely monitoring the reform coverage, with 60% “extremely or very closely” monitoring the news regarding the reform decision. However, 45% are taking a wait and see approach to the decision, leaving many employers unprepared for many of the changes that may survive. The survey also shows that 58% believe the only positive financial outcome for them is if the entire health care law is overturned.
Health Care Reform: Not going away anytime soon

Yet support for some provisions of the law remain strong. Surveyed about what portions employers, and their employees, would like to see retained; there is significant agreement between the parties.

What employers would like to remain?

- Ability to offer increased wellness incentives – 33 percent.
- Required elimination of pre-existing condition exclusions – 23 percent.
- Required coverage of adult children up to age 26 – 22 percent.

What workers would like to remain?

- Required coverage of adult children up to age 26 – 59 percent.
- Required elimination of pre-existing condition exclusions – 34 percent.
- No cost sharing for preventive care – 32 percent.

Covering adult dependent children to age 26 has been both popular and effective. In 2011, 13.7 million 19-25 year olds stayed on or joined their parents’ health plan. Of those, 6.6 million were not eligible before PPACA.

Unfortunately, these preferences are inconsistent with the reality. The pre-existing condition exclusion and the individual mandate are inextricably linked. Insurance industry cooperation with the legislation is predicated on improving access by requiring that everyone get coverage or pays a penalty/tax. We can’t have one without the other.

Indeed, the insurance industry is already lining up to keep some of the more popular parts of the law intact for members. On June 11, United Healthcare announced that they would retain three popular benefit provisions for their 9 million insured members. Another 27 million members are covered by United through self-funded employer plans that would need to make their own decision to continue these benefits for their employees.

United will continue to provide customers:

- preventive healthcare services without co-payments or other out-of-pocket charges,
- allow parents to keep adult children up to age 26 on their plans,
- maintain the more streamlined appeals process required by the law

Of course, there may be tax implications for parents who maintain their adult children on their health plan to age 26. Aetna and Humana issued similar statements later in the week. More insurance carriers are expected to follow suit if they haven’t already.

Finally, unwinding the health reform law will have an unpleasant impact on Medicare recipients. Better Medicare prescription benefits, currently helping seniors cover a portion of expenses in the so-called “donut hole”, will be lost. So will preventive care with no copays – now available to retirees and working families alike.
II. So, what should I be doing now?

So with most of us expecting the Court to keep substantial portions of the law intact, we have a number of steps to work on this summer.

- Reporting the value of employer provided health insurance is required for W-2 forms prepared on or after January 1, 2013
- Preventive care requirements for women that begin on plan years starting on or after August 1, 2012
- Medical Loss Ratio (MLR) Rebates being issued in August 2012
- Summary of benefit requirements begin on plan years beginning on or after September 23, 2012

A. W-2 Reporting Requirement

Employers issuing more than 250 W-2 Forms in the preceding calendar year are required to include the value of group health plan coverage on W-2s issued after 1/1/2013. This reporting requirement was postponed for 2012 but is expected to remain on the plan for 2013. The reporting is for informational purposes only and does not change the tax treatment of employer-sponsored coverage. Please note this refers to the number of W2s, not employees. The intent of the regulation is to report healthcare costs – though other coverages bundled with the medical insurance may need to be included. The IRS has posted a chart on their website that shows what information is required:

http://www.irs.gov/newsroom/article/0,,id=254321,00.html

Employers are required to report “aggregate cost” which would include both pre-tax and post-tax coverage. Both employer and employee contributions are to be included.

B. Women’s Preventive Care Enhancements

For health plans starting or renewing on or after August 1, 2012, PPACA has expanded requirements for women’s preventive care coverage. The new requirements are based on the Institute of Medicine’s recommendations to HHS and were released on August 1, 2011. First dollar coverage must be provided for:

- Screening for gestational diabetes
- Human Papillomavirus (HPV) testing
- Annual counseling and screening on STDs & HIV
- All FDA-approved contraceptives, sterilization procedures, and counseling, as prescribed
- Lactation support and equipment rental
- Screening and counseling for domestic violence
- At least one well-woman preventive visit annually
Most of the attention has been focused on the contraceptive coverage issue as it applies to religious organizations. Indeed, the final rule exempts churches, other houses of worship, and similar organizations. Grandfathered plans are exempt from all of the requirements unless they adopted the initial set of preventive care rules.

C. MLR Rebates

According to a recent report from the Kaiser Family Foundation of the latest estimates provided by insurers to state insurance commissioners, consumers and businesses are expected to receive an estimated $1.3 billion by this August in rebates from health insurers who spent more on administrative expenses and profits than allowed by the Affordable Care Act (ACA). Beginning in 2011, the ACA requires insurance plans to pay out a minimum percentage of premium dollars towards health care expenses and quality improvement activities, limiting the amount spent on administrative and marketing costs and profit. Under the law, large group plans are required to spend at least 85 percent of premium dollars on health care and quality improvement, while small group plans must spend at least 80 percent. These ratios are known as the Medical Loss Ratio (MLR). If an insurer fails to meet the MLR within a market segment in a state, they must issue a refund to consumers and employers.

The rebates include $541 million in the large employer market, $377 million in the small business market, and $426 million for those buying insurance on their own. Rebates in the group market will generally be provided to employers. Rebates are expected to go to one-third (31%) of consumers in the individual market. Among employers, about one-quarter (28%) of the small group market and 19% of the large group market is projected to receive rebates.

Checks are to be issued by August 1, 2012. The rebates, however, will not represent the windfall that some had predicted. The average annual rebate for 2011 calendar year premiums will be $14-127, mostly to consumers in the
individual market. Group rebates will be divided based on employer/employee contributions. Since self-funded plans are not bound by the MLR requirements, no self-funded employers or employees in a self-funded plan will get a rebate. The vast majority of insured consumers will not be entitled to any rebate at all.

If you do receive a rebate, the next question is what do you do with it? First, employers will need to establish who paid the premiums in 2011. If they were paid 100% by the employer, the employer can retain 100% of the rebate. If paid 100% by the employee, the employer must turn 100% of the rebate over to the employee. If the premiums were paid partly by the employer and partly by the employee, the rebate must be split according to the contribution formula. This is where it gets interesting.

The group policyholder must consider the portion of the rebate attributable to what the employees paid as “plan assets.” Plan assets are to be distributed for the exclusive benefit of participants and beneficiaries in the following three ways.

- The rebate can be paid to the participants, under a fair and equitable allocation method.
- The employer can apply the rebate toward future participant premium payments.
- The employer could use the rebate to provide enhanced benefits for the participants.

The DOL suggests that the second and third options should be used only if distributing payments to participants is not cost effective. To avoid being forced to establish a trust to hold the rebate, the employer should distribute the rebate within three months of receipt. If the employee's share for the impacted premium year (in this case 2011) was paid for entirely with after-tax-dollars, the rebate is not federal taxable income. If the employee paid their share using pre-tax dollars, it is taxable income. This is true if the employee gets a future premium reduction credit from the employer or a cash payment. If they get a cash payment, that payment is also subject to employment taxes.

Also, be aware, the DOL will be directing employees with questions about the rebates back to their employers.

D. Summary of Benefit Requirements

All insurers and self-funded employers will have to give people who apply for or enroll in individual or employer-sponsored coverage a standardized summary of benefits and coverage that include:

- Four page coverage summary
- Coverage terms glossary
- Coverage examples of two set medical scenarios
- Customer service and website information

The rules set the design for easy-to-understand forms describing health insurance benefits. The forms are intended to provide the same details on all policies using the same plain-English terms – defined in a proscribed glossary – so consumers can easily compare policies. The law also mandates that the forms give examples of specific coverage explaining how much a plan pays on average for common medical conditions. It even eliminates “fine print” by
Health Care Reform: Not going away anytime soon

requiring that information be printed in 12-point type, which is larger than the print in a typical newspaper article. The effective date has been delayed to plan years that begin on or after September 23, 2012. This applies to all plans, including grandfathered plans and self-funded plans. HIPAA excepted benefit plans (e.g., stand-alone dental, specific diseases, etc.) do not have to comply.

E. FSA Transition Relief

One thing we don’t have to worry about this summer is the new FSA limits on contributions. Effective January 2013, PPACA imposes a limit of $2,500 on contributions to medical FSAs. For months, we have sought guidance on the application of this new rule as it affects clients with plan years that start on dates other than January 1. Finally, on May 30, IRS Notice 2012-40 provided transition relief to non-calendar-year FSA plans by clearly establishing that the requirement does not apply for plan years that begin before 2013. The term “taxable year” in the law refers to the plan year of the cafeteria plan as this is the period for which salary reduction elections are made. Unfortunately, if an individual has already made a reduced FSA election for 2013, they may not go back and increase their contribution absent a qualifying event.

III. So then what?

Which brings us back to where we started, what will happen next?

With the shared expectation that at least major portions of the health care law will remain, if not the whole thing, how should we be preparing for the new marketplace? It is clear that no consensus exists on what needs to be done.

There is speculation that the implementation will be delayed. From both a practical and financial perspective, delay makes some sense. As detailed earlier, the states just aren’t ready to execute health care exchanges. The federal government has set a deadline of January 2013 for state exchanges to be certified by HHS. Given the current level of preparation, is this a reasonable expectation? When you add the number of other stakeholders that have delayed decisions including employers, delay sounds more appealing. Let’s face it, given the uncertainty; we’d all like more time to proceed once the Court rules.

One theory reasons that with huge budget deficits in the immediate future, the deal making in Washington will trade revenue concessions for delayed and reduced implementation of the health care law. Another theory posits that the timelines will hold so that, assuming the President is re-elected in 2012, the implementation of the law is so entrenched that a possible Republican President in 2016 would not be able to undo it.

Even without the mandate, progress is being made to create new purchasing arrangements that will greatly expand access and choice, in either public or private health exchanges. Consequently, more people will be able to buy coverage though we won’t meet the goal of universal coverage. Further, even with the mandate, the goal of universal coverage was not likely to be met. The proposed penalties are so low, and the cost of coverage remains high, that many healthy people would make the decision to pay the penalty to avoid the premium.
Health Care Reform: Not going away anytime soon

The danger of adverse selection remains. The new people attracted to the insurance market won't represent the best risks. If coverage to the sickest potential members is expanded, the risk pool will continue to degrade and cost will continue to escalate. There are numerous examples of state led reforms that increased access without mandating coverage, and these programs have failed or are struggling because cost increases have continued unabated.

Think of how we got here. Our current system has imposed a significant burden on employers and consumers. Reform in its ideal sense was supposed to address the tripod of access, cost, and quality. We can reasonably ask if the current legislation has met this target.

Significant changes are being forced upon us. The next evolution of health care insurance purchasing will require difficult decisions of all of us. Our next update will address the Supreme Court’s decision and where we go from there. Stay tuned …

In the mean time, your Lyons Employee Benefits team is ready to assist you with any questions or concerns you may have regarding PPACA. Please contact your Account Manager or you may reach me at jfecile@lyonsinsurance.com
Health Care Reform: Not going away anytime soon

References:


Commonwealth Fund Report: “Young Adults Care, Know They Need Insurance” By Dena Bunis, CQ HealthBeat Managing Editor, June 8, 2012

The Washington Post, “Largest health insurer to keep key parts of law regardless of court ruling” N.C. Aizenman, June 11, 2012


BenefitsPro.com, “Health insurer rebates to top $1 billion” by Jenny Ivy, April 26, 2012