Employee Benefits Report

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Health Care Reform: What's Happening in 2012

The centerpiece of the Patient Protection and Affordable Care Act, health insurance exchanges, won't go into effect until 2014. However, some portions of the law will begin taking effect this year. Here's an overview of some of the changes you'll see.

A new health plan model. Starting on January 1, accountable care organizations (ACOs) can enter into contracts with Medicare. The Affordable Care Act provides incentives for physicians and hospitals to join together in ACOs, integrated healthcare systems that coordinate patient care to improve quality, prevent disease and illness and reduce unnecessary hospital admissions. ACOs that furnish high-quality services will be rewarded based on standards that they help develop, based on solid medical evidence.

Many insurers and employers will be watching to see if ACOs can deliver quality healthcare at a savings to Medicare patients. If they can, look for employer groups to move to ACO models. Please see related article on Page 2.

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This Just In…

In a fall 2011 survey, the vast majority (82 percent) of employees said they were "better suited" than their employers to choosing their health plan, but their actions said otherwise. The survey, conducted by Kelton Research, found that the majority of employees didn't know much at all about their health insurance coverage and its costs.

Fewer than half (46 percent) of respondents with employer-based coverage said they reviewed their health insurance costs annually.

- **Only 35 percent knew how much their plan's annual deductible was.**
- **Only 33 percent knew how much they contributed to-**

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New plan disclosures. Starting on March 23, health insurers and group health plans must provide two documents designed to help plan members understand their benefits: a standardized summary of benefits and coverage and a uniform glossary of health insurance coverage terms. If you have a fully insured plan, your insurer will provide these documents.

The summary will contain simple and consistent information about health plan benefits and coverage. It will allow individuals to easily compare different coverage options by summarizing key features, such as covered benefits, cost-sharing provisions, coverage limitations and exceptions. People will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year, and within seven days of requesting a copy from their health insurance issuer or group health plan.

A new fee. For policy or plan years ending after Sept. 30, 2012, issuers and employers sponsoring certain group health plans must pay a fee of $1 per member per year. The fee jumps to $2 per member per year for policy or plan years ending after Sept. 30, 2013, and then is subject to adjustment. Fees will go to the Patient-Centered Outcomes Research Institute (PCORI) to fund research that will help inform health care decisions. PCORI, an independent nonprofit organization established by Congress through the Affordable Care Act, will seek to provide evidence on the effectiveness of different treatment options for different patients. Studies will compare drugs, medical devices, tests, surgeries and ways to deliver healthcare.

A new way of keeping medical records. The first regulation implementing electronic health records will go into effect on October 1. Healthcare remains one of the few industries that rely on paper records. The Affordable Care Act institutes a series of changes to standardize medical billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information. Using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and, most importantly, improve the quality of care.

New reporting requirements. Employers that issue 250 or more W-2 forms should be preparing to report their contributions toward employees' health insurance premiums on W-2s for tax year 2012 (which go out in early 2013). All other employers must comply by tax year 2014.

ward premiums for dependent coverage.

- **25 percent spent only 30 minutes or less reviewing their plan options during open enrollment.**
- **Only 18 percent knew what their employer contributed to health insurance premiums each month.**
- **Only 13 percent knew the amount their employers would pay toward dependent coverage.**

The new W-2 reporting requirements will make at least some employees better informed. Starting with tax year 2012, employers that issue more than 250 W-2 forms must show their contributions toward health insurance premiums on the W-2s. Employees will not be taxed on these amounts. By tax year 2014, the requirement will apply to all employers.

Although employees who terminate their employment before the end of 2012 may request an early W-2, employers are not required to report health coverage costs on those early W-2 forms.

The IRS has clarified that the reporting is informational only, to inform employees of the cost of their health care coverage, and does not cause excludable employer-provided health care coverage to become taxable. The IRS further clarified that "applicable employer-sponsored coverage" does not include dental or vision coverage, unless they are included in a major medical plan. It also does not include long-term care or disability coverage. Finally, the law does not require employers to send a Form W-2 with healthcare reporting information to retirees or other former employees who receive no compensation from the employer.

To calculate the premium amount, use the monthly premium rate for a fully insured plan or the COBRA premium equivalent rate minus the 2 percent administrative fee for a self-insured health plan. Include both employer and employee contributions; employer contributions to medical savings accounts (MSAs), health savings accounts (HSAs), health reimbursement arrangements and most flexible spending accounts (FSAs) are excluded.

For more information on the Patient Protection Act and how it might affect your benefit plans, please contact us.

Accountable Care Organizations: Solution or Same Old Thing?

Nearly two-thirds (65 percent) of employers surveyed by Aon Hewitt and Polako Boland in 2011 said they would be interested in using accountable care organizations (ACOs) to provide healthcare benefits to employees. Can ACOs work in the employee benefit system to deliver promised improvements in quality, communication and cost control?

What are ACOs?

Despite having higher per capita healthcare costs than any other developed nation, the U.S. falls behind on many measures of health and healthcare safety. In addition to having a relatively high rate of infant mortality, the U.S. loses 2,500 people and spends an additional $19.5 billion per year due to "preventable adverse events" (medical errors) in hospitalized patients. The Agency for Healthcare Research and Quality, a federal agency, says, "…the true number and impact of errors may be higher…" The Institute of Medicine noted that "…many of the errors in health care result from a culture and system that is fragmented, and improving health care needs to be a team sport."

The Medicare Shared Savings program created by the Affordable Care Act includes a number of policies, including ACOs, designed to encourage cooperation and communication among healthcare providers to improve quality of care and reduce costs for Medicare patients. The law permits ACOs to begin contracting with Medicare in January 2012. These accountable care organizations will offer financial incentives for healthcare providers to work together to treat an individual patient across care settings—including doctor's offices, hospitals and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower growth in healthcare costs while meeting performance standards on quality of care and putting patients first.

Patient and provider participation in an ACO will be voluntary. Medicare beneficiaries whose doctors participate in an ACO can still see doctors outside of the ACO. Patients choosing to receive care from ACO providers will have access to information about how well their doctors, hospitals or other caregivers meet quality standards.

Will ACOs Work for Employer Groups?

Health maintenance organizations (HMOs) were supposed to solve the problem of rising healthcare costs more than 20 years ago. HMOs provide comprehensive healthcare services to members in exchange for a specified monthly premium. If a member needs expensive or costly care, the HMO bears the financial risk, not the member or insurer. To control costs, HMOs limit coverage to care from doctors who work for or contract with the HMO. Many provide integrated care and focus on prevention and wellness.

However, some employee groups didn't like HMOs. They didn't like having to give up their existing healthcare providers, and they didn't like the perceived limits on the care they received. As a result, employers pressured insurers to loosen HMO network restrictions. Without control over healthcare providers, HMOs couldn't control costs as well, and today HMO premiums, on average, cost more than premiums for a PPO

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(preferred provider organization) plan.

Although ACOs can take many forms, many experts agree that to successfully control costs and ensure quality, ACOs must focus on primary care. The National Council on Healthcare Quality (NCHQ) also says, "…ACOs must include a group of physicians with a strong primary care base and sufficient other specialties that support the care needs of a defined population of patients….ACOs will also need the administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance, and organize providers around shared goals." In other words, ACOs must be large enough to provide most (if not all) of the services a patient might require, along with the necessary support structure.

HMOs All Over Again?

ACOs differ from the HMO model in three ways:

Accountability belongs to healthcare providers, not insurers. To avoid financial failure, ACOs must spread the risk among a fairly large group of healthcare providers.

Several types of provider organizations can participate in ACOs, including independent practice associations (IPAs) and physician-hospital organizations (PHOs).

ACOs could contract directly with provider organizations, rather than using a health insurer as an intermediary.

ACOs will have serious challenges to overcome. Our medical care system has created an imbalance of providers, with many specialists and a shortage of primary care physicians; ACOs will have to make primary care financially attractive for providers. Most insurance plans reward hospitals and physicians for the number of services they provide, regardless of quality or need, often leading to unnecessary and sometimes detrimental treatments. ACOs must find alternative ways to incentivize hospitals and physicians to provide only the care needed. Finally, solo practitioners and small physician groups, many of whom provide needed community-based primary care services, often lack the financial and organizational resources needed to form ACOs.

We will keep you informed of these and more developments in the group health insurance industry. For more information on controlling your employee health costs in the interim, please contact us. ■

COBRA Benefits: What You Need to Know

COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985, allows workers and family members who would otherwise lose their benefits to temporarily continue health coverage at group rates. If you had 20 or more employees in the prior year and offer a group health plan, COBRA applies to your company. Here's what you need to know about COBRA's requirements.

Employee count. Your employee count must include part-time employees; add part-timers' hours together to determine the number of full-time equivalents.

Qualified beneficiaries. Eligibility is limited to those covered by a group health plan on the day before a qualifying event (see below).

Qualifying events. Certain events will trigger the right to coverage under COBRA, including termination of employment (voluntary or involuntary), unless it is for gross misconduct, and reduction in hours worked (e.g., from full-time to part-time). An employee's death, divorce, legal separation or eligibility for Medicare are all considered qualifying events, as is a change in status of a covered dependent or spouse. Being called up for active military duty also triggers COBRA eligibility when an employer doesn't voluntarily maintain a reservist's health coverage.

Types of coverage. Employers must offer COBRA beneficiaries the same coverage as they do to non-COBRA beneficiaries — usually the same plan that was in place immediately before the qualifying event. Any benefit changes for active employees will also apply to COBRA beneficiaries, who are entitled to the same coverage choices as all other employees, such as during periods of open enrollment.

Length of coverage. COBRA provides for up to 18 months' coverage for qualifying events such as job termination or a reduced work schedule. Certain qualifying events, or a second qualifying event during

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the initial coverage period, may extend coverage to a maximum of 36 months. Employers may also provide coverage beyond COBRA maximums. Coverage begins on the date that benefits would otherwise have been lost because of a qualifying event. It may end earlier than the maximum period if the beneficiary does not pay premiums on time or if the employer stops offering any group health plan.

Notification and election. Group health plans must notify covered employees and their spouses of their COBRA rights when they first join the plan. Be sure to keep track of the various COBRA deadlines: Employers must inform plan administrators of a qualifying event within 30 days after an employee's death, termination, reduction in hours or entitlement to Medicare.

In the case of divorce, legal separation or a dependent's change of status, a qualified beneficiary has 60 days to notify the plan's administrator. The administrator then has two weeks to notify the person entitled to COBRA benefits, who has 60 days to decide whether to elect coverage. Keep in mind that though an employee may choose coverage on behalf of all other qualified beneficiaries, each beneficiary has the right to independently elect COBRA coverage. For example, if an employee has a family member with an illness at the time he is terminated, that person alone can elect coverage, should he choose.

Cost of coverage. Some companies subsidize COBRA coverage, but in most cases, the employee pays the full premiums. In fact, employers may charge up to 102 percent of the premium and keep the additional two percent to cover administrative costs. COBRA premiums may increase if costs to the plan increase but generally must be fixed before each yearly premium cycle. The beneficiary must make the initial premium payment within 45 days after the election date, and employers can terminate COBRA coverage if payments are late. The fact that employers usually must pay their group medical insurance premiums in advance gives COBRA insureds a 30-day grace period from the time the employer's payment is due.

Special rules apply to reservists called up for military service. If military service is for 30 or fewer days, the employee and dependents can continue coverage at the same cost as before their short service. If military service is longer, you can require the employee and dependents to pay as much as 102 percent of the full premium for coverage. However, military health benefits should cover these employees and their dependents.

State law. Most states have laws concerning the continuation of benefits. Some cover all employers, including small employers, so a state law might apply even if your company is exempt under the federal COBRA law. We can help you determine your COBRA obligations and assist with compliance. For more information, please contact us.

Saver's Credit Makes Saving for Retirement More Attractive

Looking to boost employee participation in your retirement plans? Remind them of the retirement savings contributions credit (saver's credit), which allows qualifying individuals to take a tax credit of up to $1,000 ($2,000 if filing jointly) for making eligible contributions to an IRA or employer-sponsored retirement plan.

Who is eligible for the credit?

1. Age 18 or older;
2. Not a full-time student;
3. Not claimed as a dependent on another person's return; and
4. With a 2011 adjusted gross income not more than:
   - $56,500 for married filing jointly ($57,500 for 2012),
   - $42,375 for heads of household ($43,125 for 2012), or
   - $28,250 for singles, married filing separately, or qualifying widow(er)s ($28,750 for 2012).

Eligible contributions include:

1. Contributions to a traditional or Roth IRA,
2. Elective deferrals (including after-tax Roth contributions, if available) to a:
   - 401(k) plan (including a SIMPLE 401(k) and the federal Thrift Savings Plan),
   - SIMPLE IRA plan
   - SARSEP
   - 403(b) annuity
   - governmental 457(b) plan
3. Contributions to a §501(c)(18) plan, and
4. Voluntary after-tax employee contributions to a qualified retirement plan or 403(b) annuity. For purposes of the credit, employee contributions will be voluntary as long as they aren't required as a condition of employment.

Rollover contributions aren't eligible for credit. Also, eligible contributions may be reduced by any recent distributions received from a retirement plan or IRA.

Amount of the credit

The amount of the credit depends on contributions made and your credit rate, which depends on income and filing status. The credit rate ranges from 10 percent to 50 percent. See IRS Form 8880 to determine the credit rate.

Example: Jill, who works at a retail store, is married and earned $30,000 in 2011. Jill's husband was unemployed in 2011 and did not have any earnings. Jill contributed $1,000 to her IRA in 2011. After deducting her IRA contribution, the adjusted gross income shown on her joint return is $29,000. Jill may claim a 50% credit, $500, for her $1,000 IRA contribution. ■

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