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#### **Employee Benefits**

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760 Pasquinelli Drive, Suite 358, Westmont, IL 60559

Editor: Ben Conley®, Employee Benefits Attorney

Seyfarth Shaw LLP (312) 460-5228

bconley@seyfarth.com

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## IRS Guidance Makes 2014 Employer Health Care Costs More Predictable

The Affordable Care Act, passed in early 2010, requires employers to either offer “affordable coverage” or pay a penalty. Since that time, there has been some confusion over what it means for coverage to be “affordable”. The IRS recently released clarifying guidance regarding the definition of “affordable” that should make it easier for employers to control health care costs starting in 2014 when the employer “play or pay” mandate kicks in. In order to understand the clarifying guidance, it is first important to understand the source of confusion within the Affordable Care Act.

### **Background - Calculating the Play or Pay Penalty**

The Affordable Care Act requires large employers (those employing 50 or more full-time equivalent employees) to either offer affordable health care coverage or pay a penalty. The play or pay penalty is made up of two components: (a) a penalty for failure to offer coverage to all full-time employees, and (b) a penalty for failure to offer “affordable” coverage. The penalties are calculated as follows:

#### **Failure to Offer Coverage**

Large employers who fail to offer major medical coverage to all full-time employees must pay an excise tax of \$2,000 per full-time employee, as long as at least one employee receives a tax credit through the 2014 health care exchanges offered in each state.

#### **Failure to Offer Affordable Coverage**

The Affordable Care Act treats coverage as “affordable” if (a) the employee’s premium does not exceed 9.5% of that employee’s household income, and (b) the employer covers at least 60% of the actuarial value of coverage. A large employer that fails to offer affordable coverage will be subject to an excise tax of \$3,000 per employee who receives a tax credit through the exchanges. While this is a larger dollar amount than the tax for failure to offer coverage, this tax is only multiplied by the number of employees who receive a tax credit, rather than by all full-time employees.

### **Affordable Care Act Created Confusion Regarding the Affordability Test**

The statutory definition of “affordable” created two problems for employers:

#### **1. Calculating Premium Cost for Purposes of Measuring Affordability.**

The Affordable Care Act did not specify whether affordability (i.e., premium contribution not to exceed 9.5% of household income) was measured using the premium for employee-only coverage or the premium for the coverage the employee actually elected (e.g., employee plus one, family, etc.).

Employers often subsidize employee-only coverage more heavily than family coverage. As a result, if the IRS issues clarifying guidance indicating the penalty would be calculated using the premium for the coverage the employee actually elected, the likely result would be that more employers would face greater penalties for offering coverage deemed “unaffordable” by the IRS.

## 2 **Measuring “Household Income”**

“Affordable” coverage is measured by comparing the premium cost to the employee’s “household income.” While employers know how much they pay the employee, they have no way of calculating an employee’s household income. As a result, it would be difficult for employers to price employees’ premium to avoid the penalty.

### **IRS Guidance Makes Affordability Test More Predictable**

Recent IRS guidance detailed how to calculate the 2014 penalty. The guidance provided a favorable interpretation of the affordability test. First, the guidance provided that the penalty would be calculated based on the cost of employee-only coverage, regardless of the coverage selected by the employee. So, the cost of employee-only coverage cannot exceed 9.5% of the employee’s household income, regardless of the actual level of coverage elected by the employee.

*For example, assume an employee has \$30,000 a year in household income. The employer covers at least 60% of the actuarial value of coverage. Employees must pay a premium of \$2,400 for employee-only coverage (8% of household income) and \$3,000 for family coverage (10% of household income). The employer will be deemed to have offered the employee affordable coverage, even if the employee elects family coverage.*

Second, the guidance created a “safe harbor” to address the unpredictability involved in calculating employees’ household income. Under the proposed safe harbor, employers that meet certain conditions, such as offering all full-time employees coverage, will not be subject to the penalty if the employee premium does not exceed 9.5% of the employee’s current W-2 wages. This is merely a safe harbor. If the employee’s premium contribution exceeds 9.5% of the employee’s W-2 wages, but the premium is still less than 9.5% of the employee’s household wages, the employer will still be deemed to have offered affordable coverage.

*For example, assume an employer knows the lowest-paid full-time employee makes \$30,000 in W-2 wages per year. If the employer (a) covers at least 60% of the*

*actuarial value of coverage, and (b) sets the employee-only premium for health coverage at \$2,850 (i.e., 9.5% of W-2 wages) no employee will ever become eligible for tax credits through the exchanges, and the employer will not be liable for the play or pay penalty.*

### **What This Means For Employers**

Under the new rules, employers should be able to better calculate and predict their potential tax liability starting in 2014 when the employer mandate begins. Employers will still face the decision of whether to stop offering coverage entirely, send all employees to the exchanges for health insurance, and simply pay the penalty for all full-time employees. Employers may instead consider adding a lower-cost option, such as a high deductible health plan, that will satisfy the affordability test.

## **New Guidance Signals Delay in Summary of Benefits and Coverage Requirement**

The Affordable Care Act requires group health plan sponsors (employers and insurers) to issue participants a short Summary of Benefits and Coverage (SBC) for each benefit package offered, starting March 23, 2012. While the SBC requirement generally applies during annual enrollment, plan sponsors are also required to provide an SBC upon special enrollment, new hire enrollment, and participant request. As a result, plan sponsors have been concerned that they must prepare SBCs for distribution as early as March 23, 2012.

The proposed regulations on the SBC requirement suggested that final regulations would be issued prior to the initial effective date. Based on the timing of the notice and comment period, however, there was some indication that plan sponsors would only have a month or less to prepare SBCs following the issuance of final regulatory guidance. Many plan sponsors expressed concern that they would be unable to comply with these onerous requirements with such a short turn-around time.

In response to these concerns, on November 17, 2011, the DOL, IRS and HHS jointly issued an FAQ declaring that the final regulations will include an effective date that gives plan sponsors time to ramp-up for compliance. The FAQ included no further indication of when the agencies will issue final regulations or how much ramp-up time will be provided.

In light of this FAQ, plan sponsors may find it better to take a “wait and see” approach. The agency FAQ hints that there may be changes to the SBC requirement in the final regulations, but

plan sponsors should be given time to adjust accordingly.

## Studies Find Connection Between Poor Oral Health and Lung-Cancer, Respiratory Disease

Two recent studies have identified a link between poor oral health and chronic diseases. A study conducted by Imperial College in London and Harvard suggested those with gum disease are 33% more likely to develop lung cancer. Further research by ITS Center for Dental Studies and Research in India found a link between oral health and respiratory disease. Dentists suggest regular brushing, flossing and check-ups to maintain healthy gums and potentially avoid these risks.

## Decreasing Trend of Vision Problems in Diabetics

Diabetes commonly leads to vision problems. However, WebMD indicates this trend is decreasing. Recent studies show that the percentage of diabetics with vision problems has decreased from 24% in 1997 to 17% in 2010. The decrease is partially attributable to heightened awareness among diabetics of proper disease management techniques, which can include annual eye exams, blood glucose management and careful monitoring of blood pressure and cholesterol. Even so, studies indicate that fewer than 40% of diabetics carefully adhere to these recommendations.

## Health Plan Costs Continue to Rise in 2011, More Increases Expected in 2012

A recent study by the Kaiser Family Foundation and the Health Research & Educational Trust confirmed that health care costs rose substantially in 2011. On average, premiums for family coverage rose 9% to \$15,703. An equally troubling survey by Consumer Reports showed that participant benefit utilization actually decreased, meaning costs rose even as less people sought medical treatment. The cost increases mostly stem from rising prices from doctors and hospitals. While utilization dropped in 2011, it is expected to rise in 2012, resulting in even greater cost increases. Most surveys suggest that only approximately 1% of the increase is attributable to expanded coverage, including adult child coverage mandated under the Affordable Care Act.

## Ideas On Spending Your 2011 FSA Money

**Review list of eligible expenses**-There could be items that you need to buy or already bought that are eligible for reimbursement.

**Submit outstanding receipts** -Receipts for health care expenses like prescriptions or doctor's appointments qualify. Locate them and submit for reimbursement. Then verify how much is left in your account.

**Purchase medical supplies**-If you need medical supplies on a regular basis, keep a backup supply on hand. This includes contact lenses and solution, prescription glasses and even band aids.

**Schedule routine appointments**-Make sure everyone in your family has routine check-ups. If you see a specialist, make sure you receive necessary care before the end of the year or grace period as well.

**Flu shot and vaccinations**-Be sure everyone in your household has received and is up to date with vaccinations and flu shots.

**Invest in wellness**-Get on track with your wellness goals this year, you'll save on future medical expenses. Smoking cessation expenses are eligible for reimbursement, as is weight loss counseling, as long as you provide receipts and a letter of medical necessity.

**Log your miles**-Submit gas and transportation receipts if the travel relates to eligible medical, dental, and vision appointments. The mileage rate for 2011 is 19 cents per mile (through June 30, 2011) and 23.5 cents per mile (from July 1, 2011 to December 31, 2011).  
*Courtesy of WageWorks.*

## IRS Announces 2012 Inflation-Adjusted Benefit Limits

The IRS has announced cost-of-living adjustments applicable to dollar limitations for retirement plans and other benefits for 2012. This marks the first notable adjustment to the limits since 2009.

	2011 Limits	2012 Limits
401(k)/403(b) Contribution	\$16,500	\$17,000
457(b) Limit	\$16,500	\$17,000
Catch-up Contribution	\$5,500	\$5,500
Compensation Limit	\$245,000	\$250,000
Highly Compensated Employees	\$110,000	\$115,000
Maximum Annual Benefit Defined Benefit Plan	\$195,000	\$200,000
Maximum Annual Contribution Defined Contribution Plan	\$49,000	\$50,000
Maximum SIMPLE Contribution	\$11,500	\$11,500
FICA Wage Base	\$106,800	\$110,100

760 Pasquinelli Drive, Suite 358, Westmont, IL 60559

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## Save The Date:

### **CFO Breakfast Event**

Thursday - December 8, 2011

7:30 am - 9:30 am

### **Trump International**

### **Hotel & Tower**

Please RSVP to Michael Booth

(630) 366 7444 or

michaelbooth@midamgroup.com

## Topic:

**What will health care reform cost  
your organization in 2014 ?**

## Long Term Care Insurance Program/CLASS Act Cut After Solvency Called into Question

On October 14th, the Department of Health and Human Services announced it would halt implementation of the Community Living Assistance Services and Supports Program (the CLASS Act).

The CLASS Act was created under the Affordable Care Act as a long-term care insurance program to assist working individuals who become disabled. Under the program, employers would deduct premiums from employee wages each payroll period, and, after satisfying minimum participation requirements, an employee would be eligible to receive subsidies to help pay for long-term care in the event he or she becomes disabled. The program permitted employers to decide whether to participate, but any employer choosing to participate was required to automatically enroll all employees that did not affirmatively opt-out. The program was scheduled to begin in October 2012. The Affordable Care Act required that the program be solvent for at least 75 years, but recent studies had indicated that the program was not likely to be able to support itself for that long. While it was projected to take in more revenue than it paid out over the first decade (largely because individuals must pay in for five years before they become eligible for benefits), the CLASS Act was projected to slip deeply into the red in later decades.

Reports out of Washington in recent weeks had hinted that the program would not be implemented. Nonetheless, supporters of the program pledged to continue working to find other ways to help individuals plan and pay for long-term care following disability.