The Top Administrative Challenges Coming Out of Health Care Reform
About the Authors

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While health care reform makes health care coverage available to millions of Americans, it creates a significant administrative challenge for employers. The legislation contains numerous legal and administrative requirements for employers, who will need to implement significant process and recordkeeping changes to be in compliance. This article provides a summary of those requirements and sets the stage for how employers might meet them—either on their own or with the support of an outsourcing partner.

When health care reform passed into law in late March 2010, it represented a significant shift in the American health care system—and a huge administrative challenge for employers. The landmark legislation provides health care to an estimated 30 million Americans previously without coverage, making it the single biggest legislation to affect employer health care programs since the creation of Social Security in 1935. From the moment it passed, employers nationwide have been determining what this legislation means to their organizations, benefit plans, and people.

One of the areas most directly affected by the legislation is employee benefits administration. The legislation requires employers to make numerous significant plan, process, and reporting changes at a time when most HR departments are leaner than ever. The fact that the debate over health care reform is not over creates additional challenges.

The Internal Revenue Service (IRS), Department of Labor (DOL), and Health and Human Services (HHS) are currently working out the details that companies are going to have to deal with from an administrative standpoint for years to come. These regulations will undoubtedly be more complex and issued later than many employers would prefer.

In addition, health care costs continue to be a major concern for employers. But with little within this legislation to help employers reduce their health care spend in the short term, companies will need to simultaneously control health care costs and meet the new legal and reporting requirements. Considering the numerous other business priorities HR is currently managing—often with limited staff and budget—it’s not difficult to understand why HR departments are feeling overwhelmed.

Where to Start?
Many HR professionals come away from reading the legislation wondering where to start. As they review options for how to best meet the legal and administrative requirements, they’re revisiting the longstanding debate over outsourcing versus insourcing. Even companies committed to handling benefits administration internally are taking a fresh look at outsourcing to determine how an outsourcing arrangement could lessen the internal burden and enable HR to focus on the true priorities of the business.

Regardless of their preferred strategy, companies wishing to comply with health care reform legislation will need to:
- Conduct a full assessment of how the legislation will affect their organizations, benefits programs, administration, and employees;
- Take stock of the organization’s strategic goals and rethink how benefit plans and plan administration fit into the mix;
Develop an action plan for complying with health reform over the multiyear implementation period and communicating those changes to employees and retirees; and

Update all plan documents, summary plan descriptions (SPDs), and other plan materials.

The Top Administrative Challenges Coming Out of Health Reform

The following high-level overview of the administrative impact of health care reform is designed to illustrate the magnitude of the challenges ahead. While not comprehensive, the summary provides a sense of the range of administrative challenges facing HR professionals today.

Let’s start with the three biggest challenges first:

1. Extension of Dependent Coverage to Age 26
   What: Starting as early as January 1, 2011, health care reform requires plans to allow dependents up to age 26 to be covered under their parents’ health plan. Prior to 2014, this requirement only applies if the adult child is not eligible to enroll in another employer-provided plan. Starting in 2014, this provision will apply to all dependents, regardless of eligibility to enroll in another employer plan. Dependents can be married, and full-time student status is no longer an eligibility consideration.

   Administrative Requirement: To comply with this seemingly straightforward requirement, employers will need to modify their plan eligibility rules for active and possibly retiree plans. In addition, employers will need to eliminate full-time student provisions and student certification requirements, since being a full-time student is no longer a condition of eligibility. Employers will also need to adjust any dependent verification or audit processes to match the new eligibility rules. With the average cost for an employer to cover a dependent between $2,000 and $2,500 per year, there’s value in validating that covered dependents are legitimate, including adult dependents.

2. Reporting of Health Insurance Coverage to Participants and the Federal Government
   What: Health care reform mandates that starting in 2011, employers must disclose the value of employer-sponsored health coverage on each employee’s annual Form W-2. The value of employer-sponsored coverage is equal to the total premium for medical, dental, and vision coverage (with the exception of stand-alone dental and vision), plus health reimbursement arrangement (HRA) contributions. Starting in 2014, employers are required to furnish to the federal government information describing the dates individuals received qualified health plan coverage, the portion of the premium required to be paid by the employee, and other information.

   Administrative Requirement: Employers need to be prepared to calculate and report these amounts to Payroll to be included in employees’ Forms W-2, and to help employees understand the new amount on their forms. At this point, reporting requirements on periods of coverage and employee contributions are unclear and may not be available until regulations are developed.

3. Excise Tax on High-Cost Coverage
   What: While not effective until 2018, another complex administrative change coming out of the legislation is an excise tax on high-cost coverage (otherwise described as “Cadillac plans”). The legislation imposes a 40 percent tax on employers/insurers if the aggregate value of employer-sponsored health coverage exceeds the threshold of $10,200 for an individual or $27,500 for a family. For workers in high-risk industries (mining, construction,
etc.) and retirees age 55 or older, those thresholds are raised to $11,850 and $30,950, respectively. Employer-sponsored coverage includes coverage under medical, prescription drug, mental health, HRAs, or health care FSAs and contributions to HSAs and other supplemental coverage. Stand-alone dental and vision coverage are not included in the excise tax calculation. Employers are responsible for calculating the amount subject to excise tax to each insurer and plan administrator, and reporting those amounts to insurers. Those who fail to properly calculate excise tax amounts could face steep penalties.

**Administrative Requirement:** Employers will need to conduct a thorough review of their current plans to determine whether they exceed the threshold and consider plan design changes to avoid it. Employers should develop an approach for calculating excise tax and a process for reporting to insurers. Some employers may want to pass the excise tax on to employees, and will need to modify enrollment processes to identify elections exceeding the threshold and calculate applicable excise tax. Excise tax calculations can be particularly complicated if an employer has multiple types of coverage (e.g., medical, prescription drug), varying coverage options (e.g., you-only medical coupled with you-plus-family dental) and multiple insurers.

**Other Administrative Challenges**

In addition to these significant changes, there are a number of other administrative challenges that employers will need to address by the legislation’s effective dates. Below is a brief summary of the other important changes.

**4. New Limits on Health Care Flexible Spending Accounts**

**What:** One relatively minor change that could cause an undue amount of headaches for employers are the changes made to health care FSAs. Starting in 2011, expenses for over-the-counter (OTC) medicine without a prescription can no longer be reimbursed by an FSA, HRA, HSA, or Archer Medical Savings Account (MSA).

Although not directly affecting administration, starting in 2011, the tax on nonqualified distributions from a HSA will increase from 10 to 20 percent. In
2013, contributions to a health care flexible spending account (FSA) will be limited to $2,500 per year (indexed to the Consumer Price Index).

**Administrative Requirement:** While relatively easy to implement, communicating these changes to employees will likely be the bigger challenge. Employers will need work with their account administrators to exclude OTC medicine and verify that these administrators do not allow these items to be purchased using debit cards. As most employers have been telling employees that FSAs are a great way to save money on OTC medication, they’re now going to have to reeducate employees and communicate how these changes impact how they should best manage their health care dollars. Employers will need to modify their plans and administrative system, including modeling tools, to limit FSA contributions to $2,500.

**5. Uniform Summary of Benefits and Coverage**

**What:** While most employers already provide plan summaries to participants online or via paper during enrollment, those summaries have evolved over time to meet the needs of employees. Starting in 2012, employers must distribute a summary of benefits to all enrollees prior to enrollment or reenrollment.

**Administrative Requirement:** Employees must receive a revised summary if plan benefits are modified. Content of the summary must be uniform and based on the standards developed by the federal government. Existing summaries, including online summaries, may need to be modified to conform to federal standards for content, format, and possibly terminology.

**6. Medicare Part D Subsidy No Longer Tax-Free**

**What:** Starting in 2013, Retiree Drug Subsidy (RDS) payments received by employers for maintaining retiree prescription drug coverage comparable to Medicare Part D will no longer be tax-free.

**Administrative Requirement:** Eliminating the tax-free status of the RDS significantly increases employer costs for providing retiree prescription drug coverage. As a result, employers will want to reevaluate their current retiree prescription drug strategies and consider other alternatives. Changes due to this provision may require substantial modifications of the administrative and carrier eligibility systems.

**7. Notice to Inform Employees of Coverage Options in Exchange**

**What:** Starting March 1, 2013, employers will be required to notify new and current employees of the existence of the Exchanges, their services, and contact information. If the employer’s plan contribution is less than 60 percent of the cost, the notice must also describe potential eligibility for premium assistance in the Exchange.

**Administrative Requirement:** Employers will need to develop the notice and a process for distributing the notice to employees.

**8. The “Free-Rider” Penalty**

**What:** While health care reform does not require employers to offer health insurance coverage per se, employers that do not must pay a $2,000 penalty per full-time employee if even one of those employees enters the Exchange to obtain coverage. Employers that offer “unaffordable” coverage must pay a $3,000 penalty per full-time employee receiving a federal subsidy in the Exchange. Full-time employees of large employers may enter the Exchange if coverage has an actuarial value of less than 60 percent or the premium exceeds
9.5 percent of the employee’s adjusted gross income (AGI). Employers should note that part-time workers are counted as full-time based on working 30 or more hours a week, which may or may not match current internal full-time definitions. The first 30 workers are excluded from the penalty calculation.

**Administrative Requirement:** Since the legislation defines a full-time employee as someone working 30 or more hours per week, employers should review current benefits eligibility rules and assess whether to expand eligibility. Similarly, employers should review their contribution strategies for employees working 30–39 hours to determine whether coverage could be considered unaffordable.

9. Free-Choice Vouchers

**What:** Under the legislation, employees may be eligible to receive a voucher from their employers to purchase coverage through the Exchange starting in 2014. Employees may be eligible for a voucher if their contribution toward coverage exceeds 8 percent of their household income but not more than 9.8 percent, and their household income is 400 percent or less of the poverty level. The voucher amount from the employer is equal to the cost the employer would have paid for coverage selected by the employee. Employers are permitted to age-rate the cost of the plan when determining the voucher amount. Employees may keep any voucher amount that exceeds the cost of Exchange coverage. The voucher amount used in the Exchange is not taxable to the employee and is deductible to the employer as compensation paid to the employee.

**Administrative Requirement:** On the administrative front, employers will want to analyze their contribution strategies to determine whether they have employees who could be eligible for “free-choice” vouchers and how they might distribute vouchers to eligible employees.

10. Limit of 90-Day Waiting Period for Coverage in Plan

**What:** Starting on January 1, 2014, employers may no longer apply a waiting period in excess of 90 days for coverage in a plan. No penalty exists for waiting periods less than 90 days.

**Administrative Requirement:** Employers who currently have waiting periods in excess of 90 days will need to reduce them to be in compliance with the law, requiring changes to administration systems.

11. Quality of Care Report

**What:** Beginning in 2014, employers will be required to submit a report during each annual enrollment period on whether their plan satisfies Quality of Care standards developed by the federal government. Reports would be available on a public Internet Web site.

**Administrative Requirement:** Employers will need to work with their health plans to develop the Quality of Care report and establish a process for providing the report to participants and the federal government. To date, the details of the report and the process are unclear and must be clarified through future guidance.

12. Notice of Qualified Health Insurance Coverage

**What:** Starting in 2014, employers are required to furnish employees with information describing the dates the individual received qualified health plan coverage, the portion of the premium required to be paid by the employer, and other information. The plan coverage information required to be provided is similar to the data provided by a HIPAA Certificate of Creditable Coverage.
Administrative Requirement: If allowable, employers may be able to leverage this notice by providing premiums and other required information. Future regulations are likely to include model notices for employers to use as an example.

13. Automatic Enrollment

What: In the past, most employers relied on an “opt-in” approach when it came to health care benefits. If employees did not enroll, they did not receive coverage. Under health care reform legislation, employers will be required to automatically enroll new, full-time employees into employer-sponsored health coverage and continue the enrollment of current employees (effective date unclear). Adequate notice must be provided, and the employee may opt out of coverage. Proof of other coverage is not required to opt out.

Administrative Requirement: Employers will need to modify new hire enrollment practices and enroll individuals who do not make an active election into health coverage and provide notice of enrollment.
Hitting the Reset Button—Hewitt Can Help

Even if HR did not have its hands full with other business initiatives, such as controlling health care costs, meeting all of the new requirements by their various effective dates would be a significant challenge for even the best staffed of departments. The fact is that most HR departments are not staffed appropriately to handle such a momentous change. While it’s natural to feel overwhelmed when reviewing this legislation, it does offer a unique opportunity to stop, take a step back, and rethink previous plan design and administration decisions. Now is the time to take a broad look at your organization’s benefit strategies, hit the reset button, and make new decisions based on the current-day realities. The good news is that you don’t have to tackle it alone—Hewitt can help.

Hewitt is dedicated to helping companies create innovative solutions to administrative and benefits design challenges. As a market leader, we’re constantly creating new solutions to help our clients deal with a host of administrative challenges, including health care reform.

With Hewitt, you’ll have the expert advantage in your corner. Hewitt provides advanced recordkeeping and Web technology; and represents your interests in national benefit organizations. As your central resource for all things benefits related, you’ll no longer need to hire and manage a collection of vendors.

Hewitt’s dedicated attorneys and benefits professionals will deliver helpful summaries, administrative options, and best-practice suggestions. Through Hewitt, you’ll learn about industry prevalence and gain a better understanding of how other employers are approaching the same challenges facing your organization.

When you’re a Hewitt client, we’ll help you determine not only what you need to do by when, but also how to do it most effectively and efficiently, helping you avoid costly penalties for improper implementation. What’s more, working with Hewitt does not necessarily mean giving up control of all of your benefit data and processes. We have a spectrum of administrative solutions that allows you to decide what you want to keep in-house and what you want to delegate to the administration professionals.

For more information about how Hewitt can help you meet the administrative challenges coming out of health care reform, contact us at peoplesolutions@hewitt.com.
# Health Care Reform Requirement Summary

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<th>Health Care Reform Requirement</th>
<th>Administrative Considerations</th>
<th>Effective Date</th>
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| 1. Extension of dependent coverage to age 26 | Requires plans to allow dependents up to age 26 to be covered under parents’ health plan  
  - Dependent may be married  
  - Full-time student status is not an eligibility consideration | 2010 or 2011, depending on plan year |
| 2. Reporting of health insurance coverage to participants and the federal government | Employers required to disclose value of employer-sponsored health coverage on the employee’s annual Form W-2 effective 2011  
  Employers required to furnish to federal government information describing the dates individuals received qualified health plan coverage, portion of the premium required to be paid by the employee, and other information effective 2014 | 2011, 2014 |
| 3. Excise tax on high-cost coverage | Imposes 40 percent tax on employers/insurers if aggregate value of employer-sponsored health coverage exceeds the threshold of $10,200 single/$27,500 family; $11,850/$30,950 for high-risk industry workers and retirees age 55 or older  
  Employer responsible for calculating amount subject to excise tax allocable to each insurer and plan administrator, and reporting those amounts to insurers  
  Penalties apply to employers who fail to properly calculate excise tax amount | 2018 |
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| 4. New limits on health care FSAs | ■ Expenses for over-the-counter (OTC) medicine without a prescription can no longer be reimbursed by an FSA, health reimbursement arrangement (HRA), health savings account (HSA), or Archer Medical Savings Account (MSA)—effective 2011  
■ Tax on nonqualified distributions from an HSA increased from 10% to 20%—Effective 2011  
■ Contributions to a health care FSA limited to $2,500 per year; limit is indexed to the Consumer Price Index—effective 2013 | 2011, 2013 |
| 5. Uniform summary of benefits and coverage | ■ Employers must distribute a summary of benefits to all enrollees prior to enrollment or reenrollment  
■ Employees must receive a revised summary if plan benefits are modified  
■ Content of summary must be uniform based on standard developed by federal government | 2012 |
| 6. Medicare Part D subsidy no longer tax-free | ■ Retiree Drug Subsidy (RDS) payments received by employers for maintaining retiree prescription drug coverage comparable to Medicare Part D would no longer be tax-free | 2013 |
| 7. Notice to inform employees of coverage options in Exchange | ■ Employers required to notify new and current employees of the existence of Exchanges, their services, and contact information  
■ If the employer’s plan contribution is less than 60% of the cost, the notice must also describe potential eligibility for premium assistance in the Exchange | 2013 |
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| 10. Limit of 90-day waiting period for coverage in plan | ■ The employer plan may not apply a waiting period in excess of 90 days  
■ No penalty for waiting periods less than 90 days | 2014 |
| 11. Quality of Care report | ■ Each annual enrollment, employers are required to provide participants a report on whether their plan satisfies Quality of Care standards developed by federal government | 2014 |
| 12. Notice of qualified health insurance coverage | ■ Employers are required to furnish employees an information return describing the dates the individual received qualified health plan coverage, the portion of the premium required to be paid by the employer, and other information | 2014 |
| 13. Automatic enrollment | ■ Employers are required to automatically enroll new, full-time employees into employer-sponsored health coverage, and to continue the enrollment of current employees  
■ Adequate notice must be provided, and the employee may opt out of coverage; proof of other coverage is not required to opt out | 2014 |
About Hewitt Associates
Hewitt Associates (NYSE: HEW) provides leading organizations around the world with expert human resources consulting and outsourcing solutions to help them anticipate and solve their most complex benefits, talent, and related financial challenges. Hewitt works with companies to design, implement, communicate, and administer a wide range of human resources, retirement, investment management, health care, compensation, and talent management strategies. With a history of exceptional client service since 1940, Hewitt has offices in more than 30 countries and employs approximately 23,000 associates who are helping make the world a better place to work. For more information, please visit www.hewitt.com.