Same-sex Marriages Affect on Employee Benefit Plans

General rule – Follow the same rules that apply to married employees.

Retirement Plans - Beneficiary

- The primary beneficiary must be the spouse unless the spouse consents to waive this right.
- If employee named someone other than the spouse as primary beneficiary, or named someone in addition to the spouse as the primary beneficiary, that election is void and the spouse is the automatically the sole primary beneficiary.
- The secondary/contingent beneficiary can be anyone the employee wants. No spousal consent required.
- Applies to IRA's too.

Retirement Plans - QJSA

- If you have a DB plan or Money Purchase Plan and the employee prefers the lump sum payout option, you may need to have the spouse complete Qualified Joint and Survivor Annuity (QJSA) waiver form. Otherwise, the default payout option my be an annuity that gives the spouse survivor benefits if the employee dies.

- Unknown
  - What do you do if the employee is already receiving an annuity payment based on single life expectancy? Do you have to recalculate the benefit payments going forward under QJSA?
  - What if the employee died? Can the spouse claim QJSA?

Retirement Plans – RMD (aka 70 ½ rule)

- Employees that are at least age 70 ½ and are either owner-employees with 5%+ controlling interest or retired must receive the Required Minimum Distribution (RMD).
- If that employee dies, the spouse may have survivorship rights.
- Applies to IRA's too.

Retirement Plans – Spousal Rollovers and QDRO's

- Spouses are able to rollover the retirement account of the employee to their own retirement plan or IRA.
- When same-sex spouses get divorced, the court can issue a Qualified Domestic Relations Order (QDRO) that give the ex-spouse rights to the some or all of the employee's account balance.
- Applies to IRA's too.

IRA's

- Primary beneficiary, Spousal rollover if employee dies, RMD's, QDRO's
- Unemployed spouse can open an IRA if filing joint and contribute the maximum limit.

- Unknown
  - Can the couple retroactively open an IRA for unemployed spouse for prior years and amend their 1040s to get the tax refunds?

Cafeteria Plans (Sec. 125/FSA/HSA)

- If you were not allowing the employee to pre-tax the same-sex spouse's premiums, you may have to amend the employee's income taxes and W-2 to include the premiums as pre-tax deductions.
- If the couple elects to file a joint tax return, you must accept the spouse's eligible expenses for caf plan reimbursements under a Flexible Spending Account (FSA) or Health Savings Account (HSA).

Caf Plan continued

- You do not have to amend the W-2 for prior years. The couple can claim the insurance premiums and healthcare or dependent care expenses by amending their prior 1040s.

- Unknown
  - What if an employee had their FSA balance forfeited at the end of the year? Can they retroactively claim spousal expenses now and get the forfeitures refunded?

COBRA

- The same-sex spouse will be treated as a qualified beneficiary and eligible to benefits under COBRA.

Actions for retirement plan sponsors to take now

- Gather updated employees' marital status information.
- Implement changes and instructions to forms and procedures to ensure that the plan will be compliant with the same-sex marriages.
- Examples include beneficiary designation instructions where spousal consent is required if a beneficiary other than the spouse is named, distribution/loan request forms requiring spousal consent, and QJSA and QDRO procedures where a same-sex spouse is considered.
- Possibly distribute new beneficiary designation forms for employees to complete.
- Consult ERISA counsel regarding any additional actions that might be necessary, such as providing an updated Summary Plan Description (with a revised definition of spouse) to employees.

Future actions pending additional guidance:

- • Amendments to the plan, such as to the definition of spouse.
- • Possible retroactive application of the repeal of DOMA and any resulting required corrections, such as the example mentioned earlier, where under the prior operation of the plan, death benefits may not have been paid to a same-sex spouse due to DOMA.

Healthcare Reform Implications for the Territories/Guam

By:
Frank J. Campillo
Health Plan Administrator
Calvo's SelectCare

Agenda

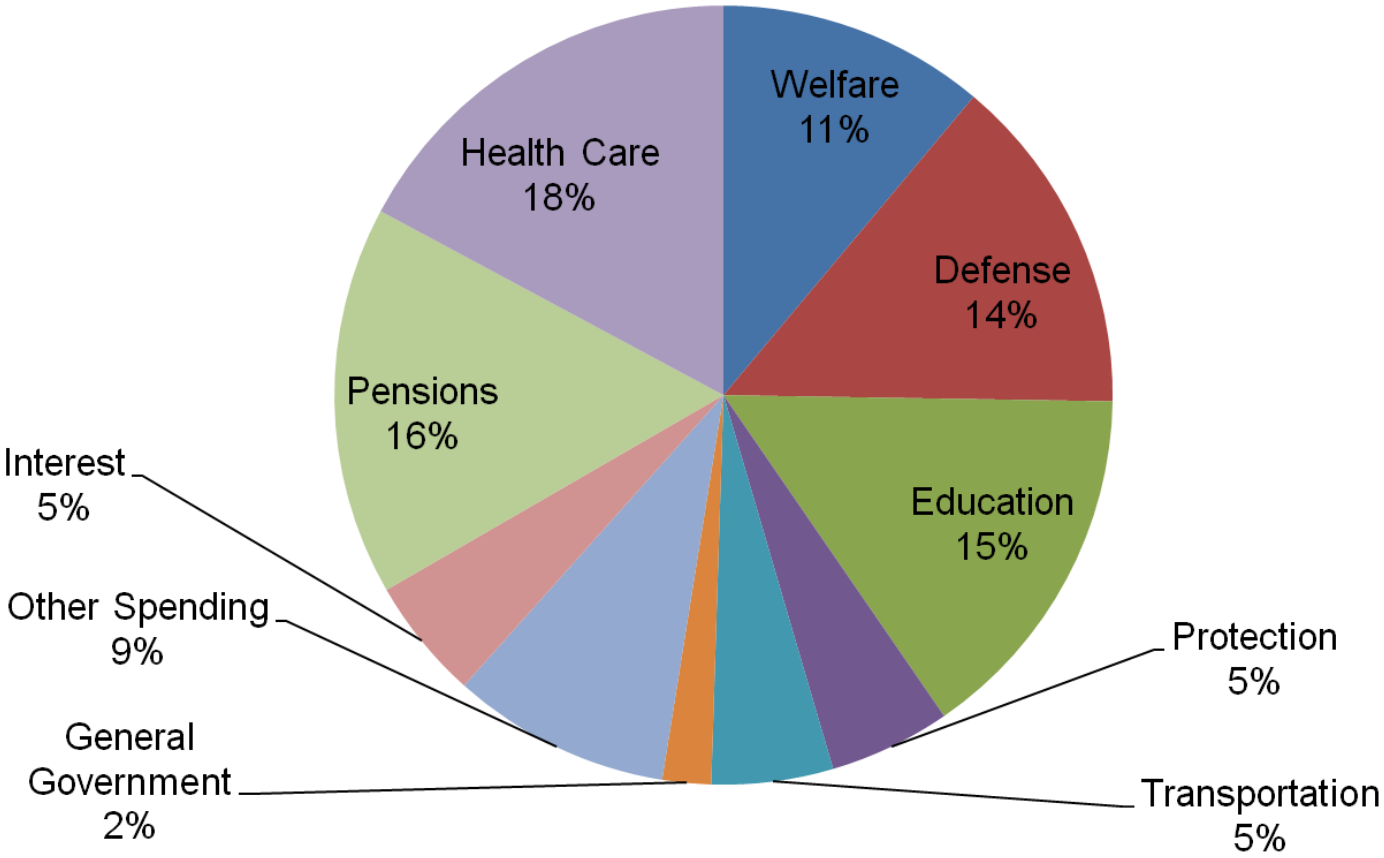
- Key Challenges to U.S. Healthcare System
- Why reform
- Implications to Guam

Health Expenditures for Selected Services 2000–2015

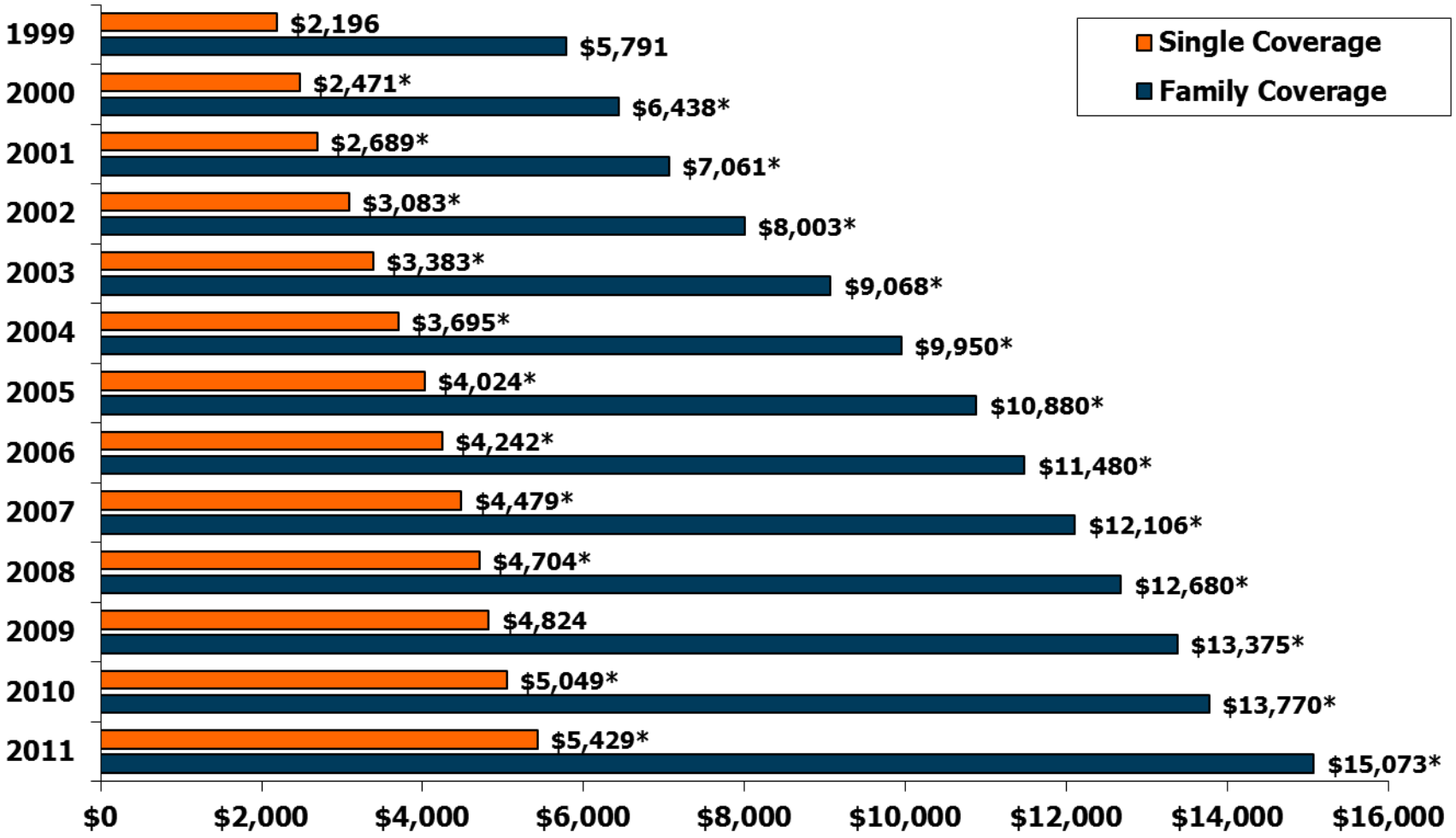
			Projected	
TOTAL	**2000**	**2005**	***2010***	***2015***
Billions	$1,353.3	$1,987.7	$2,879.4	$4,031.7
Percent GDP	13.8%	16.0%	18.0%	20.0%
BY TYPE OF SERVICE				
Hospital care	$417.0	$611.6	$882.4	$1,230.9
Physician & clinical services	288.6	421.2	610.7	849.8
Other professional services (dental, etc.)	138.2	200.5	292.6	411.5
Nursing home care	95.3	121.9	160.5	216.8
Home health care	30.5	47.5	72.3	103.7
Prescription drugs	120.8	200.7	299.2	446.2
Other medical products	49.5	58.1	69.1	83.1
Program admin. & net cost of private health insurance	81.2	143.0	210.6	289.8
Investment	88.8	126.8	191.3	268.9

Source: The Commonwealth Fund; Data from A. Catlin et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, Jan./Feb. 2007 26(1):142–53; C. Borger et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs* Web Exclusive (Feb. 22, 2006):w61–w73.

U.S. National Healthcare Expenditures



Average Annual Premiums for Single and Family Coverage, 1999-2011



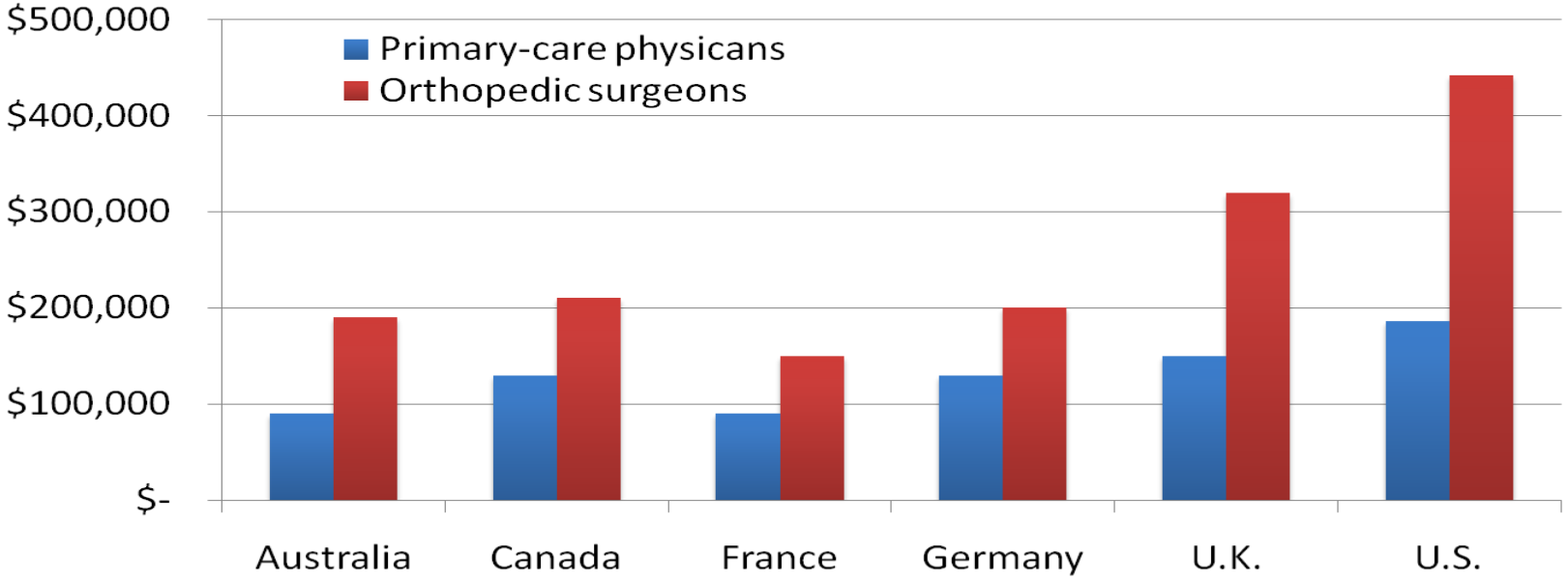
* Estimate is statistically different from estimate for the previous year shown (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011.

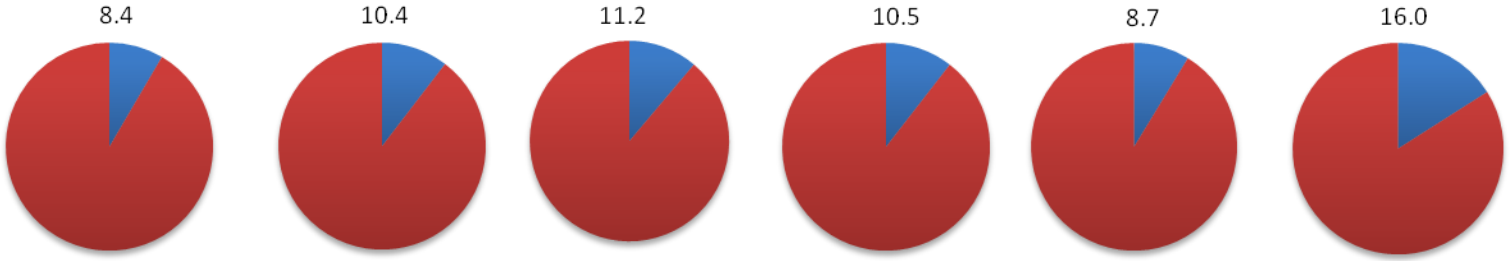
THE HENRY J. KAISER FAMILY FOUNDATION -AND- HRET HEALTH RESEARCH & EDUCATIONAL TRUST

Global Payments

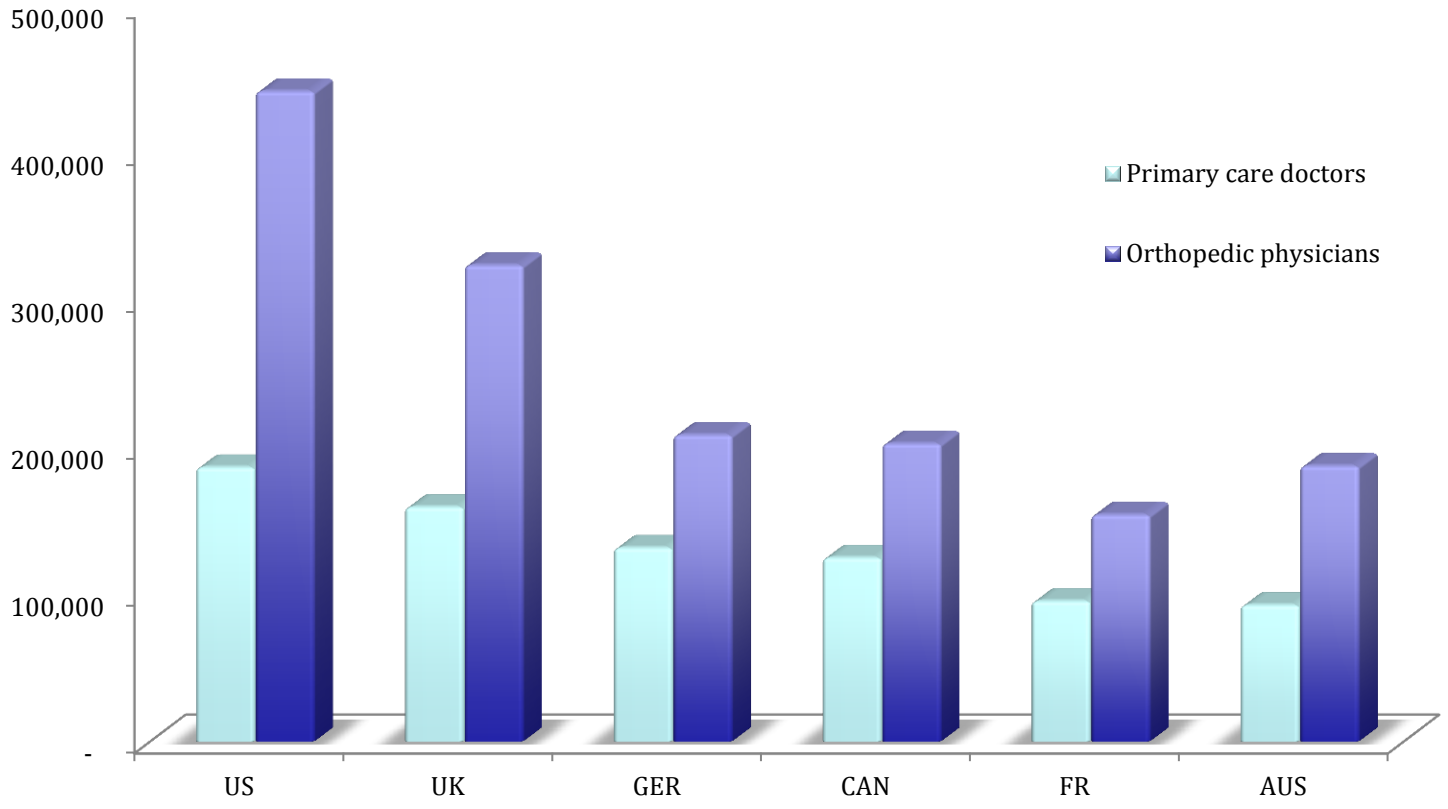
PRE-TAX EARNINGS



HEALTH SPENDING AS GDP% AND PER CAPITA

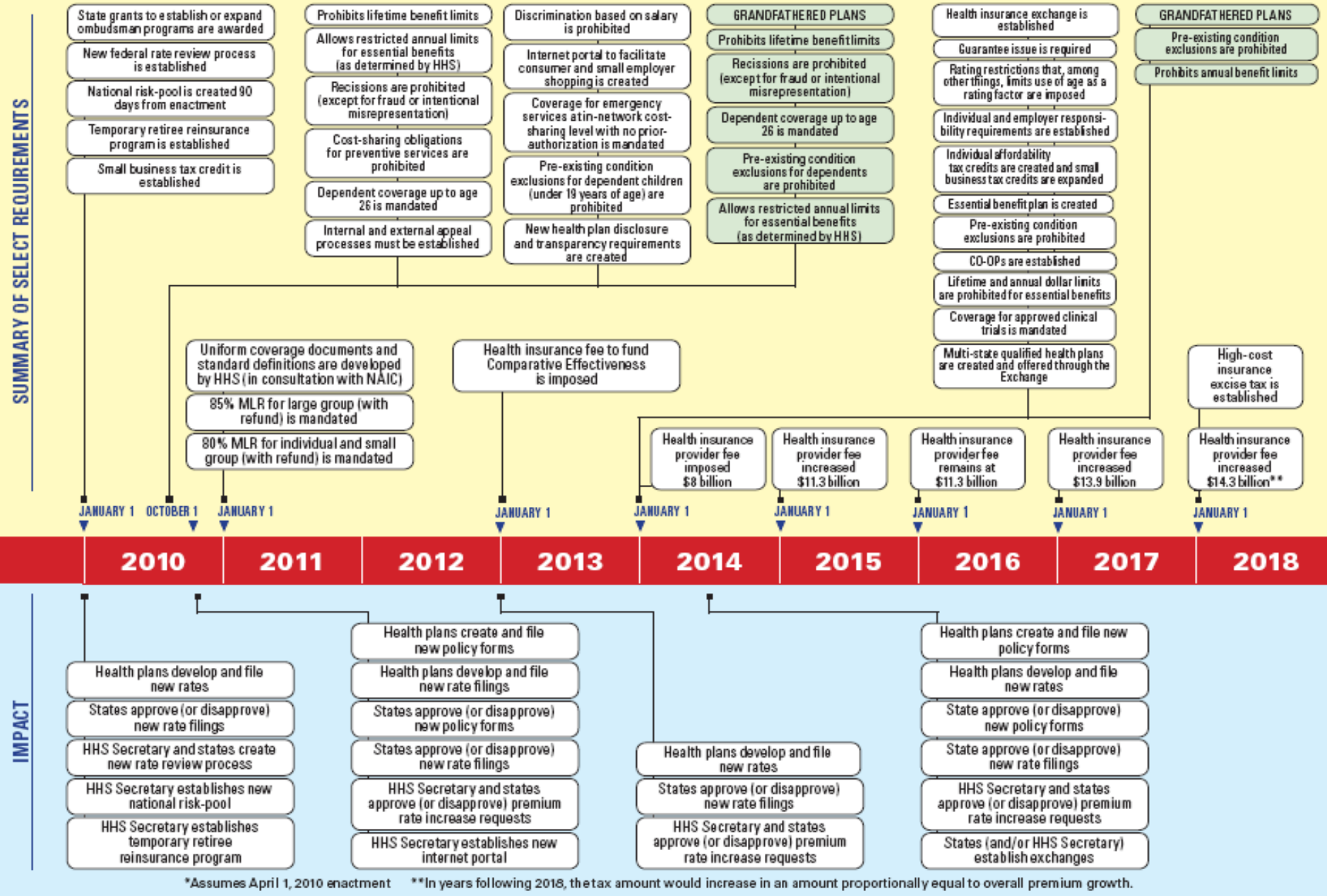


Physician Incomes, 2008
Adjusted for Differences in Cost in Living



Source: MJ Laugesen and SA Glied, "Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services Compared to Other Countries," *Health Affairs*, Sept. 2011 30(9):1647-56

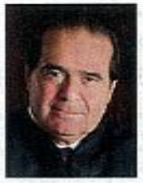
Health Care Reform Bill Insurance Market Provisions Timeline (as revised by the House Reconciliation Bill)*



*Assumes April 1, 2010 enactment **In years following 2018, the tax amount would increase in an amount proportionally equal to overall premium growth.


INDIVIDUAL MANDATE
You're going to live.
HEALTH CARE LAW
SEMELROTH ©'12

How the justices ruled on key PPACA provisions

	 Breyer	 Ginsburg	 Kagan	 Sotomayor	 Roberts	 Alito	 Kennedy	 Scalia	 Thomas
Mandate legal as tax	X	X	X	X	X				
Mandate legal under commerce clause	X	X	X	X					
Mandate unconstitu-tional						X	X	X	X
Illegal to put all Medicaid funding at stake to force expansion	X		X		X	X	X	X	X

Note: X means ruled in favor of the provision

MODERN HEALTHCARE GRAPHIC

IMMEDIATE AND LONGER TERM INSURANCE MARKET REFORMS

2010 > 2011 > 2012 > 2013 > 2014 > 2015 > 2016 > 2017 > 2018 > 2019

Upon Enactment: **FEDERAL GUIDELINES FOR REASONABLENESS OF RATES PROCESS**

IMMEDIATE REFORMS

Within 60–90-Days of Enactment:

- National High Risk Pool Established
- Internet Portal Created

For Plan Years That Begin on or After 180 Days of Enactment

- Prohibition on Lifetime Limits for Essential Benefits
- No Pre-Existing Condition Exclusions for Children Under 19
- Restricted Annual Limits for Essential Benefits
- Internal/External Appeals Process
- Rescission Restrictions
- Dependent Coverage Extended up to Age 26

By January 1, 2011:

- Mandatory Minimum Loss Ratio Requirement

LONG-TERM REFORMS

Beginning January 1, 2014:

- Co-Ops and Multi-State Qualified Plans Are Created
- Guarantee Issue Required, No Health Status Rating and Limited Age Rating, No Pre-Existing Condition Exclusions, Annual Dollar Limits Prohibited
- Individual and Employer Responsibility Requirements Established
- Individual Affordability Tax Credits Are Created
- Health Insurance Provider Fee Imposed
- Establishment of Exchanges

Beginning January 1, 2018:

- High Cost Insurance Excise Tax Imposed

Long-Term Reforms (2014): Underwriting and Rating Requirements

Guarantee Availability/Guarantee Issue – Applies Mandates that health insurance issuers accept every employer and individual that applies for coverage.

- Allows the HHS Secretary to establish open and special enrollment periods to mitigate the potential for adverse selection.

Prohibition on Pre-existing Condition Exclusions – Applies

- Prohibits the imposition of pre-existing condition exclusions

Risk Pooling

- Requires health insurance issuers to consider all enrollees in all individual market health plans (other than grandfathered plans) as a single pool.
- Requires health insurance issuers to consider all enrollees in all small group health plans (other than grandfathered plans) as a single pool.

Transitional Reinsurance/Risk Corridors/Risk Adjustment Programs - Not available to Guam

- Implements various risk spreading mechanisms in individual and small group markets

Long-Term (2014) Reforms: Benefit Requirements

Essential Health Benefits Package* for small groups Applies

- Requires the Secretary to define an essential health benefits package (EHBP) that includes coverage for at least the following general categories:
  - ambulatory patient services;
  - emergency services;
  - hospitalization;
  - maternity and newborn care;
  - mental health/substance use disorder services;
  - prescription drugs;
  - rehabilitative and habilitative services and devices;
  - laboratory services;
  - preventive and wellness services and chronic disease management; and
  - pediatric services, including oral and vision care.

Guam and other territories did not select a plan, so a default plan was assigned. The most popular FEHB plan, which single rate is in excess of $500/month.

Exchanges

- Requires states to establish an Exchange for the individual and small group markets **no later than January 1, 2014**. Not available for Guam
  - Defines “small group” as employers with at least one full-time employee and no more than 100 full-time employees.
  - State option for plan years before January 1, 2016, to define "small group" between 1 and 50 FTEs.
  - State option to expand access to large groups beginning in 2017.
  - 27 States chose not to set up an exchange and allow the Federal Government to run it
  - Federal funding is provided to create and operate state-based Exchanges by January 1, 2014.
  - States exchanges must be self-sustaining beginning on January 1, 2015, by placing an assessment or user fee on participating health insurance issuers or another funding mechanism.
    - $250 Million in HHS Grants available from 2010-2015

Incentives to Purchase Coverage

Personal Coverage Requirement – Not applicable to Guam

- The penalty charged for failing to maintain coverage is the greater of:
  - a flat fee of $695/year, or
  - 2.5% of income, phased in over time in the following manner

Year	Penalty Amount
2014	The greater of $95 or 1% of income
2015	The greater of $325 or 2% of income
2016	The greater of $695 of 2.5% of income
2017 and thereafter	The greater of $695 (+ COLA) or 2.5 % of income

Incentives to Purchase Coverage

Tax Credits for Health Insurance Cost-Sharing Obligations

- Increases cost-sharing subsidies for individuals with household incomes between 100 and 400% of the federal poverty level (FPL), as follows

FPL Percent	Amount of Subsidy Percent
100 – 150	94
151 – 200	87
201 – 250	73
251 – 400	70

Framework of PPACA or ACA

ACA frame work has been compared to a three-legged stool

- Insurance Market Reforms - Applies
- Individual and employer mandates – Does not apply to Guam
- Premium and cost sharing subsidies – Does not apply to Guam

Tax Changes Related to Financing Health Reform

- Impose new annual fees on the pharmaceutical manufacturing sector, according to the following schedule:
  – $2.8 billion in 2012-2013; – $3.0 billion in 2014-2016; – $4.0 billion in 2017;
  – $4.1 billion in 2018; and
  – $2.8 billion in 2019 and later.
- Impose an annual fee on the health insurance sector, according to the following schedule:
  – $8 billion in 2014;
  – $11.3 billion in 2015-2016; – $13.9 billion in 2017;
  – $14.3 billion in 2018
  – For subsequent years, the fee shall be the amount from the previous year increased by the rate of premium growth.

  For non-profit insurers, only 50% of net premiums are taken into account in calculating the fee. Exemptions granted for non-profit plans that receive more than 80% of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees' beneficiary associations (VEBAs) not established by an employer. (Effective January 1, 2014)

- Impose an excise tax of 2.3% on the sale of any taxable medical device. (Effective for sales after December 31, 2012)
- Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers. (Effective January 1, 2009)
- Impose a tax of 10% on the amount paid for indoor tanning services. (Effective July 1, 2010)
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit. (Effective January 1, 2010)
- Clarify application of the economic substance doctrine and increase penalties for underpayments

Concerns for Guam

- Only $3.7M in additional Medicaid money
- Other States get 100% subsidies for new Medicaid eligibles
- Insurance reforms apply to Guam but mandates do not
- The three legged stool becomes a one legged one for Guam

Questions