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HEALTH CARE REFORM

EMPLOYER HEALTH PLAN ISSUES (PART II) – 2012 AND BEYOND

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On March 23, 2010, President Obama signed The Patient Protection and Affordable Care Act (PPACA) into law. A reconciliation bill was finalized on March 26, 2010. The new health care law introduces a number of employer health plan changes which become effective on and after January 1, 2011, for calendar year health plans. We described the changes first effective in 2011 (for calendar year plans) in a prior article on Health Care Reform. This article primarily addresses those issues which will impact employer plans in 2012 and beyond.

The changes described below apply generally to both insured and self-insured plans, except that certain of the changes marked with an "*" are not applicable to "grandfathered plans" (i.e., group plans or individual coverage in place as of March 23, 2010). Plan sponsors must carefully consider the relative benefits of retaining "grandfathered" plan status when designing their health plans for 2011 and beyond. Please refer to our earlier article for those items that impact both "grandfathered" and "non-grandfathered" plans in 2011.

Grandfathered Plans

- According to interim regulations, there are a number of changes that could cause a plan to lose its grandfathered status, including:
    - entering into a new policy (i.e. changing carriers or transition from self-insured to insured) or insurance contract (except for renewal of an existing contract);
    - implementation of a significant cut or reduction in benefits;
    - an increase in co-insurance charges;
    - a significant raise in co-payments or deductibles;
    - a significant reduction in employer contributions;
    - elimination of all or substantially all benefits to diagnose or treat a specific condition; and
    - certain changes to annual or lifetime limits on the dollar value of benefits.

A statement regarding the plan's grandfathered status must be provided with the participants' plan materials. Complete record of plan design as of March, 23, 2010 must be retained to prove ability to retain grandfathered status.

2012

- Uniform Explanation of Coverage: All health plans are required to provide new uniform explanations of coverage to all new plan participants and at Annual Enrollment. The Explanations cannot exceed 4 pages, must be in 12-point font and must be written in a "culturally and linguistically appropriate manner." At a minimum, the Explanation must state cost sharing requirements (deductibles, copays) and restrictions and limitations on coverage and must state that the Plan meets/does not meet the 60% actuarial criteria for the value of benefits provided. These notices must be provided in addition to SPDs and SMMs.

- Notice of Material Modifications. Description of "material modification" in coverage must be furnished not later than 60 days before the effective date of the modification.

2013

- FSA Limits: Annual contributions to a heathcare FSA will be limited to $2,500.

- Notice of Health Care Exchanges: Employers providing coverage will be required to issue a notice to all employees advising them of where to get information about the Health Care Exchanges. Employers are also required to notify employees whether the employer's plan complies with the minimum 60% actuarial standard for health plans.

- Medicare Tax. The employee-paid portion of FICA (related to Medicare) increases .9% from 1.45% to 2.35% on all wages in excess of $200k for single filers and $250k for joint filers. Employer-paid portion of FICA is not impacted.

2014

- Free Choice Vouchers: Any employer offering a group health plan must offer a "free choice voucher" to any employee who is eligible for a premium subsidy from a Healthcare Exchange and whose premium contribution towards the employer's plan is greater than 8% but does not exceed 9.8% of his/her household income (indexed for inflation) and that household income does not exceed 400% of the Federal Poverty Level. The voucher must be for no less than the maximum amount the employer would have contributed to provide coverage to the employee. If the voucher amount exceeds the cost to buy coverage, the employee can keep the difference in cash or as a credit on his/her tax return.

- Free Rider Penalty: A "Free Rider" penalty can be assessed against an employer if an employer (1) does not offer coverage at all, and at least one

employee is eligible to receive a premium subsidy on a Health Care Exchange or (2) an employer offers coverage but it does not meet a standard of providing benefits with a 60% actuarial value, or it charges employees more than 9.5% of AGI. If the employer does not offer coverage at all, the employer must pay a "Free Rider" annual penalty equal to $2,000 times the number of full-time employees. Failure to meet the 60% actuarial value/9.5% income test thresholds subjects the employer to a "Free Rider" penalty equals of $3,000 per employee who qualifies for a subsidy on the Exchange up to a maximum of $2,000 times the number of full-time employees.

- Annual Limits: No health plan can impose annual limits on "essential health benefits." (Note: Recent regulations provide that the maximum "annual limit" for 2011 may not be less than $750,000; for 2012, not less than $1,250,000; and for 2013, not less than $2,000,000).

- Annual Reports to IRS: All health plans are required to provide a new report to the IRS each year detailing the names and SSNs of enrollees, whether the Plan covers "essential health benefits", the length of any waiting period, the employer/employee cost share, etc.

- *Clinical Trials. Health plans cannot discriminate (or disallow) employees from participating in clinical trials for cancer or other life-threatening diseases or conditions.

- *Cost Sharing Restrictions. Sponsors of group health plans must pay at least 60% of the total cost of coverage and out-of-pocket limits cannot exceed those allowed for high deductible health plans (currently $5950 (Individual) and $11,900 (Family)).

- Eligibility Waiting Periods. Large employers may not have eligibility waiting periods exceeding 90 days.

- Pre-existing Conditions. No health plan can impose a pre-existing condition on anyone, regardless of age.

- *Wellness Programs. The law codifies HIPAA's regulations on Wellness programs and increases the incentive cap to 30% from 20% that employers are allowed to grant if employees participate in wellness programs.

- *Quality of Care Reporting. All health plans must file an annual report related to various quality of care items (effective case management, preventing hospital readmissions) based on regulations to be issued by HHS.

2018

- Cadillac Plans/Excise Tax. Plans offering very rich coverage ("Cadillac" plans) will be subject to a 40% excise tax on the amount by which the aggregate costs

of coverage (including both the employee and employer portions) exceed $10,200 (Individual) and $27,500 (Family). Note: In determining plan costs, medical, Rx, and contributions to FSAs and HSAs are included.

As appeared in the Summer 2010 issue of the Willcox Savage Employment Law Outlook.