LEGAL UPDATES

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What's Next? How the Supreme Court's Decision Impacts Employers and Employer-Sponsored Health Plans

Service

Employee Benefits & Executive Compensation

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In the wake of the U.S. Supreme Court's June 28, 2012, decision upholding the constitutionality of the 2010 Patient Protection and Affordable Care Act, employers who had been awaiting the decision should now focus on compliance. We expect additional guidance will be released to implement several pending provisions, including those related to the 2014 employer responsibility provisions and increased incentives for wellness programs.

What This Means to You

Employers should work with their advisors to review existing health plans for compliance with the Affordable Care Act in light of existing and upcoming guidance and prepare for new taxes and fees. In addition, employers should anticipate and plan for the employer responsibility provisions – the so-called "play or pay" rules – that become effective in 2014. Employers with grandfathered plans should evaluate whether proposed plan design changes will jeopardize grandfathered status.

Many requirements of the Affordable Care Act are already in effect. **Both grandfathered and non-grandfathered health plans** must extend coverage to adult children to age 26 (regardless of marital or student status); eliminate lifetime and annual limits on essential health benefits (certain exceptions apply for plan years beginning before 2014); eliminate pre-existing conditions exclusions for enrollees under age 19; and prohibit retroactive rescission of coverage except for fraud, misrepresentation or nonpayment of premiums. In addition, non-grandfathered health plans must prohibit prior authorization for emergency service and prohibit greater cost-sharing for out-

of-network emergency services; provide preventive care services at no cost to participants; add external review procedures to their claims processes; and allow participants to choose primary care physicians, pediatricians or OB/GYNs without prior authorization or referral.

The following table outlines important employer action items for 2012 and beyond. These items apply to both grandfathered and non-grandfathered plans, unless otherwise noted.

Effective Date	**Provision**
Plan years beginning on or after September 23, 2010*	**IRS Nondiscrimination Rules Extended to Fully Insured Medical Plans:** Nondiscrimination rules similar to those under Section 105(h) of the Internal Revenue Code were extended to insured plans. This means that coverage under a fully insured medical plan may not discriminate in favor of highly compensated individuals. Not applicable to grandfathered plans. * Implementation of this rule is delayed pending issuance of IRS regulations.
2011; refunds are required beginning August 2012	**Medical Loss Ratio Refunds:** The Affordable Care Act requires insurers in the large group market to attain a medical loss ratio of at least 85 percent and insurers in the small group market to attain a medical loss ratio of at least 80 percent. Insurers of fully insured group health plans must issue refunds in states where the insurer does not meet the medical loss ratio target. Employers with fully insured plans will need to determine whether the plan or the employer is entitled to the refunds and what to do with the plan's portion of the refund, if any. Employers should consider amending their plans to allow any refunds to be retained solely by the employer, as opposed to treating the refund as a "plan asset" to be shared with employees.
August 1, 2012	**Preventive Services for Women:** Health plans and insurers are required to provide coverage without cost sharing for a range of preventive services for women, including contraceptive methods and counseling. Not applicable to grandfathered plans.
Open	**Summary of Benefits and Coverage (SBC):** The Affordable Care Act requires

enrollment periods and plan years beginning on or after September 23, 2012	health plans to issue SBCs to applicants and enrollees describing plan benefits and coverage in a uniform manner. The government issued final regulations and two sets of frequently asked questions concerning this requirement. Electronic delivery safe harbors are available in addition to the Department of Labor (DOL) electronic safe harbor that is applicable to Employee Retirement Income Security Act (ERISA) disclosures. Plans that willfully fail to comply may be subject to a fine of up to $1,000 for each failure per enrollee. The rules require 60 days advance notice of a plan change affecting the content of an SBC. A template SBC is available here.
Plan years ending on or after October 1, 2012	**Fees for Comparative Clinical Effectiveness Research:** A per participant fee of $2 ($1 for plan years ending before October 1, 2013) is imposed on sponsors of self-funded health plans and group health insurers. The fee is set to expire for plan years ending after October 1, 2019.
January 2013	**W-2 Reporting:** Employers must report the cost of coverage under employer-sponsored health plans on Form W-2, effective for 2012, with the first reporting required in January 2013. A transition rule delays the requirement for one year for employers who file fewer than 250 Forms W-2.
Tax years beginning after December 31, 2012	**Retiree Prescription Drug Expenses:** Repeals the deduction for retiree prescription drug expenses that are reimbursed by a qualified retiree prescription drug subsidy.
Plan years beginning on or after January 1, 2013	**Health Flexible Spending Accounts (FSA):** Employee medical FSA contributions are limited to $2,500 (indexed for cost of living). Plan sponsors should consult advisors and review plan documents to determine if any plan amendments are necessary. (More information here.)
March 1, 2013	**Employee Notice:** Employers must notify employees regarding the role of state insurance exchanges and the availability of federal premium assistance credits.
2013	**Increase in Medicare Tax on High Wage Earners:** Employers must withhold an additional 0.9 percent in Medicare taxes on wages subject to Medicare taxes above $200,000 ($250,000 for joint filers). Therefore, wages below $200,000 will continue to be subject to a combined 2.9 percent tax (1.45 percent paid by the

	employee and 1.45 percent paid by the employer) and wages above $200,000 will be subject to a combined tax of 3.8 percent (2.35 percent paid by the employee and 1.45 percent paid by the employer). Single taxpayers with modified adjusted gross income above $200,000 ($250,000 for joint filers) will also be subject to a new 3.8 percent Medicare tax on net investment income (including interest and dividends). (Employers have no reporting or withholding obligation for this tax.)
2014	**Adult Pre-existing Conditions Exclusions:** Plans must eliminate all pre-existing conditions exclusions for all enrollees.
2014	**Pay or Play Rule:** Employers must provide minimum essential health coverage to all full-time employees or face a penalty of up to $2,000 per full-time employee (after subtracting the first 30 full-time employees). Applies to employers who have (i) 50 or more full-time equivalent employees and (ii) at least one full-time employee who is eligible for premium assistance credits to purchase insurance through an insurance exchange. An employee is eligible for premium assistance credits if the employee's household income is between 100 percent and 400 percent of the federal poverty line.
2014	**Affordable Coverage Rule:** Employers with 50 or more full-time equivalent employees must provide full-time employees with "affordable" health coverage of a "minimum value" or pay a penalty. The penalty is equal to $3,000 for each employee who is eligible for premium assistance to purchase insurance through an insurance exchange unless the coverage both has "minimum value" and is "affordable." Coverage meets the "minimum value" test if the plan pays at least 60 percent of the cost of benefits provided. Coverage is "affordable" if the employee's share of the cost of single coverage is no more than 9.5 percent of his or her household income.
2014	**90-Day Waiting Period:** A plan is prohibited from imposing an enrollment waiting period longer than 90 days.
2014	**Mandatory Coverage for Clinical Trials for Life-Threatening Diseases:** Plans must cover the costs of routine care provided in connection with clinical trials. Not applicable to grandfathered plans.

2014	**Expansion of Wellness Incentives:** Wellness incentive opportunity increased from 20 percent to 30 percent of the cost of coverage (HHS secretary may increase by regulation). It is unclear whether this provision applies to grandfathered plans.
2014	**Caps on Out-of-Pocket Maximums:** Annual limits on participant out-of-pocket costs for essential benefits cannot exceed the limits for high deductible health plans. Not applicable to grandfathered plans.
Effective date is not clear; future guidance is expected and most believe this requirement will not be effective until regulations are issued	**Automatic Enrollment:** Mandatory enrollment of all eligible employees, subject to voluntary employee opt-out; applicable to employers with 200 or more employees.
2014	**Reporting Requirements:** Employers with 50 or more full-time equivalent employees must file an annual return with the IRS regarding health insurance provided to employees and costs.
2018	**Excise Tax on High Cost Employer-Sponsored Health Coverage:** The so-called "Cadillac tax" is a 40 percent nondeductible excise tax on the excess value of employer-sponsored health coverage that exceeds a threshold amount ($10,200 for self-only coverage and $27,500 for family coverage as of 2018).

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