SEYFARTH SHAW LLP
ATTORNEYS

Health Care Reform Management Alert Series

Roadmap for 2012 and Beyond — Issue 42

This is the forty-second issue in our series of alerts for employers on selected topics on health care reform. (Click here to access our general Summary of Health Care Reform and other issues in this series.) This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of the Patient Protection and Affordable Care Act (ACA). What this means for employers sponsoring group health plans is that they must forge ahead and continue to implement the applicable provisions of the ACA on a timely basis. This issue highlights what both grandfathered and non-grandfathered plans will need to consider going forward.

2012 (GRANDFATHERED AND NON-GRANDFATHERED PLANS)		
MANDATES	**EXPLANATION**	**ACTION REQUIRED**
Summary of Benefits and Coverage	Group health plans will need to provide participants and applicants a Summary of Benefits and Coverage ("SBC"). The SBC will need to describe any cost-sharing (such as deductibles, co-pays and coinsurance), exceptions, and limitations on coverage, as well as provide examples to illustrate common benefit scenarios. SBCs must conform to specific formatting requirements and be presented in a culturally and linguistically appropriate manner. SBCs must be provided prior to enrollment (open enrollment and new hires), upon request, and following special enrollment event.	• Effective the first day of the first open enrollment period beginning on or after September 23, 2012, SBCs must be provided to participants who enroll or reenroll through open enrollment. • Effective the first day of the first plan year that begins on or after September 23, 2012, SBCs must be provided to newly eligible individuals. • SBCs may be distributed electronically to new hires and individuals not enrolled, and to current participants and beneficiaries if open enrollment materrials are distributed electronically, with certain conditions • For more information on SBCs, click to access Issues *24*, *30*, *33* and *37* of our Health Care Reform Alert series.

2012 (GRANDFATHERED AND NON-GRANDFATHERED PLANS)		
MANDATES	**EXPLANATION**	**ACTION REQUIRED**
Advance Notice of Changes	Notice of any material modifications (that would impact the SBC) during the plan year must be provided no later than 60 days prior to the effective date.	• Applies to mid-year changes, so plan ahead and review bargaining changes
Patient-Centered Outcomes Research Institute (PCORI) Fee	Sponsors of self-funded group health plans and insurers of fully-insured group health plans are subject to an annual PCORI fee. The fee is imposed for each plan year ending after September 30, 2012 (meaning calendar year plans are subject to the fee in 2012). The fee sunsets in 2018. For plan years ending during the period of October 1, 2012 through September 30, 2013, the fee is one dollar times the average number of covered lives. For each plan year ending after September 30, 2013, the fee is equal to two dollars times the average number of covered lives under the policy.	• The fee must be paid annually by using IRS Form 720. The fee must be paid by July 31 each year, beginning July 31, 2013 for most plan sponsors. • Plan sponsors need to determine the number of covered lives. • For information on calculating the number of covered lives, click *here* to access Issue 39 of our Health Care Reform Alert series.
Form W-2 Reporting	Group health plans must report the aggregate cost of employer-sponsored coverage on the employee's Form W-2. Employer-sponsored coverage means group health plan coverage (other than certain listed excluded benefits). Cost is calculated under rules similar to COBRA.	• Employers must include the cost of coverage provided in 2012 in Box 12 of the W-2 issued in January 2013 (using Code DD). • For additional information on the W-2 reporting requirement, click here to access Issues *19* and *31* of our Health Care Reform Alert series.
Medical Loss Ratio (MLR) Rebates for Insured Plans	Insurers must provide rebates to enrollees when their spending for the benefit of policyholders for clinical services and health care quality improving activities, in relation to the premiums charged, is less than the MLR standards.	• Rebates are provided by August 1 each year, beginning August 1, 2012. • Plan sponsors must determine if the rebate is a plan asset, and if so, how the rebate will be allocated.

2012 (NON-GRANDFATHERED PLANS ONLY)		
MANDATES	**EXPLANATION**	**ACTION REQUIRED**
Internal and External Appeals Processes	Group health plans must implement additional standards to the existing internal claims and appeals processes as well as implement a new external review process.	• Self-funded plans should have their contracts in place with Independent Review Organizations (IROs). • For more information on the new claims processes, click here to access Issues *11*, *17* and *21* of our Health Care Reform Alert series.
Transparency Reporting	Group health plans must disclose certain enrollee information, including claims payment policies and practices and enrollee rights, to HHS and the State insurance commissioner. Group health plans must also provide information to enrollees on the amount of cost-sharing for a specific item or service.	• Uncertain effective date; waiting for guidance. • Once additional guidance is issued, provide the required information to HHS, the State insurance commissioner, and enrollees.
Quality of Care Reporting	Group health plans must annually submit a report to HHS that provides certain information on plan benefits.	• Uncertain effective date; waiting for guidance (which was due March 23, 2012). • Once guidance is issued, provide the required information to HHS and enrollees.
Preventative Care	Self-funded plans and issuers are required to provide coverage without cost sharing for certain preventive services provided to women, including but not limited to: well-women visits, contraception and contraceptive counseling, gestational diabetes screening, high-risk human papillomavirus (HPV) DNA testing, breast-feeding supplies and counseling, and domestic violence screening .	• Effective the first plan year that begins on or after August 1, 2012, plans must offer these services without cost sharing. • Review healthcare.gov to ensure all preventive services recommended (more than one year ago) are also covered. • Religious employers have a temporary enforcement safe harbor from the requirement to cover contraceptive services. The agencies have asked for comments and intend on issuing final regulations that will be effective when the temporary enforcement safe harbor expires (i..e. plan years beginning on or after August 1, 2013.)

2013 (GRANDFATHERED AND NON-GRANDFATHERED PLANS)		
MANDATES	**EXPLANATION**	**ACTION REQUIRED**
$2,500 Cap On Health FSAs	An employee may not contribute more than $2,500 to their healthcare flexible spending account ("Health FSA"). The cap does not apply to employer contributions to a Health FSA.	• For plan years beginning after December 31, 2012, limit employee Health FSA contributions to $2,500. • Employers must ensure that their plan documents have been amended no later than December 31, 2014. • For more information on the $2,500 limit, click *here* to access Issue 40 of our Health Care Reform Alert series.
Notice of Exchange	ACA requires that most employers provide to employees at the time of hiring (and to current employees, not later than March 1, 2013) written notice informing employees: • About the existence of a local Health Benefit Exchange ("Exchange"), including a description of and contact information for the Exchange, and • That they may be eligible for a tax credit or cost-sharing reduction to purchase health insurance through an Exchange if the employer's share of the costs of coverage is less than 60%, and • If they purchase coverage through an Exchange, they may lose any employer contribution toward the cost of coverage.	• Effective March 1, 2013, provide employees required notices. • Model Notices may be developed.

2013 (GRANDFATHERED AND NON-GRANDFATHERED PLANS)		
MANDATES	**EXPLANATION**	**ACTION REQUIRED**
Medicare Part A Tax	Certain employees are subject to an additional Medicare Hospital Insurance ("HI") tax. All employees are already subject to the HI tax at a 1.45% rate on all wages regardless of amount. The HI tax is increased by 0.9% for earnings over $250,000 for joint returns and $200,000 for single taxpayers effective January 1, 2013. Threshold amounts are not indexed for inflation. Employers are responsible for tax withholding on an employee's wages in excess of $200,000 at 2.35% (1.45% + 0.9%) for the additional HI tax. There is also an additional 3.8% tax on unearned income (dividends, interest, annuities, royalties, rents and capital gains) for earnings in excess of $250,000 for joint returns and $200,000 for a single taxpayer. Threshold amounts are also not indexed for inflation. The 0.9% HI tax is on wages is in addition to the 3.8% Medicare contribution tax on net investment income.	• Effective January 1, 2013, employers will need to withhold on employee's wages in excess of $200,000 at a rate of 2.35% for the HI tax.
Taxation of Medicare Part D Subsidy	Employers receiving a Federal subsidy for providing retiree prescription drug coverage at least as favorable as Medicare Part D coverage will be taxed on the amount of the subsidy (previously, the subsidy was tax-deductible). Employers may have already realized this change in tax treatment for account purposes.	• Effective January 1, 2013.

2014 (GRANDFATHERED AND NON-GRANDFATHERED PLANS)		
MANDATES	**EXPLANATION**	**ACTION REQUIRED**
No Waiting Period in Excess of 90 Days	A group health plan may not require any waiting period that exceeds 90 days.	Remove any waiting period that exceeds 90 days, effective for plan years beginning on or after January 1, 2014.

2014 (GRANDFATHERED AND NON-GRANDFATHERED PLANS)		
MANDATES	**EXPLANATION**	**ACTION REQUIRED**
No Annual Limits	Group health plans may not establish ANY annual limits on the dollar amount of essential health benefits. The limitation on annual limits began in 2011.	Remove all annual limits on essential health benefits, effective for plan years beginning on or after January 1, 2014.
No Pre-Existing Condition Exclusions	Group health plans may not impose ANY pre-existing condition exclusions or limitations. In 2011, pre-existing conditions were not allow for participants under age 19.	Remove any pre-existing condition exclusions or limitations, effective for plan years beginning on or after January 1, 2014.
Employer Mandate	Starting January 1, 2014, an employer with more than 50 full-time equivalent employees must either provide employees with "minimum essential coverage" or pay a penalty. In addition, the coverage must be affordable and provide minimum value. "Affordable" means that employee's required contribution cannot exceed 9.5% of the individual's household income. "Minimum value" means that the plans' share of the total cost of the benefits must be at least 60%.	• The Plan will need to either offer "affordable" minimum essential coverage and cover at least 60% of the cost of that coverage to full-time employees, or pay an excise tax. • For more information on the employer mandate, including determining minimum value and the number of full-time employees, click here to access Issues *20*, *26*, *34* and *38* of our Health Care Reform Alert series.
Annual Reporting (Employer Reporting)	Large employers must report certain health insurance coverage information to both its full-time employees and the IRS. Employers who offer minimum essential coverage have additional reporting requirements. Employers will be required to give a written statement to each individual whose name was included in the report disclosing the information in the report relating to that employee, along with the name, address and contact information of the reporting employer.	• The reporting requirements apply to coverage provided on or after January 1, 2014. The first information returns will be filed in 2015. • The written statement must be furnished to employees on or before January 31 of the year following the calendar year for which the information was required to be reported to the IRS.
Reinsurance Fee	Insurers and third party administrators (on behalf of self-funded group health plans) must contribute to a temporary reinsurance program established by a state operating an Exchange. If a state chooses not to establish a reinsurance program, HHS will establish the program and perform the reinsurance functions for that state.	• Reinsurance payments will be paid to the State or HHS on a quarterly basis, beginning Jan 15, 2014. • The program will be in operation from 2014 - 2016. • Although the fee or assessment is paid by third-party administrators of self-funded plans, it will likely be passed on to the plan.

2014 (NON-GRANDFATHERED PLANS ONLY		
MANDATES	**EXPLANATION**	**ACTION REQUIRED**
Wellness Incentives	Group health plans will be permitted to offer discounts of up to 30% of the cost of an employee's health coverage (currently limited to 20%) as incentive for employees to participant in HIPAA wellness programs. HHS may increase this reward up to 50%. Under this incentive, the cost of an employee's health coverage is based on the COBRA premium.	Effective for plan years beginning on or after January 1, 2014.
Coverage for Clinical Trials	Group health plans that provide coverage to an individual eligible to participant in an approved clinical trial may not deny or limit coverage of routine costs for items and services associated with participation in the clinical trial.	Effective for plan years beginning on or after January 1, 2014.
Cost-Sharing Requirements	Group health plans may not have annual cost-sharing requirements (e.g., maximum deductibles and out-of-pocket costs) that exceed the new PPACA limitations. The annual out-of-pocket maximums cannot exceed the individual and family limits for high-deductible health plans that are in effect at that time.	Effective for plan years beginning on or after January 1, 2014.
Non-Discrimination for Fully-Insured Plans	Fully-insured group health plans may not discriminate in favor of Highly Compensated Individuals (HCIs) under Internal Revenue Code Section 105(h). HCIs generally include any individual who is one of the five highest paid officers, a shareholder who owns at least 10% in value of the stock of the employer, or among the highest paid 25% of all employees.	Effective date delayed until IRS issues guidance. For information on the delayed effective date, click *here* to access Issue 16 of our Health Care Reform Alert series.

POST-2014 (GRANDFATHERED AND NON-GRANDFATHERED PLANS)		
MANDATES	**EXPLANATION**	**ACTION REQUIRED**

Automatic Enrollment	Employers with more than 200 full-time employees offering one or more health benefit plans must automatically enroll new full-time employees in a health plan and continue the enrollment of current employees.
	
	Employees must be provided with adequate notice and given the opportunity to opt-out.
		• Most likely effective after 2014.
		• Once guidance is issued:
		  • Automatically enroll new full-time employees.
		  • Continue enrollment of current employees.
		  • Provide notice and opportunity to opt-out.
		  • Determine default coverage options.

POST-2014 (GRANDFATHERED AND NON-GRANDFATHERED PLANS)		
MANDATES	**EXPLANATION**	**ACTION REQUIRED**
Cadillac Tax	The Cadillac Tax is an excise tax on high-cost health plans. The threshold for the tax varies as follows: • Individual coverage - $10,200 • Family coverage - $27,400 • The thresholds are indexed to inflation and adjusted for high-risk or elderly populations The tax amount is equal to 40% of amounts of coverage in excess of the threshold. The tax applies to the aggregate value of coverage. The tax is assessed against the provider of the coverage, which is considered to be the insurer in the fully-insured plan context.	• Effective in 2018. • Monitor costs to assess whether coverage is at risk of tax assessment.

What's Next?

Seyfarth Shaw's Health Care Reform Team is following the legislation making its way through Congress now and will be monitoring developments as the presidential election approaches. We will continue to alert you to guidance issued by the agencies, as well as approaching deadlines. In the meantime:

- Review current plan provisions against the checklists above and determine if changes are needed.
- Prepare your Summary of Benefits and Coverage before annual enrollments begin this fall and talk to your insurers to ensure that they are preparing and delivering SBCs.
- If grandfathered, decide if your plan will maintain its grandfathered status.
- Make sure procedures are in place for administering the new $2,500 cap on health FSAs.

By: *Joy Sellstrom*

Joy Sellstrom is senior counsel in Seyfarth's Chicago office. If you would like further information, please contact your Seyfarth Shaw LLP attorney or Joy Sellstrom at *jsellstrom@seyfarth.com*.