Supreme Court Upholds Health Care Reform: What’s Next for Plan Sponsors

By Sarah Millar, Dawn Sellstrom and Rob Jensen

On June 28, 2012, the U.S. Supreme Court issued its highly anticipated decision on the constitutionality of the Patient Protection and Affordable Care Act of 2010 (i.e., “health care reform”), finding the individual mandate within Congress’ taxing power and the health care reform law constitutional.\(^1\) For a more detailed discussion of the decision, please see the alert U.S. Supreme Court Upholds Affordable Care Act found here.

In upholding the validity of the Patient Protection and Affordable Care Act’s individual mandate (and, in a more narrow ruling, the Medicaid expansion provisions of the law), the U.S. Supreme Court has paved the way for full health care reform implementation in January 2014. While group health plan sponsors and plan administrators may have shifted their focus away from health care reform as the constitutionality of the law was being decided, plan sponsors and administrators will want to renew their efforts and continue to take the necessary steps to comply with new and existing requirements for 2012 and beyond.

Below is a summary of some of the key health care reform provisions requiring health plan sponsors’ and administrators’ attention in the next 18 months.

**Effective in 2012:**

- **W-2 Reporting.** Employers must report the aggregate cost of employer-sponsored health coverage on employees’ annual IRS Form W-2.

- **Summary of Benefits and Coverage and Advance Notice of Material Modification.** Plans must provide applicants and participants with a summary explanation that accurately describes the benefits and coverage available. The summary must meet specified content and format requirements. A related requirement provides that, to the extent a group health plan implements a mid-year change that is a material modification, and that change affects the content of an SBC, a notice of material modifications must be provided to participants and beneficiaries at least 60 days in advance of the effective date of the change. This rule does not apply when the change is in connection with a renewal or reissuance of coverage. For more information, please click here.

- **Patient-Centered Outcome Research Trust Fund Fee.** The plan sponsor (for self-insured plans) or the insurer (for insured plans) must pay an annual fee equal to $2 ($1 for plan years ending on or after October 1, 2012 and before October 1, 2013) multiplied by the average number of lives covered by the plan. This fee applies for plan years ending on or after October 1, 2012, and before October 1, 2019.

\(^1\) Under the individual mandate, individuals are subject to a tax if they fail to obtain minimum essential coverage.
Effective in 2013:

> **Health FSA Limits.** Cafeteria plans must limit the annual salary reduction contributions for health flexible spending arrangements to $2,500 (which may be increased in future years for cost of living adjustments).

> **Increase of the FICA Medicare Tax Rate.** The employee portion of the hospital insurance tax part of FICA, currently 1.45 percent of covered wages, will be increased by 0.9 percent on wages that exceed $200,000 ($250,000 for married couples filing jointly).

> **Elimination of Medicare Part D Subsidy Deduction.** The deduction for employers who subsidize prescription drug coverage for their Medicare Part D eligible employees will be eliminated.

> **Notice of Insurance Exchanges.** Employers must provide to employees a written notice describing the exchanges and employees’ potential eligibility for premium credits.

> **Expansion of HIPAA Electronic Transaction Rules.** While likely to be carried out by insurers or third-party administrators, group health plans must comply with new operating standards and rules for processing electronic transactions.

Effective in 2014:

> **Employer Penalties.** A penalty is imposed against employers that have at least 50 full-time employees and either fail to offer full-time employees minimum essential coverage or provide coverage that is deemed unaffordable.

> **Automatic Enrollment.** Employers with more than 200 full-time employees must automatically enroll new full-time employees and continue the enrollment of current employees in a health benefits plan offered through the employer.

> **Coverage Reporting.** Employers must file an annual return with the government that certifies whether full-time employees have the opportunity to enroll in minimum essential coverage.

> **Elimination of Excessive Waiting Periods and Pre-Existing Condition Exclusions.** Plans cannot have a waiting period for eligibility that exceeds 90 days or impose any pre-existing condition exclusions. (Before 2014, the prohibition on pre-existing exclusions applies only to children under age 19.)

> **Limitation on Cost Sharing.** Annual deductibles under plans cannot exceed $2,000 (for single coverage) and $4,000 (for family coverage). Plans’ annual out-of-pocket requirements (deductible, coinsurance, copayments, etc.) cannot exceed those applicable to health savings accounts in 2014 (currently $6,050 for singles and $12,100 for families). (Does not apply to grandfathered plans.)

> **Elimination of Annual Limits.** Plans can no longer impose restricted annual limits on the dollar value of essential health benefits. (Before 2014, plans could establish certain restricted annual limits on the dollar value of essential health benefits that did not exceed certain dollar amounts.)

> **Wellness Rewards.** A reward for participation in a wellness program that requires an individual to satisfy a standard related to a health status factor may not exceed 30 percent (increased from the current 20 percent maximum) of the cost of employee-only coverage under the health plan. The Departments of Health and Human Services (HHS), Labor, and Treasury may increase this limit to 50 percent, if deemed appropriate.

> **Transitional Reinsurance Program Fee.** The third-party administrator (for self-insured plans) or the insurer (for insured plans) must pay an annual fee to be assessed by the Department of HHS. To reduce uncertainty of insurance risk in the individual market during the first three years of the state health insurance exchanges, transitional reinsurance program fees will be used to make reinsurance payments to health insurance issuers that cover high risk individuals in the individual market. The fee applies in 2014 through 2016.

For health plans that maintain grandfathered status, plan sponsors must continue to document any plan design changes, and maintain all documents necessary to verify, explain, or clarify the plan’s grandfathered health plan status. Grandfathered plans must also continue to provide a statement in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan (i.e., the summary plan description or open enrollment materials) that the plan “believes” it is a grandfathered health plan. For a description of the limits on changes that a health plan may make and continue to maintain grandfathered status, see our client alerts here and here.

With the constitutionality of health care reform settled, now is the time for plan sponsors and administrators to turn their attention back to compliance and
implementation efforts. We anticipate that the Departments of HHS, Labor and Treasury will continue to issue implementing regulatory and other guidance, which is especially needed on provisions of the law that are scheduled to take effect in 2014. We will continue to closely monitor these and other developments related to health care reform implementation. A copy of the decision and information on our forthcoming updates and analysis, including seminars and webinars, is available through the following link: http://www.drinkerbiddle.com/news/headlines/2012/Affordable-Care-Act.

Employee Benefits & Executive Compensation Practice Group

We intend to provide updates on this topic periodically. In the meantime, should you have any questions, please contact a member of the Drinker Biddle Employee Benefits & Executive Compensation Practice Group or your regular Drinker Biddle attorney.

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