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CLIENT BULLETIN

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What Now? Health Care Reform Beyond the Supreme Court

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Last week, the U.S. Supreme Court surprised most legal experts and court observers by upholding virtually every part of the health care reform law passed in 2010. In *National Federation of Independent Business v. Sebelius*, 567 U.S. ___ (2012), the Court found that the Patient Protection and Affordable Care Act of 2010 does not violate the U.S. Constitution, paving the way for numerous changes in employer-sponsored health plans to take effect. With the court challenges to the Act resolved, employers and insurers must start preparing now to meet the new requirements.

Since the Supreme Court upheld the Act, its requirements that are already in effect continue unchanged. The most notable of these requirements are coverage of adult children up to age 26 and the elimination of caps on lifetime benefits.

The new requirements described below affect almost all aspects of employer-sponsored health plans, from coverage penalties to employee communications. Also, most of the new requirements will apply to a plan regardless of its status as a "grandfathered health plan."

Major New Requirements Before 2014

• **Summary of Benefits and Coverage** – For any open enrollment periods beginning on or after September 23, 2012, group health plans must provide employees with a new notification called a Summary of Benefits and Coverage (SBC). The SBC is similar to a Summary Plan Description but is intended to be a more concise document focusing on available coverages, cost-sharing provisions, benefit limitations, and similar issues. The SBC, however, is not a substitute for a Summary Plan Description. The group health plan must provide an SBC on an annual basis, typically during each open enrollment period. Failure to provide an SBC may result in a penalty of up to $1,000 per enrollee/participant.

• **W-2 Reporting Requirements** – Employers must report the value of employees' health coverage on annual W-2 forms. This requirement is effective for the 2012 tax year, so W-2 forms issued in January 2013 should include this information. Employers which issue fewer than 250 W-2 forms are currently exempt.

• **Changes to Health Care Spending Accounts** – Effective on January 1, 2013, the definition of "qualified medical expense" is narrowed which will affect reimburse-

ments and withdrawals under all types of health care accounts, such as flexible spending accounts, health reimbursement arrangements, health savings accounts, and Archer medical savings accounts. Over-the-counter medications will no longer be a "qualified medical expense." Additionally, the amount employees could contribute to health care flexible spending accounts will be capped at $2,500.

• **Nondiscrimination Requirements for Fully Insured Plans** – Group health plans which are fully insured will be subjected to annual testing to determine whether their benefits are disproportionately favorable to highly-compensated employees. The effective date of these requirements has been delayed, and further guidance is expected before they become effective. Grandfathered health plans will not be subject to testing.

Major New Requirements Beginning in 2014

• **Penalty for No Coverage Offered** – Employers with more than 50 employees that do not offer any group health coverage and have at least one full-time employee who receives a premium tax credit (toward coverage through an Exchange) will be assessed a monthly penalty. The penalty is calculated as $166.67 per month (1/12 of $2,000 annual penalty) multiplied by the number of full-time employees in that month, excluding the first 30 employees. The rules for calculating who qualifies as a "full-time employee" are complex.

• **Other Possible Penalty** - Employers with more than 50 employees that offer group health coverage but still have at least one full-time employee receiving a premium tax credit (toward coverage through an Exchange) will pay $3,000 for each employee receiving a premium credit, subject to certain overall limits. These provisions apply even to grandfathered health plans.

• **"Minimum Essential Coverage" Certification** – Employers must certify to the U.S. Department of Health and Human Services whether their health plans provide "minimum essential coverage," as set forth in federal regulations. Other information as to employer cost and employee premiums will be required.

• **Preexisting Condition Exclusions** – Group health plans may not impose preexisting condition exclusions beginning in 2014. (Recall that plans may not impose preexisting condition exclusions for children under the age of 19 for plan years which began on or after September 23, 2010.) This requirement also applies to grandfathered health plans.

• **Annual Benefit Limits Prohibited** – As with the current prohibition on lifetime benefit limits, all annual benefit limitations are prohibited. This requirement also applies to grandfathered health plans.

• **Maximum Waiting Period** – A group health plan may not impose a waiting period on new participants and their dependents in excess of 90 days. This requirement also applies to grandfathered health plans.

• **Wellness Program Incentives** – The maximum incentive which may be offered in connection with an employer-sponsored wellness program is raised from 20% to 30% of the applicable premium.

Preparing to implement these new requirements during the next 18 months will be challenging and time-consuming, so we urge you to begin preparing and coordinating with your insurer now. Additional regulatory guidance will be issued as well, potentially making compliance even more complex.

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If you would like to discuss the continuing impact of health care reform on your benefit plans, please contact any member of Constangy's **Employee Benefits practice group**, or the Constangy attorney of your choice.

About Constangy, Brooks & Smith, LLP

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