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Healthcare Reform: What Connecticut Employers Need to Know After Supreme Court's Health Law Ruling

Posted by George J. Kasper, September 2012

On June 28, 2012, the Supreme court ruled that the Patient Protection and Affordable Care Act (the "Act") is constitutional. What does the decision mean for employers?

The Supreme Court's decision rests on some interesting legal arguments, including that the Act is a valid exercise of Congress's right to impose taxes. However, the practical effects go well beyond the academic analysis. The individual coverage mandate has been upheld, removing one of the major uncertainties about the Act. The Court's decision means the many provisions that already have taken effect will remain intact and paves the way for implementation of the many sweeping reforms that take effect in 2013 and beyond. The requirements for Medicare withholding for high earners, coverage of dependents up to age 26, health FSA contribution dollar limits, new W-2 reporting requirements, and state health exchanges are now realities.

Nothing in the Court's Ruling changes employer responsibilities under the Act. Employers therefore should continue to comply with the provisions of the Act that are already effective and to plan for those that are to take effect in the future.

In the near term, employers need to renew their efforts to implement the health plan changes and open enrollment for the 2013 plan year. The new rules pose compliance challenges for health plan sponsors, including plan document and administrative changes which may require coordination with third party vendors.

Key Provisions Coming Due. Notably, now that the Court has ruled, some of the law's key provisions require employer action now. Here is what employers and plan sponsors need to know:

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- **Summaries of Benefits and Coverage** - For open enrollment periods beginning on or after September 23, 2012, employers who sponsor medical plans (both self-insured and fully insured) must provide all employees eligible for coverage with a "4-page" summary of benefits and coverage describing the plan's key terms. These "SBCs" must be designed in accordance with detailed content and appearance requirements established by the Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments). If an employer sponsors more than one medical plan option, an SBC must be prepared for each option offered.
- *Key Steps Now:* Be prepared for the SBCs this fall by contacting your insurer, third party administrator (TPA) or consultant to arrange or coordinate the preparation and distribution of the SBCs.
- **Health FSA Contributions Dollar Limit** - Beginning in 2013, the annual dollar amount each employee may contribute to a health flexible spending account (Health FSA) through salary reduction contributions is limited to $2,500. This amount will be indexed for inflation in subsequent years. This change will require an amendment to cafeteria plan documents.
- *Key Steps Now:* Consult with counsel to get your plan document amendment(s) ready and timely adopted.
- **W-2 Reporting Requirements** - The Act requires employers to report annually on Form W-2 the cost of coverage under an employer-sponsored group health plan. In January 2013, employers will generally have to report the aggregate value of employer sponsored health coverage on the 2012 W-2 in Box 12, Code DD, if they have issued at least 250 W-2s in 2011. Generally, until further guidance is issued, employers who are filing fewer than 250 Forms W-2 for a preceding year generally are not required to report, although reporting is optional. Similarly, employers are not required to report such information on Form W-2s provided in response to employees who terminate before the end of a calendar year and request in writing a Form W-2 before the end of that year. The aggregate value is equal to the premium paid for insured plans and includes both the employer and employee payments. Self-insured plans may use the COBRA equivalent rate or another approved method of establishing plan value.
- *Key Steps Now:* Identify and value all group health plans that are subject to reporting; consult with insurer, TPA or consultant to assist with determining value; work with payroll departments or payroll administrators to make sure their systems are updated to capture and report the value of such coverage.
- **New Tax on Health Plans -** The Act established a non-profit organization, the Patient-Centered Outcomes Research Institute, to perform clinical effectiveness research intended to assist patients, clinicians, purchasers and policy-makers in making informed health decisions. This Institute will be funded by the new tax on employer sponsors (including governmental entities) of self-insured health plans and on issuers of health insurance policies. The tax, which will apply to plan years (policy years in the case of insurance issuers) ending after September 30, 2012, equals $1 per covered life for the first year and $2 per covered life (indexed for inflation after the second year) for each succeeding year. The tax will be paid annually with Form 720 and generally will be due by July 31 of the calendar year immediately following the last day of the plan or policy year, but is scheduled to phase out in six years. Internal Revenue Service proposed

regulations provide three alternatives for determining the number of covered lives for this purpose.

- *Key Steps Now:* Employer-sponsors of self- insured health plans need to understand and plan for the new tax; review the options available for determining the fee to determine the most effective approach for their plans.
- **Maintenance of "Grandfathered" Status -** A grandfathered plan is a group health plan or individual insurance policy that was in existence on March 23, 2010. These plans are able to take advantage of certain delayed effective dates for changes required by the healthcare reform law. Though reserving a grandfathered status provides the ability to delay specific aspects of health care reform, rising health care costs, among other factors, are forcing employers to make plan changes that end grandfathered status. Upon forfeiting grandfathered status, plans become subject to numerous additional healthcare reform requirements.
- *Key Steps Now:* Plan sponsors that maintain plans with "grandfathered" status need to determine whether retaining the plan's grandfathered status has significant value, closely monitor any changes under health care reform, and keep up to date on applicable notice requirements.
- **Medicare Tax** – Beginning in 2013, individuals who earn more than $200,000 ($250,000 for those who file a joint tax return) will be required to pay an additional Medicare Part A tax rate of 0.9%. The tax rate will rise from its current level of 1.45% to 2.35% of earnings above $200,000 ($250,000 for joint filers). Employers are responsible for withholding the additional 0.9% on each such employee's wages and compensation paid in excess of $200,000 in a calendar year. Employers are required to begin withholding the additional amount in the pay period in which it pays wages and compensation in excess of $200,000 to an employee.
- *Key Steps Now:* Inform payroll staff and coordinate with third-party payroll processors to adjust withholdings beginning in 2013.

Looking Beyond 2013. Significant additional new rules implementing health care reform are scheduled to go into effect in 2014. These include the following requirements:

- Employers with more than 200 employees must automatically enroll full-time employees in their health plans (provided the DOL issues regulations);
- Plans must not have waiting periods for entry into a plan in excess of 90 days (effective in 2014;
- Plans must eliminate any pre-existing condition exclusions for all participants and their covered dependents (effective in 2014);
- Insured plans must not discriminate in favor of highly compensated participants, under rules similar to the nondiscrimination rules already applicable to self-insured plans (enforcement delayed until regulations are issued; non-grandfathered plans only).

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- Beginning in 2014, employers must provide "minimum essential" health benefit coverage to their full-time employees, or pay a penalty (the "pay or play" mandate).

The Department of Labor has issued informal guidance indicating that it is working with the Internal Revenue Service and the Department of Health and Human Services to issue guidance relating to the requirements listed above. There are a number of pending regulations that will be important to employers, including the requirements under the pay or play employer mandate, the definition of a full-time employee under the law, and the application of the nondiscrimination rules to insured plans. Additionally, a significant portion of the existing guidance has been issued on an "interim" basis and final changes are likely.

Considering the lead time needed to arrange and implement the necessary document and administrative changes, employers should take steps to ensure that they are not caught off guard as the Act's key provisions take effect.