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Health Care Reform

What to Expect in 2013-2014

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Health Care Reform: What to Expect in 2013–2014

The focus on Health Care Reform turns back to compliance following the presidential election and a U.S. Supreme Court challenge in 2012. With several of the biggest changes yet to come, here's a look at some of the key provisions that may affect employers and insured group health plans over the next two years.

Note: This summary is for general reference purposes only and is not all-inclusive. The information is subject to change based on new government requirements or amendments to the law. Additionally, your group plan may be exempt from certain requirements. If you have any questions regarding your obligations with respect to Health Care Reform, you should consult with a knowledgeable employment law attorney and your carrier.

(Certain requirements under Health Care Reform apply on a plan year basis, meaning that the changes will take effect when a group health plan begins a new plan year. As a result, compliance deadlines may vary.)

2013

Availability of Health Insurance Exchanges—Employer Notice Requirements

In anticipation of open enrollment for exchanges (scheduled to begin on October 1, 2013), employers are required to provide each employee a written notice with information about an exchange, including notice that the employee may be eligible for a premium tax credit (if applicable) and that the employee may lose employer health plan contributions if the employee buys a qualified health plan through the exchange.

Special Update: The U.S. Department of Labor (DOL) has delayed the original March 1 deadline for employers to comply with this notice requirement. The timing for distribution of the notices is expected to be **late summer or fall of 2013** and employers are not required to comply with the requirement until further guidance is issued. The DOL is also considering providing a model notice that employers may use to satisfy this requirement.

Expanded Coverage of Women's Preventive Services for Non-Grandfathered Plans

Non-grandfathered group health plans are required to cover additional women's preventive services such as well-woman visits, breastfeeding support, domestic violence screening, and contraception without charging a co-payment, co-insurance or deductible, starting with **plan years beginning on or after August 1, 2012**.

Note: Group health plans sponsored by certain religious employers are exempt from the requirement to cover contraceptive services. Non-profit organizations with religious objections to covering contraception services have been provided an additional year—until August 1, 2013—to comply with this requirement.

Health FSA Contribution Limits

Effective for **plan years beginning on or after January 1, 2013**, the amount of salary reduction contributions to a health flexible spending account (FSA) is limited to $2,500 annually, adjusted for inflation. An amendment to a written cafeteria plan reflecting this change may be adopted at any time through the end of calendar year 2014.

The $2,500 limit does not apply to contributions or amounts available for reimbursement under other types of FSAs, health savings accounts (HSAs), or health reimbursement arrangements (HRAs), or to salary reduction contributions to cafeteria plans used to pay an employee's share of health coverage premiums.

A grandfathered group health plan is a plan in existence as of March 23, 2010 that has not made changes which significantly reduce benefits or increase out-of-pocket spending for individuals covered under the plan.

2013 (continued)

Medicare Tax Increase for High Earners

Employers are required to withhold Additional Medicare Tax (at a rate of 0.9%) on wages or compensation paid to an employee in excess of $200,000 in a calendar year, for **taxable years beginning after December 31, 2012**. There is no "employer match" for the Additional Medicare Tax and there is no requirement that an employer notify its employees when it begins withholding the Additional Medicare Tax.

Restrictions on Annual Limits

Annual dollar limits on "essential health benefits" are being phased out according to the limits set by law. For plan years starting between September 23, 2012 and January 1, 2014, these limits may be no lower than $2 million.

Note: Stand-alone HRAs that were in effect prior to September 23, 2010, as well as certain limited benefit or "mini-med" plans that received temporary waivers, are **exempt from the annual limit restrictions for plan years beginning before January 1, 2014**. Such plans must comply with specific notice requirements.

Reporting of Employer-Sponsored Health Plan Coverage on Forms W-2

Beginning with **calendar year 2012 Forms W-2** (required **to be furnished to employees in January 2013**), employers that provide a group health plan to employees and who have not been granted transitional relief generally must report the cost of the coverage provided to each employee annually. This requirement **does not apply to employers that were required to file fewer than 250 Forms W-2 for the preceding calendar year**, unless and until the IRS publishes further guidance giving at least 6 months' advance notice.

Summary of Benefits & Coverage (SBC) and Notice of Plan Changes

Effective for **plan years and open enrollment periods beginning on or after September 23, 2012**, group health plans and health insurance issuers offering group coverage are required to provide participants and beneficiaries with a summary of benefits and coverage (SBC) containing specific information about the plan and coverage, at several points during the enrollment process and upon request.

Additionally, notice of any material change in any of the terms of the plan or coverage that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, generally must be provided to enrollees **at least 60 days before the effective date of the change**.

2014

90-Day Limitation on Waiting Periods

In **plan years beginning on or after January 1, 2014**, a group health plan may not apply any waiting period that exceeds 90 days. A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective.

Availability of Health Insurance Exchanges

Exchanges are expected to begin operating in 2014 as an option for individuals to buy private health insurance. Exchanges will also operate a small business health options program (SHOP) as an option for qualified small employers to purchase employee health coverage. Businesses with up to 100 employees will be eligible to participate in SHOPs, although states may limit participation to businesses with up to 50 employees until 2016.

2014 (continued)

Coverage of Essential Health Benefits

Non-grandfathered plans offered in the small group market (both inside and outside of exchanges) must cover a core package of items and services known as "essential health benefits" beginning in 2014. Final rules have been issued which outline issuer standards related to coverage of these essential health benefits.

Dependent Coverage to Age 26 for Grandfathered Plans Without Exception

The temporary exception for grandfathered plans from the requirement that dependents be covered to age 26 (which currently allows the exclusion of adult children who are eligible to enroll in an employer-sponsored health plan other than the group health plan of a parent) no longer applies for **plan years beginning on or after January 1, 2014**. As a result, both grandfathered and non-grandfathered group health plans that cover dependents must make coverage available until a child reaches age 26, regardless of other coverage options.

Employer Shared Responsibility ("Pay or Play")

Beginning in 2014, employers with **50 or more full-time equivalent employees** may be required to make an annual shared responsibility payment if any full-time employee is certified to receive a premium tax credit or cost-sharing reduction payment.

(1) If an employer does not offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, the penalty amount is $2,000 for each full-time employee (excluding the first 30 full-time employees).
(2) If an employer offers the opportunity to enroll in minimum essential coverage that is either unaffordable relative to an employee's household income or does not provide minimum value, the penalty is the lesser of $3,000 for each full-time employee receiving a tax credit or cost-sharing reduction, or $2,000 for each full-time employee (excluding the first 30 full-time employees as above).

Note: Proposed rules have been issued which provide that an employer who is subject to the requirements would generally be treated as offering coverage to its full-time employees for a calendar month if, for that month, it offers coverage to **at least 95% of its full-time employees**. Under the proposed rules, after 2014, these provisions would apply to large employers that do not offer health coverage or that offer coverage to less than 95% of full-time employees **and their dependents** (i.e., children under 26 years of age).

Coverage is unaffordable for an employee if the required contribution for self-only coverage exceeds 9.5% of household income for the taxable year. (At least through the end of 2014, employers may rely on a number of safe harbors for determining if the coverage offered is affordable, including **reliance on the employee's Form W-2 wages**.) An eligible employer-sponsored plan generally provides minimum value if the plan pays for at least 60% of covered health care expenses.

Guaranteed Availability of Coverage and Limits on Variations in Premiums

For plan years beginning on or after January 1, 2014, issuers offering non-grandfathered group plans must accept every employer that applies for coverage, with certain exceptions. Issuers that offer coverage in the small group market must limit any variation in premiums with regard to a particular plan or coverage to age and tobacco use (within limits), family size, and geography. Final rules have been issued to implement these requirements.

2014 (continued)

No Annual Limits or Preexisting Condition Exclusions

All annual dollar limits on coverage of "essential health benefits" are prohibited for group health plans issued or renewed beginning January 1, 2014.

Also effective for **plan years beginning on or after January 1, 2014**, group health plans are not permitted to exclude individuals from coverage or limit or deny benefits on the basis of preexisting medical conditions. (Group plans are currently subject to this requirement only with respect to children under 19 years of age).

Small Business Tax Credit

For up to two years starting in 2014, eligible small businesses (generally those with fewer than 25 full-time equivalent employees with average annual wages below $50,000) that buy health coverage through a SHOP and pay at least half of the premium cost for employees may receive a tax credit of up to 50% of the contribution.

Wellness Programs and Nondiscrimination

Wellness programs that require an individual to satisfy a standard based on a health factor in order to obtain a reward must comply with specific nondiscrimination rules under HIPAA (the Health Insurance Portability and Accountability Act). For **plan years beginning on or after January 1, 2014**, the maximum permissible reward that may be offered for such programs is increased from 20% to 30% of the cost of coverage (proposed rules further raise the maximum from 20% to 50% for wellness programs designed to prevent or reduce tobacco use).

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