Benefits Alert

Published by Bradley Arant Boult Cummings LLP

The Patient Protection and Affordable Care Act: Post-2011 Changes That May (Or May Not) Come to Pass

April 26, 2010

This is our second newsletter summarizing important changes in the law governing employer-sponsored group health plans under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Act"). In the first, we described the requirements that are effective immediately or as of the next plan year beginning on or after September 23, 2010 (for calendar year plans, January 1, 2011). In this newsletter, we turn to provisions of the Act that do not take effect until 2012 or later. *Employers sponsoring health plans should bear in the mind the distinct possibility that some of the changes scheduled to take effect in future years will be modified by subsequent legislation.*

Effective March 23, 2012

- Uniform Explanation of Coverage and Notice of Plan Changes. Under the Act, plans must use government-developed uniform explanation of coverage documents (which will be no longer than 4 pages in 12 point type). These are to be issued by the Department of Health and Human Services ("HHS") by March 23, 2011, for use in connection with enrollments that occur on or after March 23, 2012. There is a $1,000 per participant penalty for each willful failure to distribute the required explanation. As a related matter, notices of material modifications of the terms of a plan must generally be provided 60 days before the change becomes effective. *These requirements are in addition to ERISA disclosure requirements and will likely require changes to the plan's administrative processes.*

- Quality of Care Reporting Requirements. Under HHS regulations issued by March 23, 2012, plans will be required to provide annually to participants and HHS a report on whether the benefits under the plans satisfy certain required elements of coverage, including improving health outcomes, preventing hospital re-admissions, improving patient safety, and promoting wellness. *HHS is authorized under the Act to develop the penalties for noncompliance with these reporting requirements.*

Effective for plan years ending on or after September 30, 2012

- Annual Plan Fee. Fully-insured and self-insured plans will be required to pay a fee equal to the product of $2 ($1 in the case of plan years ending during 2013) (indexed annually) multiplied by the average number of lives covered under the plan. The fee expires for plan years ending after September 30, 2019, and does not apply to certain excepted benefits (including stand-alone dental or disability plans). The fee will be paid by the insurer for a fully-insured plan and by the plan sponsor for a self-insured plan.

Effective January 1, 2013

- Reduced Limits on Healthcare Flexible Savings Accounts ("FSAs"). The Act limits the amount of employee contributions to FSAs to $2,500 per year (indexed for inflation

continued on page 2

Authors

B. David Joffe
615.252.2368
djoffe@babc.com

Andrew Elbon
615.252.2378
aelbon@babc.com

Related Attorneys

J. S. Christie, Jr.
205.521.8387
jchristie@babc.com

Kevin J. Henderson
205.521.8346
khenderson@babc.com

Gordon Earle Nichols
615.252.2387
gnichols@babc.com

John M. Scannapieco
615.252.2352
jscannapieco@babc.com

beginning in 2014). *Employers that currently provide a higher limit will need to amend their plans. To the extent higher limits have been used as part of an overall plan design, employers will want to reevaluate their plans.*

- Elimination of Medicare Part D Tax Deduction. The Act eliminates the federal income tax deduction for the subsidy provided to employers who maintain prescription drug plans for their Part D eligible retirees. *For those employers who have taken advantage of the deduction, its loss can be significant; these employers may want to evaluate the continued viability of their prescription drug plans.*

- Additional Medicare Tax on High-Income Taxpayers. The Act imposes an additional 0.9% Medicare tax for employees (not employers) on wages over $200,000 ($250,000 for joint filers), for a total of 2.35%.

Effective March 1, 2013

- Notice Requirements Regarding Exchanges and Plan Information. There are new employer notice requirements under the Act to inform employees of the following: information about the availability of coverage under state insurance exchanges; if a plan's share of total allowed costs of benefits is less than 60%; the availability of a tax credit; and the availability of free choice vouchers. *Employers will need to become familiar with the new notice requirements and information they will need to provide to their employees.*

Effective January 1, 2014

- Enhanced Employer Responsibilities and "Free Rider" Penalties. The Act imposes various penalties on an employer that fails to provide "minimum essential coverage" for its employees under its health plan. These penalties apply to an "applicable large employer" (determined on a controlled group basis), which is an employer that employs at least 50 full-time employees during the preceding calendar year. "Full-time employees" mean employees who are employed on average at least 30 hours per week (with special rules for converting part-time employees to full-time).

  - Penalty When Required Coverage Not Offered. If the employer fails to offer such coverage for any month to any full-time employee and *one* full-time employee enrolls in a "qualified health plan" (plans that provide "essential health benefits" and meet certain requirements to be established by HHS and the state exchanges) and receives a premium tax credit or cost-sharing reduction, the employer will be required to pay a penalty of 1/12th of $2,000 per month ($167) for each full-time employee employed during the month *excluding the first 30 full-time employees*.

  - Penalty When Required Coverage Offered. Even if the employer offers "minimum essential coverage" to its full-time employees, if *one* or more of such employees enrolls in a qualified health plan for any month with respect to which the employee receives the a premium tax credit or cost-sharing reduction, the employer must pay a penalty that is the lesser of (i) 1/12 of $2,000 per month ($167) times the number of full-time employees; or (ii) 1/12 of $3,000 per month ($250) times the number of employees receiving the credit or reduction.

- Employee Vouchers. Employers offering minimum essential coverage through an eligible employer-sponsored plan and paying any portion of that coverage will have to provide "qualified employees" with a voucher whose value can be applied to the purchase of a health plan through a state insurance exchange. Qualified employees are those employees who do not participate in the employer's health plan, whose required contribution for employer sponsored minimum essential coverage (if they did participate in the plan) exceeds 8% but not 9.5% of household income, and whose total household income does not exceed 400% of the poverty line for the family. After 2014, the 8% and 9.5% will be indexed to account for the excess of premium growth for the preceding calendar year. Employers will pay the voucher amount to the exchange; the employee is entitled to be paid in cash the excess value of the voucher over the exchange premium. *It is likely then that the voucher program will result in some increased out-of-pocket cost for many employers.*

- State Insurance Exchanges. The Act provides for the creation of health insurance exchanges at the state level in 2014, where individuals and small employers would be able to buy health coverage in a manner similar to that of larger employers. Initially, the state exchanges would be open to individuals and small employers with 100 or fewer employees, unless the state opts to limit this to organizations with 50 or fewer employees. Beginning in 2017, states would have the option to expand the exchange to larger employers. *Small employers may stand to benefit from the additional option of purchasing insurance through an exchange.*

- Elimination of All Pre-Existing Condition Exclusions. The prohibition on pre-existing condition exclusions will apply to all participants. *Previously, the prohibition only applied to individuals under age 19.*

- Reduced Cost-Sharing Limits. Plans must limit participant annual out-of-pocket maximums to no more than the limit imposed on high deductible health plans that are compatible with health savings accounts. In addition, deductibles may not exceed

$2,000 for single coverage or $4,000 for family coverage (both indexed annually). *Plans will need to be amended accordingly.*

- Nondiscrimination Regarding Providers. Plans may not discriminate with respect to participation under the plan against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. However, this prohibition does not require a plan to offer the services of "any willing provider."

- Availability of Clinical Trials. Plans must provide coverage for participation by qualified individuals in any clinical trials.

- Elimination of Annual Benefit Limits. Annual limits on "essential health benefits" are prohibited. *Previously, plans were subject to caps set by HHS. Plans that retained annual limits under the HHS caps will need to remove them.*

- Coverage Reporting Requirements. Every person (insurer or self-funded plan) who provides minimum essential coverage must file coverage information with the IRS and give each individual receiving such coverage a coverage statement.[16] Also, large employers required to provide health coverage and employers offering vouchers must file a return with the IRS with information on coverage and give each full-time employee a statement with coverage information. There is a $50 per return penalty if either return is not filed with the IRS or provided to the individual (subject to a maximum amount).

- Increased Incentives for Wellness Programs. The Act provides that employers can offer increased incentives to employees for participation in a wellness program or for meeting certain targets related to health status. The Act permits rewards or penalties, such as premium discounts of up to 30 percent (instead of the current 20%) of the cost of coverage. HHS is also authorized under the Act to increase this amount up to 50%. *The increase may make wellness programs more attractive to employers.*

- Reduction of Waiting Periods. The Act prohibits waiting periods greater than 90 days. *Employers with longer waiting periods or those that only permit enrollment on certain days (such as the first day of the month) will need to amend their plans.*

Effective January 1, 2018

- High-Cost ("Cadillac") Plan Excise Tax. A 40% nondeductible excise tax will be levied on insurance companies and plan administrators of self-funded group health plans for any health coverage plan to the extent that the annual premium exceeds $10,200 for single coverage and $27,500 for family coverage. An additional threshold amount of $1,650 for single coverage and $3,450 for family coverage will apply for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions. The tax will apply to self-insured plans and plans sold in the group market but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). The costs of stand-alone dental and vision plans are not included when calculating the tax. The dollar amount thresholds will be automatically increased if the inflation rate for group medical premiums between 2010 and 2018 is higher than the Congressional Budget Office estimates in 2010.

As noted in our last newsletter, "grandfathered" plans will have different effective dates for some changes under the Act and will not be subject to other changes at all. Also, plans subject to a collective bargaining agreement ratified on or before March 23, 2010, are generally not required to comply with certain coverage standards until the agreement terminates.

If you have any questions about the Act, please contact one of the attorneys in the Employee Benefits & Executive Compensation Group at Bradley Arant Boult Cummings LLP.