

**ALERT:
HEALTH CARE REFORM BILL**

July 2011

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COMPLIANCE AFTER 2011**

Now that the earliest health care reform compliance deadlines have passed for most employer-sponsored plans (see our **timeline of health care reform effective dates**), many employers are looking ahead to the changes that will become effective after 2011. Those changes are discussed below in five categories:

- **Provisions Expanding Coverage**
- **PHSA Coverage Reforms**
- **Wellness Provisions**
- **Reporting and Disclosure Requirements**
- **Tax Provisions**

In discussing these provisions, our perspective is that of an employer providing health coverage to its employees. We focus on what the various provisions require, assuming they will survive current and future judicial, legislative and regulatory challenges. This is not to dismiss those challenges – or the constitutional and policy issues involved – as unimportant to employers and others. We are simply addressing the provisions as they are currently in effect. We also disregard the obligations of market participants other than employers (e.g., individuals and insurers) except as those obligations affect employers.

PROVISIONS EXPANDING COVERAGE

A major objective of the health care reform law is reducing the number of uninsured individuals. Several provisions contribute to that goal, but none more directly than the employer pay-or-play provisions and the individual mandate. These requirements are facilitated by the health insurance exchanges created under the law and the federal assistance made available to certain individuals purchasing coverage through the exchanges.

Repeal of Free Choice Voucher Obligations. In April, the “free choice voucher” provision of the health care reform law was repealed. That provision would have required employers to issue vouchers to certain employees beginning January 1, 2014 if the employees’ required contributions for employer-provided health coverage exceeded certain thresholds. Equal to the employer’s normal contribution toward health coverage, the vouchers would have been valid for purchasing coverage through a state health insurance exchange.

EMPLOYER PAY-OR-PLAY PROVISIONS

Starting in 2014, large employers – those with 50 or more full-time employees – may incur an excise/penalty tax unless they meet standards for offering health coverage to their full-time employees. No guidance has been issued on this excise tax, but the IRS acknowledged in a recent request for comments that determining whether the tax applies and calculating the amount of the tax raise many detailed definitional issues.

“LARGE EMPLOYERS” MAY INCUR THE EXCISE/PENALTY TAX

Large employers are subject to the pay-or-play provisions. Other employers will not incur the pay-or-play excise/penalty tax regardless of what coverage they offer (or do not offer) to their employees. An employer will determine for each calendar year whether it is a large employer based on employment during the previous calendar year. For 2014, the first year that the provision is effective, employers will look at the individuals they employed during 2013 to determine if, on average, they had 50 or more full-time employees.

The pay-or-play provision of the statute includes some details on making this determination, including:

- A full-time employee with respect to any month is an individual who is employed, on average, for at least 30 hours of service per week
- Part-time employees are treated as fractions of full-time employees and counted toward the total when making the large employer determination
- Seasonal employees may be excluded from the large employer determination if they work fewer than 120 days during the year and qualify under a DOL definition
- New employers that were not in existence in the prior calendar year will make the large employer determination based on the average number of employees reasonably expected to be employed in the current calendar year

Many details of the large employer calculation remain to be specified, and employers have asked for guidance on alternatives. The IRS has indicated that future guidance will address such issues as whether to count hours of paid or unpaid time off, how many hours of service to count for non-hourly employees, when to treat multiple companies as a single employer, whether to count particular types of workers (e.g., independent contractors) as employees, and how to address fluctuations in hours worked.

CONDITIONS FOR LARGE EMPLOYERS TO INCUR PAY-OR-PLAY EXCISE/PENALTY TAXES

The pay-or-play excise/penalty tax applies on a monthly basis, and an employer will incur the tax if two conditions are met for a given month:


1. The employer must fail to meet certain standards for offering health coverage to its full-time employees (standards described below)
2. A full-time employee of the employer must be certified by a health insurance exchange to receive certain federal assistance in connection with coverage purchased through the exchange (more details on this condition below)

Definition of “Full-Time”

The definition of full-time employee used when determining whether the two conditions noted above have been met is the same definition used for determining whether an employer is a large employer. That is, for any calendar month, a full-time employee is one who is employed, on average, for at least 30 hours of service per week. That is where any similarity to the full-time employee determination described above ends, however.

Unlike the determination of whether an employer is subject to the pay-or-play provision (i.e., whether the employer is a large employer), when determining if a large employer has incurred the excise/penalty tax (i.e., whether the two conditions listed above have been met), part-time employees are completely disregarded and seasonal employees may qualify as full-time employees. It appears that, once the large employer determination is made, part-time employees working fewer than 30 hours per week are not counted. In addition, a large employer that has seasonal employees apparently may incur the excise tax with respect to those seasonal employees if they work an average of at least 30 hours per week during a month.

The large employer determination is also made for an entire calendar year based on employment during the previous calendar year. If an employer is not a large employer for a calendar year, the pay-or-play excise/penalty tax simply does not apply to any month during that year. For a large employer that is subject to the pay-or-play provision for a year, the statute apparently requires determining whether the excise tax applies with respect to each month during the year based on whether the two conditions listed above were met with respect to that month (i.e.,



based on an individual employee's hours of employment, health coverage and qualification for federal assistance during that month).

The IRS has acknowledged that the month-by-month determination of full-time employee status creates “uncertainty and inability to predictably identify which employees are considered full-time and, consequently, inability to forecast or avoid” the pay-or-play excise/penalty tax. Therefore, the IRS has committed to providing guidance that alleviates these difficulties. The guidance is likely to allow an employer to treat an employee as having or not having full-time status for a particular month based on hours worked during a look-back period.

Standards for Offering Health Coverage

A large employer will not incur the pay-or-play excise/penalty tax if it offers its full-time employees and their dependents “minimum essential coverage” that is both affordable and sufficiently valuable. Several aspects of this standard remain to be defined in future guidance, but the statute provides some parameters.

- Minimum essential coverage is virtually any medical coverage an employer provides to its employees that does not consist of excepted benefits (see the text box below that explains excepted benefits and the separate text box that discusses the difference between minimum essential coverage and essential health benefits).
- Minimum essential coverage is considered affordable if a full-time employee's required contributions for self-only coverage are no greater than 9.5% of household income.
- Minimum essential coverage is sufficiently valuable if it has an actuarial value of 60% or greater.

What's a Plan's Actuarial Value? A plan's actuarial value is the percentage of average costs for covered benefits that a plan will cover. A plan with a 60% actuarial value will pay, on average, 60% of covered expenses. The plan may pay a higher or lower percentage in the case of particular expenses, and any covered individual might be responsible for more or less than 40% of covered expenses. Regulations are needed to fully define this term, but the determination will be based on providing essential health benefits (see the text box below discussing this term) to a standard population (even if the plan does not actually cover a standard population).

AMOUNT OF THE PAY-OR-PLAY EXCISE/PENALTY TAX

Offering minimum essential coverage to full-time employees and their dependents that is both affordable and sufficiently valuable allows an employer to avoid the pay-or-play excise/penalty tax altogether. Even if an employer is not able to avoid the tax altogether, however, it can minimize the tax it might incur by offering minimum essential coverage even if that minimum essential coverage falls short of the affordability or value standard noted above. An employer that offers minimum essential coverage (e.g., a mini-med plan) that is either unaffordable or insufficiently valuable may incur the pay-or-play excise/penalty tax, but the tax will generally be lower (and should never be higher) than the tax that would apply if the employer did not offer minimum essential coverage. Offering virtually any coverage that reimburses medical expenses (including mini-med coverage) will prevent the higher level of the pay-or-play excise/penalty tax from applying. (Such coverage is, however, subject to various federal requirements, including some or all of the PHSA coverage reforms discussed later in this article.)

- **If minimum essential coverage is NOT provided**, the 2014 pay-or-play excise/penalty tax will be \$166.67 per month for each of the employer's full-time employees (excluding the first 30 full-time employees) if, for that month:

- The employer fails to offer minimum essential coverage to full-time employees and their dependents
- AND one or more of the employer's full-time employees is certified for federal assistance in connection with coverage purchased through the exchange

- **If minimum essential coverage is provided**, the 2014 pay-or-play excise/penalty tax will be the lesser of (1) the tax that applies if minimum essential coverage is not provided and (2) \$250 per month for each full-time employee that:
 - Is offered minimum essential coverage that, under the standards noted above, is unaffordable, insufficiently valuable or both
 - AND opts out of that employer-sponsored coverage
 - AND is certified for federal assistance in connection with coverage purchased through the exchange

For calendar years after 2014, the \$166.67 and \$250 monthly amounts will be adjusted for inflation.

Minimum essential coverage ≠ essential health benefits. Despite the apparent similarity of these terms, they have very different meanings.

“Minimum essential coverage” means coverage under any of several different arrangements, including a group health plan or group health insurance coverage offered by an employer to its employees, so long as the coverage does not consist of excepted benefits (see the text box below regarding excepted benefits). Whether an employer provides minimum essential coverage determines, in part, if and how the pay-or-play excise tax applies to the employer. Because this term is so similar to “essential health benefits,” it often is incorrectly stated that an employer must provide essential health benefits in order to avoid incurring the pay-or-play excise/penalty tax. Unlike the term “essential health benefits” (see definition below), this term does not include any standards requiring a minimum level or scope of coverage. As health coverage providing non-excepted benefits, however, minimum essential coverage is subject to various federal requirements, including some or all of the PHSA coverage reforms discussed later in this article. Also, minimum essential coverage that meets certain standards will prevent an employer from incurring the pay-or-play excise/penalty tax. As of August 1, 2011, no regulations have been issued interpreting the term “minimum essential coverage.” When issued, regulations might make standards for the level or scope of coverage part of the definition of minimum essential coverage.

“Essential health benefits” are to be defined in future guidance so that they are similar in scope to typical employer-provided health benefits and include coverage in the following essential health benefit categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

While essential health benefits are to be defined with reference to employer-sponsored health plans, there generally is no requirement that employers ensure that their plans provide essential health benefits. (Insurers may be required, however, to ensure that the group policies they sell to employers in the small group market or through an insurance exchange provide essential health benefits.) In addition, employers need not provide essential health benefits in order to avoid the pay-or-play excise tax. Among other things, the term “essential health benefits” is used in connection with the restrictions on annual and lifetime dollar limits on benefits (see our discussion of the restrictions on annual dollar limits below).

AUTOMATIC ENROLLMENT REQUIREMENTS

Companies that offer coverage and have more than 200 full-time employees must automatically enroll new full-time employees in health coverage. These automatic enrollment provisions will require notices and opt-out capability. Companies subject to this requirement must also continue enrollment of current employees in coverage.

The only guidance that has been issued on these provisions states that federal agencies will not enforce the requirements until regulations are issued. That guidance was particularly helpful because nothing in the statute specifies an effective date and, until regulations are issued, it will not be clear what employers must do to fulfill their responsibilities under this provision. While the provision could take effect as soon as regulations are released, more likely it will take effect in 2014.

Among other things, regulations will define the full-time employees that are entitled to automatic enrollment. We expect that the definition for this purpose will be coordinated with the definition of full-time employee under the pay-or-play excise/penalty tax provisions described above. It will also be important for regulations to define the type of coverage that must be automatically applied to newly eligible full-time employees. Another matter that will be addressed is the obligation to continue enrollment of current employees. For example, it is not clear what requirements will apply if one of several coverage options is eliminated.

INDIVIDUAL MANDATE

The health care reform law includes a requirement that individuals have medical coverage or face a penalty. The penalty applies on a monthly basis and is relatively low, equaling 1/12 of the greater of two numbers:

- 2.5% of household income (generally equivalent to taxable income), except that a lower percentage is used in 2014 (1%) and 2015 (2%)
- \$695 per household member, except that:
 - A lower dollar amount is used in 2014 (\$95) and 2015 (\$325)
 - After 2016, the \$695 amount will be adjusted for inflation
 - The dollar amount per household member is reduced by one-half for dependents under the age of 18
 - The total for all household members is limited to 300% of the dollar amount per household member

There is an overall limit on the amount of the penalty. It cannot exceed the national average premium based on the individual's family size for bronze-level qualified health plans (i.e., plans with 60%

actuarial value) offered through the state health insurance exchanges (discussed below).

For most, the penalty will be substantially less than the cost of obtaining health coverage. For example, the maximum penalty in 2016 for an individual whose household income is \$100,000 will be \$2,500.

The penalty applies to individuals who do not have "minimum essential coverage," unless they are exempt from the requirement. As discussed above, virtually any medical coverage that an employer provides for its employees – including a mini-med plan – meets the statute's definition of minimum essential coverage. In addition to the pay-or-play excise/penalty tax structure explained above, this feature of the individual mandate – along with employers' desires to help employees meet the mandate – provides an incentive for employers to maintain their plans even after other options become available through the health insurance exchanges. Of course, these factors must be balanced against the difficulty of making any changes to the employer-provided health coverage that are necessary to comply with other provisions of the health care reform law (e.g., the PHSA coverage reforms discussed below).

HEALTH INSURANCE EXCHANGES

The health care reform law contemplates that each state will establish an insurance marketplace for individuals and small employers known as an "exchange" by January 1, 2014. The exchanges are intended to be a new competitive market outlet with standardized plans. The health insurance exchanges promise individuals and small employers improved access to health coverage and lower administrative costs.

States are not required to establish exchanges. The law requires HHS to award grants to states for planning and establishing

the exchanges. If HHS determines that a state will not have an operational exchange by 2014, HHS would establish and operate the exchange.

The exchanges are to be open to individuals and employers with 100 or fewer employees. However, until 2016, states may elect to limit availability to individuals and employers with 50 or fewer employees. States are permitted, but not required, to open the exchanges to larger employers (those with more than 100 employees) in 2017.

COVERAGE OFFERED THROUGH EXCHANGES

Even though all exchange plans must provide essential health benefits (see the text box above regarding essential health benefits), they may offer various levels of coverage based on the individual plans' cost-sharing provisions. The exchanges will classify the different levels of coverage based on actuarial value (see the discussion of this term above): bronze (60%), silver (70%), gold (80%) and platinum (90%). (All carriers are required to offer at least a silver and a gold plan.) In addition, carriers may offer individual policies providing catastrophic coverage to individuals up to age 30 and to those who are exempt from the individual mandate to purchase coverage.

EXCHANGES AND CAFETERIA PLANS


In most cases, an employer cannot include the option of paying for exchange-purchased coverage on a pre-tax basis under its cafeteria plan. This means that an employer cannot allow individuals who elect to purchase individual coverage through an exchange to pay for that coverage on a pre-tax basis through the employer's cafeteria plan. If, however, an exchange-eligible employer purchases coverage for its employees through an exchange, that employer may also offer its employees the opportunity to pay for the coverage on a pre-tax basis under a cafeteria plan. An exchange-eligible employer is, in tax years beginning after December 31, 2013, a small employer electing to make all of its full-time employees eligible for one or more qualified health plans offered in the small group market through an exchange.

EXCHANGES AND FEDERAL ASSISTANCE

The health care reform law did not include a government-run health care plan, but assistance may be available to certain individuals who obtain coverage through an exchange. The details of the assistance available to individuals are beyond the scope of this article. As explained above, however, an employer may incur a pay-or-play excise/penalty tax if one or more of its full-time employees qualifies for certain federal assistance with respect to coverage obtained through an exchange. This, of course, raises the question of how an employer would know about such assistance. The health care reform law includes a provision requiring exchanges to report such assistance to the relevant employer.

PHSA COVERAGE REFORMS

Several coverage reforms – including prohibitions of lifetime dollar limits on benefits, restrictions on annual dollar limits and requirements to make coverage available for certain adult children – became effective for plan years beginning on or after September 23, 2010. The same group health plans that are subject to those 2010-2011 coverage reforms will become subject to additional coverage reforms when their 2014 plan years begin. We refer to these as the PHSA coverage reforms because the health care reform law enacted them as amendments to the Public Health Service Act (PHSA) which were then incorporated by reference into ERISA and the Internal Revenue Code. (The group health plans that are subject to [or exempt from] the PHSA coverage reforms are described in the discussion below.) This section addresses the PHSA coverage reforms that become effective for plan years starting on or after January 1, 2014.



PHSA COVERAGE REFORMS DO NOT APPLY TO EXCEPTED BENEFITS Any employer-sponsored plan – whether insured or self-insured – that provides, pays for or reimburses the cost of health care is a “group health plan” that may be subject to the PHSA coverage reforms. And any type of employer (e.g., religious, governmental, for-profit and not-for-profit) may maintain a group health plan that is potentially subject to the PHSA coverage reforms. To the extent that a plan consists of “excepted benefits,” meaning coverage of the types (and offered under the conditions) listed below, the plan is exempt from the PHSA coverage reforms.

STAND-ALONE DENTAL OR VISION coverage provides dental or vision benefits through a policy, certificate or contract of insurance separate from a major medical plan or is optional, with employees who elect the coverage being required to pay an additional amount.

HEALTH FSA is one type of flexible spending account offered through a cafeteria plan. In most cases, employers do not contribute to health FSAs – all contributions are employee pre-tax amounts. We use this term to refer to a program that: (1) is offered in addition to a major medical plan that has an annual open enrollment and (2) has a maximum available benefit no greater than twice the employee’s pre-tax contribution or, if greater, \$500 plus the employee’s pre-tax contribution. A health reimbursement arrangement (HRA) (under which an employer makes a specified dollar amount available to reimburse health care expenses, with no employee contributions) is treated the same as an exempt health FSA if it provides a maximum annual benefit of \$500 or less and otherwise meets the conditions noted for health FSAs.

HOSPITAL OR FIXED INDEMNITY coverage is provided under a separate policy, certificate or contract of insurance, does not coordinate benefits with any other plan of the employer, and pays a specified dollar amount for each day (or other period) that a covered individual is hospitalized or ill, regardless of whether or how much the individual incurs for care while hospitalized or ill and regardless of whether or how much any other plan of the employer pays.

SPECIFIED DISEASE coverage is provided under a separate policy, certificate or contract of insurance, covers a specified disease or illness, such as cancer or heart disease, including reimbursement of expenses for treatment, and does not coordinate benefits with any other plan of the employer.

SUPPLEMENTAL coverage is provided under a policy, certificate or contract of insurance that is a Medicare or Tricare supplement or “similar” supplemental coverage that is specifically designed to fill gaps in the primary coverage, costs no more than 15% of the cost for the primary coverage and does not vary eligibility, premiums or benefits based on any health factor of an employee or dependent.

A separate exemption from the coverage reforms applies to a plan that is a separate ERISA plan from any plan that covers two or more current employees on the first day of the plan year. A separate ERISA plan would satisfy this requirement if all participants in that plan were retirees. In addition, a very small employer’s plan is exempt if it covers fewer than two current employees on the first day of the plan year.

Finally, grandfathered plans are exempted from the coverage reforms described in the sections entitled “Discrimination against Health Care Providers,” “Annual Cost-Sharing Limits” and “Clinical Trial Coverage.” Grandfathered plans are discussed in Willis Human Capital Practice *Alert*, July 2010, “**Regulations on Grandfathered Plans**” and Willis Human Capital Practice *Alert*, November 2010, “**Agencies Amend Grandfather Regulations.**” Other exemptions are specific to individual coverage reforms and are described in the discussion of the specific PHSA coverage reforms they affect.

WAITING PERIODS LONGER THAN 90 DAYS PROHIBITED

This provision is remarkably simple: Health plans (including grandfathered health plans) “shall not apply any waiting period ... that exceeds 90 days.” For this purpose, a waiting period is “the period that must pass with respect to [an] individual before the individual is eligible to be covered for benefits under the terms of the plan.” Although the provision is simple, it is likely to raise complex issues when it is applied to specific health plans’ eligibility and enrollment provisions.

Nothing available currently addresses even simple operational issues, such as:

- Whether a plan may require an individual who has completed a 90-day waiting period to wait until the beginning of the following month to enroll.
- Whether a plan that allows enrollment upon completion of a 90-day waiting period may also provide that enrollees will not receive employer contributions toward the cost of coverage during a specified period after they begin plan participation.

In a recent request for comments, the IRS acknowledged that regulations will need to address how this provision applies to specific plan designs. The IRS also noted that guidance on this provision should coordinate with guidance on the automatic enrollment and pay-or-play provisions described above.

PREEXISTING CONDITION EXCLUSIONS PROHIBITED FOR ALL ENROLLEES

The prohibition of preexisting condition exclusions becomes effective in two steps. It applies first with respect to enrollees under age 19, effective for plan years beginning on or after September 23, 2010. The second step – prohibition for all enrollees – is effective for plan years starting in 2014. The prohibition applies to both grandfathered and non-grandfathered plans. For details of regulatory guidance issued on this prohibition, see Willis Human Capital Practice *Alert*, July 2010, “**Patient’s Bill of Rights Guidance Issued.**”

ALL ANNUAL DOLLAR LIMITS ON ESSENTIAL BENEFITS PROHIBITED

The prohibition of annual dollar limits on essential health benefits is another coverage reform that becomes effective in steps and applies to both grandfathered and non-grandfathered plans. The complete prohibition of annual dollar limits is effective for plan years starting on or after January 1, 2014. For details of regulatory guidance issued on this prohibition, including the restricted annual dollar limits permitted before 2014, see Willis Human Capital Practice *Alert*, July 2010, “**Patient’s Bill of Rights Guidance Issued.**” Until 2014, plans may obtain a waiver of the restricted annual dollar limits

permitted during the phase-in period, which would allow lower annual limits to apply, through an HHS program. For details of recent guidance on the annual limit waiver program, see **Willis HR Focus, Issue #43, January 2011, “HHS Issues Additional Guidance for Waiver Process”** and Willis Human Capital Practice *Alert*, June 2011, “**Limited Medical Plan Waiver Guidance Released.**”

GRANDFATHERED PLANS AND ADULT CHILDREN

Until plan years beginning in 2014, grandfathered plans may deny coverage to participants’ children based on eligibility for other employment-based coverage, other than through a parent. Non-grandfathered plans do not have this ability with respect to most children. For plan years beginning on or after September 23, 2010, non-grandfathered plans are not allowed to disqualify participants’ children under 26 based on availability of other coverage. (For this purpose, a child includes an employee’s natural, adopted, placed-for-adoption, step or eligible foster child.) Starting with the 2014 plan year, both grandfathered and non-grandfathered plans will be prohibited from applying eligibility criteria to participants’ children (as defined) other than age and relationship to the participant. For purposes of this provision, a participant is a covered employee, covered former employee, covered survivor or covered COBRA qualified beneficiary. For details of the regulatory guidance on coverage for adult children, see Willis Human Capital Practice *Alert*, May 2010, “**Adult Children Health Coverage Extension: Regulations Published**” and Willis *HR Focus*, Issue #41, November 2010, “**New Guidance on Age 26 Mandate and Other Topics.**”

DISCRIMINATION AGAINST HEALTH CARE PROVIDERS

Grandfathered plans are exempt from the health care reform law’s provision that prohibits group health plans from discriminating against any health care provider acting within the scope of the provider’s license or certification under applicable state law. For non-grandfathered

plans, this requirement does not prevent a group health plan, an insurer or HHS from establishing varying reimbursement rates based on quality or performance measures. It also does not require a group health plan or insurer to contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or insurer. Many states have enacted “any-willing-provider” laws that require certain managed care organizations, such as HMOs and PPOs, to include in their networks any provider willing to accept the health plan’s rates and to abide by the terms of the plan’s provider contract. While this provision does not prevent enforcement of those state laws, it is not intended to operate as a federal any-willing-provider law. Regulations are needed to determine what plans must do to comply.

ANNUAL COST-SHARING LIMITS

Grandfathered health plans are also exempt from two provisions that limit certain cost-sharing requirements plans frequently impose. While not entirely clear, it appears that these limits apply to the same group health plans (including self-insured plans) as the other PHSA coverage reforms. However, these provisions possibly apply only to insured coverage sold in the individual and small group markets or through a health insurance exchange. This applicability issue is one of many points on which regulatory guidance is needed.

LIMITS ON ANNUAL DEDUCTIBLES

For plan years starting in 2014, a health plan’s annual deductible cannot exceed \$2,000 for self-only coverage or \$4,000 for coverage other than self-only coverage. (Under this provision and the preventive care mandate, non-grandfathered plans may not apply any deductible to in-network benefits for preventive care. For details of the regulatory guidance on the preventive care mandate, see Willis Human Capital Practice *Alert*, September 2010, “**More Health Care Reform Regulations: Interim Final Rules on Preventive Care.**”)

These dollar limits are increased by the maximum amount of reimbursement reasonably available to a participant under a health flexible spending arrangement, including a health reimbursement arrangement (HRA) or a health FSA under a cafeteria plan (even if all FSA contributions are made by salary reduction). For plan years beginning after 2014, the deductible limits are indexed under a complex formula related to increases in health coverage premiums. It is not clear how these limits will apply to a plan that has separate deductibles for in-network and out-of-network benefits. For example, the limits might only apply to the deductible for in-network benefits.

OUT-OF-POCKET MAXIMUMS

A health plan’s out-of-pocket maximums for its 2014 plan year cannot exceed those permitted that year for the high-deductible health plan (HDHP) coverage that an individual must have to be eligible for tax-favored contributions to a health savings account (HSA). (To qualify as an HDHP, among other things, a health plan’s out-of-pocket maximums cannot be higher than a specified amount

that is adjusted for inflation each year, with any changes being announced by June 1 of the previous year.) We do not know the dollar limit on HDHP out-of-pocket maximums that will apply in 2014 when this provision becomes effective – it probably will be announced in May 2013. For illustrative purposes only, the dollar limits on the out-of-pocket maximum under an HDHP for 2012 are \$6,050 for self-only coverage and \$12,100 for family coverage. Guidance is needed to determine exactly which expenses must be counted toward a plan’s out-of-pocket maximum, including how closely those items will match previous guidance with respect to HDHPs.

COVERAGE IN CONNECTION WITH CLINICAL TRIALS

One of the PHSA coverage reforms requires that non-grandfathered plans cover certain items in connection with clinical trials for certain individuals, but it does not require coverage of the item being investigated in the clinical trial. Clinical trials generally are studies that test new drugs, procedures or devices on humans. To be subject to the requirements, a clinical trial must be a phase I through phase IV clinical trial that is being conducted in connection with the prevention, detection or treatment of cancer, or other life-threatening disease or condition and is:

- Federally funded through a variety of entities or departments of the federal government
- OR conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration
- OR exempt from investigational new drug application requirements

To qualify for coverage in connection with a clinical trial, a participant or beneficiary must be eligible, according to the clinical trial’s protocol, to participate in a clinical trial meeting the criteria noted above for the treatment of cancer or other life-threatening disease or condition (which is likely to result in death unless the disease or condition is interrupted). In addition, either:

- The referring health care professional is a participating provider and has concluded that the participant's or beneficiary's participation in the clinical trial would be appropriate
- OR the participant or beneficiary provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

For qualifying individuals and clinical trials, group health plans may not deny participation in a clinical trial, deny (or otherwise limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with the clinical trial, or discriminate against the individual based on participation in the trial. Routine patient costs relate to items and services typically provided under the plan for a participant not enrolled in a clinical trial. In other words, if certain items and services are typically covered under the plan, the plan must cover them when the items and services are provided to a participant in an approved clinical trial. Such items and services do not include:

- The investigational item, device or service itself
- Items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis
- Any service clearly not consistent with widely accepted and established standards of care for the particular diagnosis

The plan may require a qualifying individual to use an in-network provider participating in a clinical trial if the provider will accept the individual as a participant. However, the requirements also apply to participation in a clinical trial conducted outside the state of the individual's residence if the plan provides out-of-network coverage for routine patient costs.

WELLNESS PROVISIONS

Several provisions of the health care reform law emphasize the importance of wellness programs in controlling health care costs. At the same time, the health care reform law leaves the rules that govern wellness programs under employer-sponsored health plans largely unchanged, subject to some important modifications.

INCREASED WELLNESS INCENTIVES

Currently, federal regulations set out the health factor nondiscrimination standards that govern operation of wellness programs providing plan-related rewards based on achievement of health status goals. The health care reform law incorporates into ERISA, the Code and the PHSA provisions very similar to those in the final nondiscrimination regulations, subject to a few changes. Most importantly, the health care reform law increases the permissible health plan reward available as a result of meeting goals under all health-factor-related wellness programs. The maximum permissible incentive increases to 30% (from 20%) of the total cost of coverage under the plan for an individual employee (or, if

dependents may participate in the wellness program, the cost of the coverage category in which the employee and any dependents are enrolled). In addition, the DOL, IRS and HHS may allow for health plan rewards up to 50% of these amounts if they determine that a higher level is appropriate. (For information on the cap currently in effect, see Willis Employee Benefits *Alert*, March 2008, **“More Guidance, More Flexibility on Wellness Programs.”**)

This increase in permissible incentives is not yet effective. It is scheduled to go into effect for plan years starting on or after January 1, 2014, and then apparently would apply to non-grandfathered plans only. The DOL has announced in FAQs posted on its website, however, that the agencies intend to propose regulations increasing the maximum permissible incentive to 30% before 2014. Presumably, any such increase would also be available to grandfathered plans.

WELLNESS PROGRAMS AND FIREARMS

The health care reform law includes a provision under which certain “wellness and health promotion activit[ies]” may not require disclosures regarding lawfully possessed firearms and ammunition. In addition, wellness program discounts, rebates or rewards under a health plan may not vary based on ownership, possession, use or storage of firearms. It is unclear exactly which plans and employers are subject to these prohibitions and when they become effective, although it appears that grandfathered plans are exempt.

SMALL EMPLOYER WELLNESS GRANTS

To foster creation of workplace wellness programs by small employers, the health care reform law creates a \$200 million, five-year grant program under which small employers receive funds so they can provide their employees “comprehensive workplace wellness programs.” The law directs HHS to

develop criteria for comprehensive workplace wellness programs and requires that such programs include:

- Health awareness initiatives (including health education, preventive screenings and health risk assessments)
- Efforts to maximize employee involvement and participation
- Initiatives (including coaching, seminars, online programs and self-help materials) to change unhealthy behaviors and lifestyle choices
- Workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity and improved mental health

To be eligible for a grant, a small employer must have fewer than 100 employees who work 25 or more hours per week. In addition, grants would only be available to small employers that did not have a wellness program in place on March 23, 2010. HHS is to create an application process (it has not yet done so) under which an eligible employer would submit a proposal for providing a comprehensive workplace wellness program for its employees. When the application process will be created so that this program can begin making grants is as yet unclear.

REPORTING AND DISCLOSURE REQUIREMENTS

Along with the other measures in the health care reform law, various reporting and disclosure requirements are intended to make individuals more aware of their health coverage options and better able to understand and compare those options. Some of those obligations are assigned to employers that sponsor group health plans.

REPORTING HEALTH COVERAGE ON FORM W-2

The health care reform law included a requirement that employers report the value of the health coverage they provide to employees on the Form W-2s that they issue to employees. That requirement was originally scheduled to become effective for W-2s reporting pay during 2011 (i.e., the W-2s that generally will be issued in January 2012). In October 2010, however, the IRS announced that W-2s issued for 2011 (the ones generally due in January 2012) do not need to include the cost of health coverage provided by the employer during the year. Reporting those amounts is optional for coverage provided in 2011.

Then, in late March 2011, the IRS issued interim guidance regarding this W-2 reporting requirement for health coverage. Under the guidance, W-2 reporting of health coverage remains optional for

coverage provided during 2011 (the W-2s for 2011 generally will be issued in January 2012). For coverage provided during 2012, the new guidance specifies that W-2 reporting will remain optional for employers filing fewer than 250 W-2s (the W-2s for 2012 generally will be issued in January 2013). For larger employers (and those who choose to report voluntarily), the guidance provides details on what coverage provided during 2012 must be reported and how to determine the cost of that coverage (the W-2s for 2012 generally will be issued in January 2013). For additional information on the W-2 reporting requirement, see Willis Human Capital Practice Alert, July 2011, **“W-2 Cost of Coverage Requirement – That Was Easy!”**

The exemptions from this reporting requirement differ from the exemptions that apply with respect to the PHSA coverage mandates. This means that employers may be obligated to report the value of some health coverage that is listed as excepted in the text box above that explains excepted benefits. At the same time, coverage that is subject to the PHSA coverage mandates may be exempt from this W-2 reporting requirement.

The IRS emphasized in its March guidance that nothing in the W-2 reporting requirement or any guidance relating to it has or will cause health coverage that employers provide to employees and their dependents to become taxable. Such coverage generally continues to be excludable from an employee's income.

UNIFORM EXPLANATIONS OF COVERAGE

The health care reform law expanded the disclosure obligations of group health plans subject to the PHSA coverage mandates (see the text box above regarding excepted benefits). Starting March 23, 2012, administrators of self-insured plans and insurers of fully-insured plans are required to

distribute a uniform four-page “summary of benefits and coverage.” For group health plans that are subject to ERISA, this four-page summary of benefits and coverage will be required *in addition* to the summary plan description and other disclosures required by ERISA.

The health care reform law specified that, by March 23, 2011, HHS was to have provided “standards” for creating and providing the summaries as required, and it is widely assumed that HHS will provide a template for the summaries as part of those standards. As of August 1, 2011, however, no standards have been issued. The statute specifies, however, that HHS’ standards for the summary must provide for:

- A uniform format, no more than four pages in length, and including no print smaller than 12-point font
- Use of terminology understandable by the average plan enrollee and presentation in a culturally and linguistically appropriate manner
- Content that includes:
 - Uniform definitions of standard insurance and medical terms so that consumers may understand and compare health insurance coverage and exceptions to coverage
 - Description of the coverage, including the cost sharing, for each category of essential health benefits (see the description of essential health benefits above) and other benefits identified by HHS
 - Exceptions, reductions and limitations on coverage
 - Cost sharing, including deductibles, coinsurance and copayments
 - Renewability and continuation of coverage provisions
 - A “coverage facts label” with examples of benefits for pregnancy, for serious or chronic medical conditions and for other common scenarios
 - Statements of whether the coverage –
 - ◆ Is minimum essential coverage (see the description of minimum essential coverage above)
 - ◆ Pays at least 60% of total allowed costs (see the description above of when the pay-or-play excise/penalty tax may apply)
 - Reminder that the four-page summary is a summary and that other documents determine the coverage terms
 - Contact number for questions and an internet web address where “the actual individual coverage policy or group certificate of coverage can be reviewed or obtained”


Both grandfathered and non-grandfathered plans will be subject to this four-page summary requirement. In addition, while the law assigns responsibility for providing the summary to the insurer providing benefits under an insured plan, it is not clear that the employer sponsoring an insured plan has no responsibility for the plan’s compliance with this requirement. Any group health plan or insurer that willfully fails to provide the four-page summary as required may be fined up to \$1,000 per enrollee who is not provided the summary.

The summary must be distributed to all applicants, policyholders and enrollees when they apply for coverage and when they become covered. In addition, it appears that there is an annual distribution requirement. Detailed regulations explaining exactly who must be provided the summary, as well as when and how it must be provided, will be important to employers and insurers implementing the requirements. It would also be helpful if guidance clarified the responsibilities of insurers and employers with respect to insured group health plans.

ADVANCE NOTICE OF MATERIAL MODIFICATIONS

Once group health plans and health insurers are required to provide the four-page summary of benefits and coverage described above (i.e., no later than March 23, 2012), they also become subject to a requirement to provide at least 60 days’ advance notice of “material modifications” that are not reflected in the summary. (Like the four-page summary requirement, this advance notice requirement applies to group health plans that are subject to the PHSA coverage mandates [see the text box above regarding excepted benefits].) A material modification for this purpose is the same as it is for purposes of providing a summary of material modifications (SMM) as required by ERISA. Any material modification of plan terms or coverage that is not reflected in the most recently provided four-page summary must be disclosed at least 60 days before the modification becomes effective. This is much earlier than ERISA plans currently are required to provide notice of material modifications.

Both grandfathered and non-grandfathered plans will be subject to this accelerated notice of changes requirement. It is clear in the case of a self-insured plan that the compliance obligation rests with the plan administrator and plan sponsor. In the case of an insured plan, however, it appears that the insurer has at least



concurrent responsibility for providing notice of changes as required. This arrangement differs from current ERISA standards, under which the insurer has no direct responsibility for providing an SMM. As in the case of the four-page summary requirement, detailed regulations explaining exactly who must be provided advance notice of changes, as well as when and how it must be provided, will be important to employers and insurers implementing the advance notice requirements. It would also be helpful if guidance clarified the responsibilities of insurers and employers with respect to insured group health plans.

NOTICE OF INSURANCE EXCHANGES AND POTENTIAL FEDERAL PREMIUM OR COST-SHARING ASSISTANCE

No later than March 1, 2013, employers that are subject to the Fair Labor Standards Act are required to provide all of their current employees written notice that they may be eligible to purchase health coverage through a health insurance exchange in lieu of participating in employer-sponsored coverage. Employees hired after March 1, 2013 must be provided the notice at time of hire. It is important to note that employers are subject to this notice requirement even if they do not offer any health benefits to employees, and employees are entitled to the notice even if they are not eligible for any health plan offered by the employer.

The required notice must inform employees of the existence of a health insurance exchange, must describe the services that the exchange provides and must tell employees how to contact the exchange to request assistance. The notice must also explain that

employees may be eligible for a premium tax credit or a cost-sharing reduction through the exchange in certain circumstances (see the discussion of the pay-or-play excise/penalty tax above). Finally, the notice must explain the potential consequences to the employee of choosing to purchase coverage through the exchange (i.e., loss of any employer contributions toward the cost of coverage under the employer's health plan and loss of the federal tax exclusion for most such employer contributions). The DOL will likely issue guidance on fulfilling this notice requirement, and one hopes that the guidance will include a model notice.

QUALITY OF CARE, TRANSPARENCY AND OTHER REPORTING REQUIREMENTS

Health care reform places new reporting requirements on group health plans and health insurers, including:

- “Quality of care” reporting to HHS regarding benefits and provider reimbursement structures that may affect the quality of care (grandfathered plans exempt)
- “Transparency in coverage” reporting to HHS covering a variety of plan operations, policies and features (grandfathered plans exempt)
- Two separate requirements for reporting to the IRS on health coverage provided to an individual (applies to both grandfathered and non-grandfathered plans)

For each of these reporting requirements, the health care reform law lists several pieces of information that are to be reported but, as with all reporting obligations, reports cannot be filed until the relevant agency defines the reporting process and format. That has not happened yet for any of these requirements. HHS is required to issue guidance regarding quality of care reporting no later than March 23, 2012, but there is otherwise no deadline for implementation guidance on these reporting requirements.

In fact, in the case of the first two requirements, the date when reporting is to begin is not defined by the health care reform law, but is not expected to be any earlier than 2013. The obligations to report health coverage to the IRS clearly are not effective until 2014. We expect that IRS guidance will coordinate those two reporting obligations and, possibly, the W-2 reporting obligation noted above. Until guidance is issued, we can only speculate on how these reporting requirements will affect employers.

TAX PROVISIONS

The health care reform law generally has not changed the federal income tax treatment of employer-sponsored health coverage. Employer contributions toward the cost of health coverage generally are excluded from employees' income (exceptions apply, e.g., contributions toward the cost of a non-dependent domestic partner's coverage). Health benefits paid under employer-sponsored health coverage also are generally excluded from employees' income. The health care reform law does make some changes in the rules governing taxability of health coverage contributions and benefits, however.

ANNUAL SALARY REDUCTION CONTRIBUTIONS TO A HEALTH FSA LIMITED TO \$2,500

Most employers that include health FSAs in their cafeteria plans set annual limits on employees' health FSA elections. A 2006 survey by the International Foundation of Employee Benefit Plans showed 90% of surveyed employers offered flexible spending accounts and that the most common maximum for a health spending account was \$5,000 (42% of survey responses). These limits do not reflect a tax code requirement for cafeteria plans or health FSAs, however. If it wished, an employer could design its cafeteria plan health FSA without any limits on the dollar amount of employees' health FSA elections or with very high annual limits. (There are several good reasons that employers generally choose lower annual limits, however.)

A provision in the health care reform law requires that, effective January 1, 2013, cafeteria plan health FSAs limit an employee's pre-tax contributions to \$2,500 per year. For most health FSAs this will amount to reimbursements being limited to \$2,500 per year because the employer does not contribute to the health FSA (i.e., all contributions to the health FSA are employees' pre-tax salary reduction contributions).

Some key points for employers to note about this change:

- It is effective January 1, 2013 for all cafeteria plans and health FSAs, regardless of plan year. Therefore, employers with non-calendar year plans will need to plan for complying with the limit starting with their 2012 plan year.
- It applies to both grandfathered and non-grandfathered health FSAs. It also applies to health FSAs that qualify for exemption from the PHSA coverage mandates (see the discussion of excepted benefits above).
- The limit applies only to employees' pre-tax salary reduction contributions. Employers may still make unlimited non-elective contributions to health FSAs.
- All other rules regarding health FSAs (e.g., uniform availability, use or lose, etc.) remain in effect.

COMPARATIVE EFFECTIVENESS RESEARCH FEE

A comparative effectiveness research fee becomes effective starting in 2012, as explained in Willis Human Capital Practice *Alert*, May 2010, "**Beyond the Excise Tax: New Health Care Reform Taxes and Fees.**"

REQUIREMENT TO REDUCE EMPLOYER'S DEDUCTION BY PART D SUBSIDY AMOUNT

Starting in 2013, employers who receive nontaxable Medicare Part D subsidy payments may only take an income tax deduction for their net cost of providing prescription drug coverage to retirees, as explained in Willis Human Capital Practice *Alert*, May 2010, "**Beyond the Excise Tax: New Health Care Reform Taxes and Fees.**"



EXCISE TAX ON HIGH-COST (“CADILLAC”) COVERAGE

Starting in 2018, a 40% excise/penalty tax will apply to certain high-cost health coverage, but only to the extent that the coverage exceeds certain thresholds which are at least \$10,200 (single) and \$27,500 (family). If an individual has single coverage with a value of \$10,210 and the applicable threshold is \$10,200, the 40% excise/penalty tax will apply only to the \$10.00 excess, resulting in an excise/penalty tax payment of \$4. As noted, the minimum thresholds that will be in effect in 2018 are:

- For single coverage, \$10,200
- For family coverage, \$27,500

These thresholds are increased for retirees and for individuals in high-risk professions such as law enforcement, construction and mining (to \$11,850 for single coverage and to \$30,950 for family coverage). In addition, the 2018 thresholds – both the standard and the retiree/high risk – will be higher if the cumulative cost increases for the Federal Employees Health Benefit Plan, Blue Cross/Blue Shield Standard Option exceed 55% during the period from 2010 to 2018. The 2018 thresholds may be further adjusted for employers whose age and gender demographics differ from those of the national workforce.

The thresholds established for 2018 as described above will be adjusted for inflation in later years, and will continue to be subject to adjustment for differences between an employer’s age and gender demographics and those of the national workforce.

The cost of coverage for this purpose will include both employer and employee shares of the cost and will generally be calculated in the same manner as COBRA applicable premiums. Certain types of coverage will be excluded from the calculation of the cost, but clearly much more than the cost of “major medical” coverage is included. For example, the cost of coverage includes reimbursements under a health FSA or an HRA and employer contributions to an HSA.

The grandfather rule does not provide any exemption from this excise/penalty tax.

CONCLUSION

With most employers having implemented the first set of health care reform changes, it is a good time to take stock of what employers will need to implement after 2011. It is unclear, however, what obligations employers have under many of the provisions, given the need for agency guidance. So far, the relevant agencies have issued health care reform guidance at a blistering pace (compared to the usually glacial progress of federal regulations), and we hope that they will continue to do so. In addition to regulatory developments, legislative and judicial developments could drastically change employers’ health care reform obligations. Willis will continue to provide updates as developments occur.

KEY CONTACTS

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