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Milliman

CLIENT ACTION Bulletin
Employee Benefits

Proceeding with PPACA's Health Reforms

SUMMARY **With the U.S. Supreme Court upholding the individual mandate and other provisions of the Patient Protection and Affordable Care Act (PPACA) affecting employment-based healthcare coverage, group health plan sponsors should turn their focus to implementing and complying with the law's various reforms. A number of provisions become effective in the near term, while others engage several years from now. PPACA's effects on employer-sponsored group health plans will differ in part on whether a plan is "grandfathered" (i.e., existing in relatively unmodified form since the law's March 23, 2010 enactment), insured, or considered large, but many of the law's requirements apply regardless.**

This *Client Action Bulletin* summarizes PPACA's upcoming provisions for which employer-sponsored group health plans should prepare. Because the federal agencies with oversight – the Departments of Treasury, Labor, and/or Health and Human Services (Treasury, DOL, DHHS) – have not published all necessary guidance to date, plan sponsors may face additional pressures and uncertainties about their responsibilities and with compliance issues.

DISCUSSION

Next Up: 2012 – 2013 PPACA Provisions

For plans operating on a calendar year, the immediate next step to act on is the distribution of summaries of benefits and coverage (SBC), as well as a uniform glossary of coverage and medical terms, to participants and beneficiaries. This requirement applies to open enrollment periods that begin on or after Sept. 23, 2012. An exception applies to health savings accounts, retiree-only plans, or other "excepted benefits" such as stand-alone dental or vision plans and most health flexible spending accounts (FSAs). (See ***Client Action Bulletin 12-3***.)

In addition, the following three PPACA requirements have varying effective dates, but for calendar-year group health plans or insurance policies, the provisions become effective beginning Jan. 1, 2013:

- ***Women's preventive healthcare services*** – Beginning with plan/policy years starting on or after Aug. 1, 2012, *nongrandfathered* plans sponsored by employers with more than 50 employees must expand the list of preventive services covered in full to include, among other benefits, well-woman visits, screening for gestational diabetes, and screening/counseling for domestic violence and for HIV. Unless an exception applies (e.g., for religious organizations), contraceptives also must be covered without charge.
- ***Restricted annual limits*** – Unless a waiver from DHHS applies, *all* employer-sponsored group health plans with plan years beginning on or after Sept. 23, 2012, and before Jan. 1, 2014, the annual dollar limit on the value of "essential health benefits" must not be less than $2 million.
- ***Outcomes research excise tax*** – For plan/policy years ending after Sept. 30, 2012, and before Oct. 1, 2019, *self-insured* plans and *insurance* issuers are subject to an excise tax to fund the Patient-Centered Outcomes Research Institute (PCORI), which is charged with evaluating and comparing the effectiveness of various medical treatments, services, procedures, and drugs. The tax for plan years ending before Oct. 1, 2013, is $1 per covered life, generally to be reported and paid on July 31, 2013, under the IRS's Apr. 17, 2012 proposed rule. The fee increases in later plan years; the last assessment will be for the 2018 plan/policy year.

For the 2013 calendar year – that is, regardless of the plan/policy year – two tax provisions become effective. First, a cap of $2,500 applies to health FSA contributions. Second, the Medicare Part A payroll tax rate paid by employees (but not employers) increases from 1.45% to 2.35% on earnings over $200,000/$250,000 individual/joint. In addition, large employers must report the aggregate cost of

coverage on employees' Forms W-2 in January 2013 for calendar year 2012; and employers that offer retiree health coverage will no longer be able to deduct the retiree drug subsidy in 2013.

Planning in 2013 for the 2014 Exchanges and Other Provisions

Employers in 2013 also will have to plan for and make decisions before the Jan. 1, 2014 effective date of some of the most significant provisions of PPACA. For plan/policy years that begin on or after that date, *self-insured* and *insured* group health plans (except as otherwise noted below) are subject to the following:

- no annual limits on the dollar value of essential health benefits;
- no coverage exclusions based on preexisting conditions;
- no waiting periods longer than 90 days;
- deductibles limited to $2,000/$4,000 individual/family for *fully insured nongrandfathered small group* plans (pending further guidance that may expose these limits to other plans), and out-of-pocket expenses limited to the maximum for health savings account-compatible high deductible health plans ($6,250/$12,500 individual/family in 2013) for all *nongrandfathered* plans;
- "minimum essential coverage" that satisfies affordability and value tests (employers with at least 50 full-time employees);
- coverage for clinical trials for cancer or life threatening diseases (except *grandfathered* plans);
- notification – by March 1, 2013 – to employees about the 2014 availability of health insurance exchanges (see below);
- reporting of employer-provided coverage to the IRS;
- notification to employees about wellness programs; and
- extension of coverage to nondependent children up to age 26 regardless of whether coverage under another employer plan is available to them.

The state-based health insurance exchanges are expected to be operational in 2014, at least in states that are moving forward to establish them. The federal government will run an exchange for states that opt not to establish one or that are otherwise late to do so. With the availability of exchanges and other PPACA provisions applying, employers with have to consider several key issues:

- Small employers – those with 50 or fewer (or, if state law so defines, up to 100) employees – will be able to purchase coverage through the exchanges.
- Large employers that do not provide qualified coverage or that have at least one employee qualifying for federal tax credits or assistance will be subject to penalties.
- Employees with low or moderate incomes may be eligible for coverage under Medicaid or federal assistance with which to purchase coverage.
- Nearly all individuals will be required to have coverage, which could result in more enrollment for employer-sponsored plans.

ACTION For many employers that sponsor healthcare coverage, the U.S. Supreme Court's ruling likely did little to alter the planning processes already undertaken in preparation of PPACA's provisions. The federal agencies can be expected to issue significant guidance in the coming months, creating added pressures on employers to comply within relatively short timeframes. Politics also add to employers' uncertainty. If the elections in November result in a change in the Presidency and/or the parties in control of the houses of Congress, those political differences could lead efforts to repeal or modify PPACA, or to delay or restrict regulations.

Plan sponsors should prudently proceed with their reviews of their plans, taking into account design elements that may improve healthcare outcomes and lower costs within the framework of PPACA's requirements. Preparations to implement necessary changes should continue, with ongoing discussions with insurers, third-party advisors, and administrative and/or health service providers.

For additional information about the U.S. Supreme Court's ruling on PPACA or for assistance with implementation of the health reform law's provisions, please contact your Milliman consultant.