

Health Care Reform Update

Since the final provisions of the long debated health care reform legislation were recently signed into law by the President, we wanted to provide a brief at-a-glance overview of provisions in this legislation that may affect your health care benefit programs. This outline is general in nature and is not intended to encompass all issues that may impact your business. We welcome any questions you may have and highly recommend that you consult with your benefits consultants and appropriate tax/legal advisors on specific implications for your business.

2010

Employer benefit mandates (first plan year after September 30, 2010)

- Must cover dependent children through age 26 regardless of student or marital status, unless eligible for other group coverage
- No lifetime limits on benefits
- Restrictions on annual limits of “essential” benefits (further regulatory guidance is pending)
- Employer sponsored plans must have an HHS-approved external review process for disputed claims
- Plans may not limit coverage for pre-existing conditions for children under age 19
- Plans must provide preventive care with no cost-sharing

2011

Elimination of over-the-counter (OTC) medications as qualified medical expenses

- Prohibits pre-tax reimbursement of non-prescribed OTC medications from FSAs, HRAs, and HSAs

New long term care program run by the federal government

(Community Living Assistance Services and Supports or CLASS Act)

- Although voluntary, employers are expected to auto-enroll employees in the program and deduct monthly premiums from employees’ paychecks (employees may opt-out of the program, but certain re-enrollment restrictions apply)
- Employers may coordinate benefits with other disability benefit programs

2012

Employers must report the value of health benefits on all employees’ W-2 forms

(beginning January 2012 for 2011 annual earnings)

- Generally based on COBRA rate (includes employer and employee contributions)

2013

Auto-enrollment required for group health plans – Employers with 200 or more employees must auto-enroll all eligible employees in the employer’s group health plan (default option determined by employer) and provide employees instructions to opt-out
Note: this date is not clear in the legislation and could possibly be implemented sooner.

Medicare D subsidy taxed – Eliminates the employer’s deduction for the amount of the Medicare Part D retiree drug subsidy

Contribution limits to FSAs – Contributions to FSAs are limited to \$2,500 (adjusted for inflation in subsequent years)

Medicare surtax for higher income earners – Employers must change withholding to collect additional .9 percent surtax on adjusted gross incomes in excess of \$200,000 (\$250,000 for families)

Comparative Effectiveness Research Fees – employers with self-funded plans will be assessed \$2 per covered life to fund research (\$1 per life in 2014 and thereafter)

2014

“Play or Pay” mandate for employers – Employers with more than 50 employees must offer comprehensive and affordable coverage to employees or may otherwise be required to pay a free rider assessment per employee (\$2,000 per employee)

Additional employer benefit mandates

- No pre-existing condition exclusions
- Deductible and out-of-pocket limits for qualified (HSA compatible) high deductible health plans (HDHPs)
- Waiting periods no longer than 90 days

Individual coverage mandate – With certain exceptions, all individuals must have health insurance coverage (subsidies and penalties applicable depending on income levels)

Insurance exchanges - Employers must provide notification to employees regarding qualifying for vouchers to purchase coverage through the exchange (depending on income).

Wellness incentives – Allowable differential for standards-based wellness programs under HIPAA guidelines increases from 20 percent to 30 percent, with DOL discretion to increase to 50 percent

Excise tax on certain drugs and medical devices – Cost will be embedded in price of products

2017

Employers of all sizes can purchase coverage from the exchanges

2018

“Cadillac” plan excise tax – 40 percent tax imposed on plans with coverage value exceeding \$10,200 for an individual and \$27,500 for a family (calculation generally based on COBRA rates)

- Calculation includes cost of core medical plan coverage as well as employer contributions to FSA, HRA, and HSA programs. Dental and vision are not included in the value of the calculation
- Thresholds indexed annually to CPI beginning in 2020, with certain provisions for adjustment
- Allows higher thresholds for plans covering high-risk professions such as police, fire and certain construction industries, and those with higher costs due to age and gender of their covered members

More Information

Visit nwbetterhealth.com later this month to hear our chief health care strategist Joe San Filippo speak about health care reform, including how the bill impacts self-funded employers and strategies for managing costs.