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Plan Year Changes for Group Health Plans for Year-End 2015 and 2016

TIFFANY N. SANTOS

As the end of the 2015 calendar plan year and the next open enrollment period for the 2016 calendar year group health plan fast approach, employers and other plan sponsors of self-insured health plans must implement and administer a number of changes to comply with the Affordable Care Act (the "ACA") and other applicable law. These changes include:

- ***Administering the Limit on Cost-Sharing and High Deductible Health Plans ("HDHP") Plan Design Implications:*** For plan years that begin in or after 2016, plan administrators will be required to implement clarification regarding the administration of the ACA's annual limit on cost-sharing that caught many employers and other plan sponsors by surprise earlier this year. On May 26, 2015, the Departments of Labor, Health and Human Services and Treasury jointly issued a set of Frequently Asked Questions ("FAQs") on the requirement to limit annual cost-sharing by non-grandfathered plans (cost-sharing includes: deductibles, coinsurance, copayments, or similar charges, and any other charge that an individual must pay for a qualified medical expense that is considered an "essential health benefit" and that is covered by the plan[1]), http://www.dol.gov/ebsa/faqs/faq-aca27.html. For plan years beginning in 2016, the maximum annual limitations on cost sharing or "out-of-pocket" ("OOP") maximums that a plan may impose are: $6,850 for "self-only" coverage and $13,700 for all other coverage options (note: a plan may administer lower OOP maximums). Somewhat surprisingly, the FAQs "clarified" that non-grandfathered plans must apply an "embedded" "self-only" OOP maximum with respect to each individual who is enrolled in any coverage other than "self-only" coverage.

  This means that if a family of four is enrolled in "family coverage", the plan may not require any individual in the family to pay more than $6,850 in cost-sharing. For example, if the plan that covers this family of four has an aggregate OOP maximum for all family members of $13,000 for the 2016 plan year and one individual in the family incurs claims that are associated with $10,000 in cost-sharing, the plan is required to cover the difference between $10,000 and $6,850 with respect to that individual *(i.e.,* $3,150) even though the family OOP maximum has not yet been reached.

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[1] As described in FAQs Part XVIII (http://www.dol.gov/ebsa/faqs/faq-aca18.html), non-grandfathered plans are not required to include the following items when administering the annual limit on cost-sharing: costs associated with out-of-network items, premiums, balance billing amounts for non-network providers, or spending for non-covered services.

For employers and other plan sponsors with HDHPs that are intended to allow participants to contribute to a Health Savings Account ("HSA"), the 2016 annual out-of-pocket maximum for deductibles, co-payments, and other amounts, but not premiums) for the HDHP may not exceed $6,650 for self-only coverage or $13,100 for family coverage, see Revenue Procedure 2015-30 (http://www.irs.gov/pub/irs-drop/rp-15-30.pdf). Because these HDHP limits are lower than the OOP maximums permitted by the ACA, plan sponsors must ensure that their HDHPs are appropriately designed to follow the HDHP rules if they wish to permit participants to contribute to their HSAs in 2016. [*Note:* The other 2016 limits applicable to HDHPs and HSAs are as follows: (1) annual deductibles —not less than $1,300 for self-only coverage or $2,600 for family coverage; and (2) the annual contribution limit to an HSA — $3,350 for an individual with self-only coverage or $6,750 for an individual with family coverage.]

- ***Preventive Care Coverage:*** With each new plan year, non-grandfathered health plans must ensure that their administrators implement the most current and applicable list of required preventive health services, see https://www.healthcare.gov/preventive-care-benefits/. As the requirements applicable to contraceptive coverage have significantly changed and the final regulations implementing the preventive care coverage requirement include a number of changes from the interim regulations in effect since 2010, plans must ensure that they are aware of the changes and are able to timely implement them. Please see our July 2015 newsletter article for a description of these changes.

- ***State Taxation of Coverage Provided to a Same-Sex Spouse:*** On June 26, 2015, the United States Supreme Court in Obergefell v. Hodges (http://www.supremecourt.gov/opinions/14pdf/14-556_3204.pdf) ruled that it was unconstitutional under the Fourteenth Amendment of the United States Constitution for states to limit marriage to persons of the opposite sex and requires states to recognize same-sex marriages validly entered into in another state or other jurisdiction. For health plans that cover same-sex spouses of employees, the decision means that income may no longer be imputed on such coverage. Several states have provided tax guidance on same-sex marriage in response to the ruling, with both Ohio and Michigan issuing specific guidance requiring employers to adjust withholding on affected employees' 2015 wages to correct for any overwithholding that occurred BEFORE the Obergefell decision on coverage provided to a same-sex marriage during the first part of the year.[2] [Note: Obergefell does not affect domestic partnerships, civil unions or other similar relationships. Thus, coverage provided to such partners must continue to be taxed unless the partner qualifies as the employee's tax dependent.]

Lastly, while *Obergefell* did not address whether employers who sponsor self-insured plans are required to offer coverage to same-sex spouses on the same basis as coverage offered to opposite-sex spouses, the decision may affect current and future court challenges. A class action suit has already been filed in the District Court of Massachusetts seeking damages

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[2] http://www.tax.ohio.gov/Portals/0/employer_withholding/EWH%20Info%20Release%20Marriage.pdf, and http://www.michigan.gov/documents/taxes/Notice_US_Supreme_Court_Obergefell_493269_7.pdf

against Wal-Mart for violating Title VII of the federal Civil Rights Act for refusing to enroll same-sex spouse in its self-insured group health plan on the same basis as the opposite-sex spouses of employees prior to January 1, 2014 and a permanent injunction prohibiting Wal-Mart from denying equal future health plan benefits to same-sex spouses (see *Cote v. Wal-Mart,* case number 1:15-cv-12945). The case follows the a finding by the Equal Employment Opportunity Commission that Wal-Mart's failure to enroll same-sex spouses on the same basis as opposite-sex spouses constituted sexual discrimination under Title VII.

If you have any questions regarding the foregoing changes, please contact the author of this article.

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