2012 Healthcare Reform Issues for Employer Sponsored Health Plans

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Most employers are aware that many of the significant aspects of the Affordable Care Act (ACA) begin to take effect in 2014. There are, however, a number of provisions included in the ACA that will affect employer sponsored health plans in 2012. This summary provides a review of these issues which are specific to 2012. The actual impact each of these provisions will have on any particular employer will depend on a number of factors:

- The effective dates of some of the issues covered in this summary are still not clear. We included the effective dates in this review if it is possible, or likely, that employers will need to deal with the provision in 2012.
- Some of the requirements are based on if an employer has retained grandfathered status for any of its benefit options.

Overview

The following elements of the ACA are further detailed in this summary:

Issues employers must deal with in 2012

- **Summary of Benefits and Coverage** – Employers are required to provide a standardized summary of benefits and coverage to all applicants and enrollees at initial enrollment and at annual enrollment. Effective Date: 3/23/12
- **W-2 Reporting Requirement** - Employers are required to report the aggregate cost of applicable employer-sponsored health coverage on W-2s provided to employees. Effective Date: Depends on the number of W-2s filed by the employer for tax year 2011.
- **Comparative Clinical Effectiveness Research Fee** – The ACA imposes a fee on all health plans to fund comparative clinical effectiveness research. Effective Date: Plan years beginning November 1, 2011.
- **Limit on Health Flexible Spending Account Salary Reductions** – Employee pre-tax contributions to a Section 125 health flexible spending account will be limited to $2,500 annually. Effective Date: Effective beginning tax year 2013; however, non-calendar year Section 125 plans will need to begin to limit payroll deductions in 2012.

Issues that may be effective in 2012

- **§105(h) Nondiscrimination Rules** - The ACA requires fully insured health plans to follow nondiscrimination rules similar to existing §105(h) nondiscrimination rules, which prohibit employers from offering health benefits in a manner that discriminates in favor of highly compensated employees. Effective Date: The IRS has delayed enforcement of this rule until after the release of regulatory guidance.
- **Automatic Enrollment** – Employers with at least 200 employees will be required to offer an automatic enrollment into employer sponsored health plans. Effective Date: Requirement will be effective sometime after regulations are released.

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Summary of Benefits and Coverage (SBC)

Effective Date

Employers are currently required to distribute an SBC beginning on March 23, 2012. However the proposed regulations recognize that a mid-year communication requirement may be problematic for employers and the regulatory agencies are seeking comments on a phased-in approach to the rule. It is possible that final regulations will provide for distribution based on a plan's renewal date.

Grandfathered Plans

This requirement applies to both grandfathered and non-grandfathered plans.

Distribution

Fully- Insured Plans

In the case of fully-insured plans, the insurance carrier is responsible to produce and provide a valid SBC. However, the rules also require that the summary be provided to individuals "as part of any written application materials that are distributed by the plan or issuer for enrollment. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage…". As a result, employers will need to provide the summary as part of the new employee enrollments and their open enrollment process, and not just after an employee actually enrolls in a plan.

Self-Funded Plans

Employers who sponsor self-funded plans will be responsible for the production and distribution of the SBC. However, it is anticipated that most administrators will provide some assistance to their employer clients in meeting these requirements. Parker, Smith & Feek will also be assisting self-insured clients with creating these SBC's

Additional distribution requirements include:

- Initially an SBC must be provided for each "benefit package" for which an employee is eligible.
- Upon renewal, an SBC need only be provided for the specific benefit package in which a participant is enrolled.
- The SBC must be provided to participants upon request, no later than seven days following a request.
- Individuals who enter the plan due to a HIPAA special enrollment must be provided with an SBC within seven days of when they request special enrollment.

The regulatory agencies have published samples and templates that can be used as a basis for developing an SBC. The templates and instructions can be found on the DOL website at *http://www.dol.gov/ebsa/healthreform/*.

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60 Day Advance Notice Requirement

The ACA also required that employers notify participants of certain changes to the plan at least 60 days in advance.

- The 60 day advance notice requirement does not apply to changes made as part of the annual renewal of the plan.
- Plans will be required to distribute a new SBC whenever a mid plan year "material" change is made to the plan.

Specific Content Requirements

Proposed regulations contain a number of specific content requirements:

- Uniform definitions of standard insurance and medical terms.
- A description of the coverage, including cost sharing, for each category of benefits.
- The exceptions, reductions, and limitations of the coverage.
- The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations.
- The renewability and continuation of coverage provisions.
- With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage as defined in the ACA.
- A statement that the Summary is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage.
- Contact information for questions and obtaining a copy of the plan.
- For plans that maintain one or more networks of providers, an internet address (or similar contact information) for obtaining a list of network providers.
- For plans and issuers that use a formulary in providing prescription drug coverage, an internet address (or similar contact information) for obtaining information on prescription drug coverage.
- Premiums (or in the case of a self-insured group health plan, cost of coverage).
- Coverage examples that illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions).

Plans must also provide access to a uniform glossary of terms. The Regulatory Agencies have provided a glossary of terms for this purpose and an employer can meet this requirement by providing a link to an internet location that contains the glossary.

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W-2 Health Costs Reporting Requirement

Effective Date

The Internal Revenue Service (IRS) has delayed this requirement for certain employers depending on the number of Form W-2's that are filed by the employer in 2011.

- Employers who file 250 or more Form W-2's for tax year 2011 are required to report health costs on Form W-2 beginning with the 2012 tax year (i.e. W-2's that are provided to employees generally in January 2013).
- Employers who file fewer than 250 Form W-2's for tax year 2011 are required to report health costs on Form W-2 beginning with the 2013 tax year (i.e. W-2's that are provided to employees generally in January 2014).

Grandfathered Plans

This requirement applies to grandfathered and non-grandfathered plans.

Summary

Employers are required to report the aggregate cost of applicable employer-sponsored coverage on W-2s provided to employees. This is a reporting requirement for informational purposes only and cost of the coverage will not be taxable to the employee.

The aggregate cost of coverage includes costs paid by both employer and employee and should be calculated on a calendar year basis regardless of when the plan renews. Fully-insured plans may rely on the applicable premium charged by insurance company. Self-funded plans should apply the method required to calculate COBRA premiums (not including the 2% COBRA administration fee).

Coverage specifically excluded from the reporting requirement includes:

- Accident-only insurance
- Disability income insurance
- Long term care coverage
- Coverage for a specified disease
- Hospital indemnity or other fixed indemnity insurance
- Health reimbursement arrangements (HRA)
- Health FSA salary reductions
- Health Savings Account (HSA) employer contributions (Employer HSA contributions are already required to be reported in a separate box)
- Stand-alone dental and vision coverage

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Comparative Clinical Effectiveness Research Fee

Effective Date

This fee is effective for plan years beginning 11/1/2011; however, the IRS has yet to release regulations regarding the timing of the payment of the fee. The fee will no longer apply for plan years ending after September 30, 2019.

Grandfathered Plans

The fee applies to both grandfathered and non-grandfathered plans.

Summary

The ACA imposes a fee on specified health insurance policies and applicable self-insured health plans based on the average number of lives covered under the policy or plan. The fee is equal to $1.00 (one dollar) per year per member for plan years ending before October 1, 2013, and $2.00 (two dollars) per year per member for plan years ending after that date. Covered employees, spouses, and dependents will be included in the total number of members.

For fully-insured plans, the fee will be paid by the health insurance carrier (and yes, we expect it will be passed onto the plans via the insured premiums). The fee for self-funded plans must be paid by the plan sponsor; however, the IRS is considering regulations that would allow an administrator to pay the fee on behalf of the self-funded employer.

Section 125 Health Flexible Spending Account Contribution Limit

Effective Date

Tax Year 2013

Grandfathered Plans

Not Applicable

Summary

Effective for tax years beginning after December 31, 2012, the ACA imposes a $2,500 annual limit on salary reduction contributions made to a Health Flexible Spending Account (HFSA) through a cafeteria plan.

Employers who sponsor a non-calendar year Section 125 plan will need to begin to restrict employee pre-tax elections in 2012; otherwise, an HFSA election made by an employee in 2012 could result in payroll deductions exceeding $2,500 in 2013.

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Section 105(h) Non-discrimination Rules

Effective Date

In December 2010, IRS Notice 2011-1 delayed the application of the Section 105(h) nondiscrimination rules to fully-insured plans until plan years that begin some time after the release of regulatory guidance.

Grandfathered Plans

These non-discrimination rules will apply to fully-insured non-grandfathered plans. Fully-insured grandfathered plans are not subject to these provisions.

All self-funded plans, both grandfathered and non-grandfathered, were already subject to 105(h) non-discrimination rules prior to the ACA. The IRS enforcement delay does not apply to self-funded plans.

Summary

The §105(h) non-discrimination rules prohibit employers from offering health benefits in a manner that discriminates in favor of highly compensated individuals (HCIs). §105(h) defines an HCI as:

- One of the five highest-paid officers
- A shareholder who owns more than 10% of the employer's stock
- An individual who is among the highest-paid 25% of all employees

Current §105(h) rules, applicable to self-funded health plans, prohibit an employer from favoring HCIs in terms of the benefits, eligibility and employer contributions. The rules permit benefits to vary based on reasonable classifications of employees (such as hourly vs. salary) as long as the result is not discriminatory in favor of HCIs. While it is expected that the rules applicable to fully insured plans will be very similar to the current self-funded rules, there may be some differences. Employers who sponsor fully insured health plans should review their current benefit structure as soon as the IRS releases guidance.

Automatic Enrollment

Effective Date

To be determined based on the release of regulatory guidance by the Department of Labor. Effective date could be as soon as 2012, but will more likely be 2014.

Grandfathered Plans

Applies to employers with at least 200 employees with both grandfathered and non-grandfathered plans.

Summary

The ACA requires employers who have more than 200 full-time employees to automatically enroll new full-time employees in one of the employer's health benefit plans (subject to any waiting period) and to automatically continue the enrollment of current employees. A notice must be provided by the employer and employees who are automatically enrolled must be given an opportunity to opt out of coverage.