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Health Care Reform: Action Items for Employers for This Year and Beyond in the Wake of the Supreme Court Decision

Edward A. Frueh and Christopher T. Scanlan

In June, the U.S. Supreme Court issued its much anticipated decision on the constitutionality of the Affordable Care Act (ACA). The Court issued two key rulings. First, it upheld the individual mandate to purchase health insurance coverage as a legitimate exercise of the taxing power. Second, it circumscribed the expansion of Medicaid by holding that provision in ACA which threatens the states with loss of existing Medicaid funding if they decline to comply with the expansion is unconstitutional. For employers, however, the impact of the decision goes far beyond these particular holdings. Specifically, a large number of compliance deadlines are rapidly approaching. In fact, many of the key provisions of ACA which are intended to expand health insurance depend on employer compliance.

This article summarizes some of the key changes under ACA as they affect employers and suggests some of the steps employers might take to comply with the requirements. Time is particularly of the essence for employers with collectively bargained workforces; in some circumstances, those employers may be required under the National Labor Relations Act or other applicable labor relations statues to provide advance notice to labor unions of contemplated changes and/or bargain over the changes. Also, note that so-called "grandfathered" plans (including many collectively bargained plans) are exempt from some of the requirements of ACA, or subject to them only in modified form. The requirements for meeting and maintaining grandfathered status are complex, and certain changes to a plan's benefit design may cause it to lose its grandfathered status entirely.

Requirements Already in Effect

Prior to the Supreme Court decision, a number of requirements of ACA had already gone into effect. As a result of the decision, these requirements remain unchanged. Some of the more significant requirements include:

- Dependents remain eligible for coverage until they reach age 26.
- Lifetime dollar limits are prohibited and only restricted annual limits are allowed.
- Certain preventive care must be provided without deductibles, copayments, or other cost-sharing.
- Exclusions for pre-existing conditions for children under age 19 are prohibited.
- Enhanced claims procedures are in effect.

New Requirements in 2012 and 2013: Immediate Action Needed

Over the next several months, a number of new requirements become effective. Many employers and insurers have delayed implementing these requirements pending the Supreme Court decision; accordingly, at this point, immediate action may be needed to ensure compliance.

Some of the most significant of the new requirements are the following.

Summary of Benefits and Coverage (SBC)

The most onerous requirement taking effect within the next several months is that of providing an SBC. The SBC is a four-page (double-sided) document designed to summarize benefits and coverage under group health plans. It must be provided to participants and beneficiaries during open enrollment, upon request and at certain other specified times (such as a HIPAA special open enrollment period). The effective dates are:

- The first open enrollment period beginning on or after September 23, 2012, for participants and beneficiaries who enroll or re-enroll during an open enrollment period.
- The first plan year beginning on or after September 23, 2012, for participant requests and for participants and beneficiaries who enroll as newly eligible for coverage or in some other way than through normal open enrollment.

Regulations on the SBC were issued jointly by the Department of Labor, the Internal Revenue Service (the IRS) and the Department of Health and Human Service and are long, complex and highly detailed. They provide a template which must be used. The regulations also set forth substantive requirements, page and format requirements and guidance on delivery. For fully insured plans, insurers are required to provide the SBC to the plan sponsor, though the regulations make clear that the plan sponsor is ultimately responsible for ensuring that the SBC is provided to all participants and beneficiaries. For self-insured plans, employers will generally be responsible for drafting and distributing the SBC, though in some cases this may be done by third party administrators.

Employers should note that the SBC is distinct from, and in addition to, the summary plan description (SPD). The SBC may be provided either as a separate document or it may be combined with the SPD.

Action items for employers include:

- Determine how to provide the SBC, as part of the SPD or as a stand-alone document.
- Check with insurers and/or third party administrators to confirm who will prepare and deliver SBC.
- Review SBC.
- Determine manner of delivery.

Due to the complexity of the SBC rules, employers need to be certain that proper compliance procedures are in place. Penalties for noncompliance can be substantial.

Health Flexible Spending Accounts: US$2,500 Limit

Effective for plan years beginning on and after January 1, 2013, contributions to a health flexible spending account (FSA) are limited to US$2,500. The limit will be subject to cost-of-living indexing. The US$2,500 limit does not apply to amounts contributed for the previous plan year and remaining as part of a grace period. The limit does not affect health savings accounts or health reimbursement arrangements. Salary reduction contributions exceeding the US$2,500 limit may be corrected by the employer if they are due to reasonable mistake and not willful neglect.

Action items include:

- Develop communication materials for employees to explain the new limit and how it works.
- Coordinate with third party administrator and payroll department to ensure new limit is observed.
- Amend cafeteria and FSA documents to comply with new requirement (last day for amendment is December 31, 2014).

Form W-2 Reporting

Effective with the Form W-2 issued in January 2013 for 2012, employers must report to employees on the Form W-2 the aggregate cost of their coverage under employer sponsored group health plans.

The requirement generally applies to all employers who cover their employees under a group health plan. The only exceptions are for employers that filed fewer than 250 Forms W-2 in the preceding year and federally recognized Indian tribal governments. The reporting does not mean that the cost is taxable to the employer; instead the reporting is designed to supply information to employees.

The IRS has issued guidance on two key points: what must be reported and how the aggregate cost of coverage is determined.

For purposes of the requirement, what must be reported is "applicable employer-sponsored coverage." This is coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under Section 106 of the Internal Revenue Code. This does not include:

- Limited dental and vision coverage if provided under a separate policy.
- Other HIPAA "excepted benefits," such as accident insurance, disability insurance, or workmen's compensation, where benefits for medical care are incidental.
- Coverage for a specific disease or illness, hospital indemnity insurance, or other fixed indemnity insurance.

For determining the aggregate cost of coverage, employers may generally use one of three methods described by the IRS. The IRS has also identified an extensive list of costs that should be excluded from aggregate cost calculations.

Employers must prepare for this requirement well in advance of the January 2013 deadline. Action items for immediate attention are:

- Coordinate with payroll department or outside payroll administrator.
- Identify those plans and arrangements that qualify as "applicable employer-sponsored coverage."
- Select method of calculating aggregate cost and determine costs to be excluded.

Comparative Effectiveness Research Fee

Effective for the first plan year ending on or after October 1, 2012, insured and self-insured plans must pay a fee for each person covered under the plan.

For insured plans, the fee will be paid by the insurer. For self-insured plans, the plan sponsor will pay the fee. For the first year, the fee will be US$1 per person covered. In subsequent years, the fee will be US$2 per person covered, subject to review and change. Plan sponsors may calculate the number of persons covered under a plan in one of three ways: actual count, snapshot approach or using the Form 5500. A special rule is available for the first year the fee

is in effect: for a plan year beginning before July 11, 2012, and ending on or after October 1, 2012, the plan sponsor may use any reasonable method to calculate covered persons.

The fee generally applies to group health insurance plans. It does not apply to:

- Limited dental and vision coverage if provided under a separate policy.
- Other HIPAA "excepted benefits."
- Arrangements such as employee assistance programs and wellness programs where benefits for medical care are incidental.
- Expatriate plans that cover employees living and working outside the United States.

The purpose of the fee is to fund research into the comparative effectiveness of different treatment methods for different conditions. The fee is due by July 31 following the close of the plan year. Thus, for a calendar year plan, the first annual comparative effectiveness research fee is due July 31, 2013.

Action items for plan sponsors include:

- Determine benefits subject to the fee.
- Select appropriate option for counting covered persons.
- Include estimate of fees in budget projections.

New Requirements in 2014: Planning for the New Benefits Cycle

In 2014, a large number of new requirements become effective. These requirements are much more complex and more numerous than those becoming effective during any other year of ACA's implementation. Many of them necessitate changes in plan design, plan amendments, participant communication materials or government filings. Insurers will be responsible for some of the requirements, but employers will be responsible for seeing that a number of the requirements are met. The situation is even more complex because the Departments of Labor and Health and Human Services and the IRS have not yet addressed in regulations or other guidance many of the issues that the new requirements raise.

Given the complexity and number of the 2014 requirements, employers should begin planning now for the 2014 benefit cycle, even as they deal with the more immediate requirements of ACA. Some of the most significant changes for 2014 to consider in this planning process include the following.

Benefits, Benefit Levels, and Eligibility: Plan Design Considerations

Effective January 1, 2014, the following new insurance requirements apply:

- Cost sharing limits will be in place. Annual out-of-pocket limits cannot exceed the health savings account limit. For new plans, deductibles cannot exceed US$2,000 for a single person or US$4,000 for family coverage.
- Restricted annual limits will be prohibited.
- Exclusions for pre-existing conditions for all individuals will be prohibited.
- No waiting periods in excess of 90 days will be allowed for coverage under a plan.
- New plans must cover routine costs for trial participants.
- New plans cannot discriminate against providers with regard to plan participation.

Employers should initiate the planning for these changes now. Actions to take now include:

- Coordinate implementation and roll-out with insurers and third party providers.
- As needed, develop cost projections.
- Develop a strategy for communicating changes to employees.
- Identify documents that may need to be revised, including summary plan descriptions and employee handbooks.

Employer Mandate

Employers with an average 50 or more full-time employees must offer minimum essential coverage to their employees or pay a "free rider" penalty. The coverage must meet affordability and value requirements. The penalty will be the lesser of US$2,000 per employee (subtracting the first 30 employees) or US$3,000 per employee certified on a state insurance exchange. In years after 2014, this amount will be adjusted for inflation. Full-time employees are those working at least 30 hours per week. There is a limited exemption for seasonal employees.

A key issue affecting this requirement at this time is the lack of government guidance. For example, full-time employee will need to be more clearly defined. Similarly, guidance on cost calculations and safe-harbors will be necessary.

At the present time, employers should:

- Determine the possible applicability of the mandate and the "free rider" penalty.
- As needed, make a cost/benefit analysis of their current plan and possible alternatives; however, no decisions should be made until appropriate government agencies provide the necessary guidance.
- Analyze current payments-in-lieu-of-benefits that are offered to employees and assess their compliance with the employer mandate.

Automatic Enrollment

Employers with more than 200 employees that offer health coverage will be required to enroll employees automatically. In general, employees now have to make an affirmative decision to enroll in health care. This will change when the new automatic default rule becomes effective. Employees will then need to opt out or they will be covered. Automatic enrollment will almost certainly lead

to greater participation in plans and a corresponding increase in subsidy costs paid by employers.

Automatic enrollment will be required effective as of 2014 at the earliest; the precise time depends on when the Department of Labor issues necessary guidance.

In the interim, however, employers should:

- Determine if the requirement is likely apply to them.
- As needed, develop projections for the likely increase in costs.
- Analyze current payments-in-lieu-of-benefits that are offered to employees and assess their compliance with the automatic enrollment requirement.
- Consider what changes will be necessary in the enrollment process and in employee communication materials.

Wellness Programs

Currently, employers are allowed to reward employees who participate in wellness programs designed to promote health and prevent disease by reducing their premium costs for health insurance plans by up to 20 percent. Effective, January 1, 2014, group health plans can provide reductions of up to 30 percent for participation.

All wellness programs must meet certain standards. They must be voluntary and nondiscriminatory: that is, they cannot be a mere ploy for discriminating based on health status. They must give eligible employees the opportunity to qualify for the reward at least once a year and there must be alternatives for obtaining the reward.

As is the case with other changes becoming effective in 2014, the guidance on this change is minimal. Employers may, however, begin to:

- Review their current wellness program to determine both its compliance with current requirements and whether they wish to take advantage of the new 30 percent reduction. Any such review should also consider potential risks under the Genetic Information Nondiscrimination Act and the Americans with Disabilities Act.
- If applicable, identify enhancements to the program in light of the increased reward.
- Identify participant materials that will need to be updated.

Much of the discussion of ACA over the last two years has focused on the question of its constitutionality and its wisdom as public policy. With the major constitutional questions now settled, employers are at the front lines of implementing this controversial and ambitious legislation.

Summary Table of Effective Dates

Summary of Benefits and Coverage	September 23, 2012 (see discussion above for details)
US$2,500 Limit on Health Flexible Spending Accounts	Plan years beginning on or after January 1, 2013
Form W-2 Reporting	January 2013 (due date of Form W-2)
Comparative Effectiveness Research Fee	Due: for plan years ending on or after October 1, 2012 Payable: July 31 of the following year First payment: July 31, 2013
Insurance Requirements	Plan years beginning on or after January 1, 2014
Employer Mandate	January 1, 2014
Automatic Enrollment	2014 (or later, depending on when implementation guidance is issued)
Wellness Programs	Plan years beginning on or after January 1, 2014

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