After the Supreme Court Decision - What Should Employers Do Now? Part I of III

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PRACTICE AREAS

Employee Benefits and ERISA

Employment and Labor

On June 28, 2012, the U.S. Supreme Court handed down a landmark decision upholding the Patient Protection and Affordable Care Act ("Affordable Care Act") in the *National Federation of Independent Business, et al., v. Sebelius* (567 U.S. _ (2012)). The question for employers now is: "Since the Affordable Care Act was in general upheld, what should employers do?" This *Newsflash* is the first part of a series of three *Newsflash* articles to provide information in summary to employers on what actions should be taken at this time. This first part will cover what employers should do in the calendar year 2012. The next two articles will cover what employers should do in year 2013 and 2014.

Summary of Benefits and Coverage

An imminent change under the Affordable Care Act is the requirement to provide a Summary of Benefits and Coverage ("SBC") to participants and beneficiaries beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. The SBC is in addition to the Summary Plan Description ("SPD") and must provide participants and beneficiaries clear and understandable information about their group health plans in a uniform, summary format that allows participants and beneficiaries to compare their benefits with other plans.

For fully-insured group health plans, the insurer is required to distribute the SBC to the Plan Sponsor of the group health plan but both the insurer and the Plan Sponsor are responsible for

distributing the SBC to participants and beneficiaries. If the insurer distributes the SBC to participants and beneficiaries, the Plan Sponsor does not also have to provide the SBC to participants and beneficiaries. In the case of a self-funded group health plan, the Plan Administrator is responsible for distributing the SBC. An SBC is required for all group health plans, including a stand-alone Health Reimbursement Arrangement ("HRA") but is not required for a stand-alone dental or vision plan, a Health FSA that is an "excepted benefits" plan under HIPAA nor a Health Savings Account ("HSA").

Advance Notice of Material Modifications

A second change under the Affordable Care Act provides that if a group health plan or an insurer makes a mid-year "material" change to the group health plan, a notice must be provided to participants and beneficiaries at least 60 days in advance of the effective date of the change. The prior notice of a material change is an important change for group health plans.

Form W-2 Reporting

A third change requires employers to report to the IRS a full-time employee's 2012 cost for group health coverage on Form W-2 received by employee in 2013. The required Form W-2 reporting is for employers who issued 250 or more W-2's in 2012. The aggregate cost of applicable employee and employer portions of employer-sponsored coverage must be reported, whether or not the employee cost is paid on a pre-tax or after-tax basis. The report must provide the cost of coverage for the employee plus any dependents and domestic partners and any portion of the cost that is includible in the employee's gross income. The coverage reported includes medical, dental, vision, Employee Assistance Plans (EAP), wellness and onsite medical clinics, if the coverage is under a group health plan. Note, the reporting of costs of an EAP, wellness program, and onsite medical clinics is not required if the employer does not charge a premium with respect to that type of coverage under COBRA. The reporting also does not include dental and vision coverage if not integrated with a group health plan, most HIPAA-excepted benefits, long-term care coverage, contributions to an HSA and Archer MSA, cost of coverage under an HRA and Health FSA salary deferrals.

Patient-Centered Outcomes Research Trust Fund Fee

The Affordable Care Act created a new entity, called the Patient-Centered Outcomes Research Institute, to review, evaluate and compare clinical effectiveness research on medical treatments, services, procedures, drugs and other items. The ACA also creates an annual fee for the Patient-Centered Outcomes Research Trust Fund for both fully-insured and self-insured group health plans for Plan Years ending on or after October 1, 2012 through 2018. The fee is imposed on the insurer for fully-insured plans and the Plan Sponsor for self-funded plans. The fee is $1.00 times

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the average number of covered lives in 2012 and $2.00 times the average number of covered lives for 2013. In 2014, the fee increases based on increases in the projected per capita amount of National Health Expenditures. The fee is paid by filing IRS Form 720 Quarterly Federal Excise Tax Return by July 31st of each year for the Plan Year that ends during the preceding Plan Year. The first payment will be due July 31, 2013. You will note the filing date coincides with the Form 5500 filing due date for other benefit plans.

Medical Loss Ratio Rebates

Finally, there are medical loss ratio rebates for fully-insured group health plans. Health insurers are now subject medical loss ratio standards. These standards are the percentage of premiums that insurers spend on medical care. In some cases, the insurer must provide a rebate to the employer that is the policyholder if the medical loss ratio is less than 85% in a large group market and less than 80% in small group and individual markets. The insurers must file a report with HHS by June 1st following the end of a reporting year and a rebate, if any, is due by August 1st to the policyholder, which typically will be the Plan Sponsor. A notice must be sent to each participant if a rebate is paid by the insurer. Note the important issue is if an employer receives a rebate whether or not the rebate is plan assets. If rebates are plan assets, then fiduciary duties attached to the rebates and the rebates must be used to either pay benefits or plan expenses. Plan assets may not be kept by the employer. Further discussions and careful attention should be paid to these funds if any rebates are issued.

This article is the first part of a three-part series regarding what to do now after the Supreme Court's landmark decision upheld the Affordable Care Act. This article is intended to only provide a brief summary of items that may affect Plan Sponsors of group health plans. If you have any questions regarding the case or the Affordable Care Act, please don't hesitate to call us.