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Employment & Employee Benefits Developments

2012 Year-End Health Plan Highlights and Reminders

Over the past year, the Departments of Labor ("DOL"), Treasury and Health and Human Services ("HHS") (collectively, the "Departments"), as well as the Internal Revenue Service ("IRS"), have issued a variety of statutory and regulatory provisions with which group health plans must comply. In this issue we provide an overview of these provisions, including, now that the election has come and gone, updated guidance on the Patient Protection and Affordable Care Act ("PPACA") and a summary of the key PPACA provisions set to take effect in 2014 and beyond, so that employers and other plan sponsors (collectively referred to throughout as "plan sponsors") can continue to assess the effects that these changes will have on financial and administrative planning and to ensure their plans maintain compliance.

PPACA Now

Form W-2 Reporting

PPACA requires certain employers to report the total cost of employees' employer-sponsored health insurance coverage on their Forms W-2 effective Jan. 1, 2013 — i.e., with the issuance of employees' 2012 Forms W-2. "Total cost" of coverage means both the employer's and employee's share of the total premium. The reporting is for informational purposes only.

Exceptions

Employers required to file fewer than 250 Forms W-2 for the preceding calendar year, determined without regard to any aggregation rules or controlled-group status, and employers contributing to multiemployer plans, do not have to comply with this reporting requirement unless and until the IRS issues guidance extending this requirement to these types of employers.

Medical Loss Ratio Rebates

Plan sponsors of insured group health plans must use care when developing procedures for how to distribute any Medical Loss Ratio rebate they may have already received for the 2011–2012 plan year, or may receive for future plan years. The DOL has issued guidance to help plan sponsors determine how to distribute any rebate they may receive which states that decisions on how to distribute a rebate are considered fiduciary decisions. This means that the decision must be made solely in the interest of plan participants and beneficiaries, and in accordance with the terms of the plan to the extent those terms are consistent with ERISA. According to the DOL, the allocation method must be reasonable, fair and objective.

It is important to note that, unless a plan provides otherwise, only the portion of the rebate attributable to employee contributions is considered a "plan asset" and must therefore be distributed to participants. Plan sponsors should review their plan documents to confirm whether they explain how any rebates should be distributed; if the plan documents are silent on the matter, plan sponsors should consider amending their plans to include such language.

Health Flexible Spending Account ("FSA") Cap at $2,500

Effective Jan. 1, 2013, for calendar year plans, health FSAs must be capped at $2,500. Fiscal-year plans must comply with the cap after the end of their 2012-2013 plan year. Plan sponsors that have not yet amended their plan must prepare and adopt an amendment to impose the $2,500 cap before Dec. 31, 2014. The cap applies

only to health FSA contributions attributable to salary reduction arrangements and not to employer non-elective contributions (sometimes referred to as "flex credits"). For plans that provide a "grace period" allowing employees to use unused salary reduction contributions until a maximum of two months and 15 days after the close of the plan year, unused salary reduction contributions for plan years beginning in 2012 that are carried over into the grace period in 2013 will not count towards the $2,500 cap for the next plan year.

"Given the complexities in condensing all relevant coverage information into the eight-page form, the Departments have stated that during this first year of applicability, they will not impose penalties on plans and issuers that work diligently and in good faith to provide the SBC in a manner that complies in both form and content with the final regulations."

Review Annual Limit Waivers

Plan sponsors of group health plans that wish to extend their waiver from PPACA's annual limit requirement for the plan year beginning on or after Sept. 23, 2012 must do so by Dec. 31, 2012. These plan sponsors must update the information provided in last year's extension request and should also provide an updated Attestation. Plan sponsors that do not obtain a waiver for the plan year beginning on or after Sept. 23, 2012 must comply with a $2 million annual limit for this upcoming plan year.

Summary of Benefits and Coverage

Plan administrators of self-insured group health plans and health insurance issuers of fully insured group health plans must provide a Summary of Benefits and Coverage (the "SBC") to participants and beneficiaries during open enrollment for the first plan year beginning on or after Sept. 23, 2012 (for more information, please see our April 11, 2012 *Alert Final Rule on Summary of Benefits and Coverage)*. The SBC is an eight-page standardized document required by PPACA that summarizes the benefits and terms of coverage for plan participants and beneficiaries.

For participants and beneficiaries who do not enroll in coverage through open enrollment (i.e., individuals who enroll during HIPAA special enrollment periods), the SBC must be provided on the first day of the first plan year beginning after Sept. 23, 2012 (Jan. 1, 2013 for calendar year plans).

Given the complexities in condensing all relevant coverage information into the eight-page form, the Departments have stated that during this first year of applicability, they will not impose penalties on plans and issuers that work diligently and in good faith to provide the SBC in a manner that complies in both form and content with the final regulations. Further guidance is expected over the next two years as to how the SBC will change once additional provisions of PPACA become effective; these key provisions are discussed on page 4 of this newsletter.

Additional Medicare Tax

An additional Medicare tax of .9 percent will be imposed on an employee's wages over $200,000 ($250,000 for married, filing jointly) earned after Dec. 31, 2012. This means that the current Medicare rate of 2.9 percent will increase to 3.8 percent, and the employee-paid Medicare tax rate will increase from 1.45 percent to 2.35 percent.

Notice of Exchanges

No later than March 1, 2013, employers must notify their employees (including new hires) about the upcoming health insurance Exchanges, which are intended to be up and running by Jan. 1, 2014. The notice must include:

- A description of the services provided by the Exchange and how employees can contact the Exchange for further assistance;
- A statement — if the group health plan's share of total allowed costs of benefits offered under the plan is less than 60 percent of such costs (i.e., the plan does not offer "minimum value") — that the employee may be eligible for a premium tax credit and/or a cost-sharing subsidy should the employee decide to purchase coverage through the Exchange; and

- A statement that, if employees decide to purchase coverage through the Exchange, they may lose the employer contribution (if any) to any health plan offered by the employer, and that all or a portion of the contribution may be excludable from income for federal income tax purposes.

Although the notice deadline is approaching, the Departments have not yet issued any supplemental guidance with additional information (i.e., whether any employers are exempt from this requirement, how the information can be provided by March 2013 if a state's Exchange is not yet up and running, and how the notice must be delivered), nor have they issued a model notice employers can rely on to ensure compliance with the requirement. We will update you when such guidance is provided, though this guidance may be further delayed as HHS recently extended the deadline for states to submit their Exchange plans to Dec. 14, 2012 (the deadline was initially Nov. 16, 2012). Plan sponsors should note, however, that the Exchanges are still expected to begin open enrollment by October 2013.

Comparative Effectiveness Research Fees

In order to advance clinical effectiveness research related to patient-centered outcomes, including helping patients, physicians and policymakers make informed health decisions, PPACA established the Patient-Centered Outcomes Research Institute (the "Institute"), to be funded by the Patient-Centered Outcomes Research Trust Fund (the "Trust Fund"). Issuers of health insurance policies and sponsors of self-insured health plans will be required to pay fees to help fund the Trust Fund.

For self-insured health plans, the fee will be imposed on "applicable self-insured health plans" — generally any plan that provides accident or health coverage if such coverage is provided other than through an insurance policy and the plan is established or maintained by at least one employer for the benefit of the employer's employees or former employees. The fee will be imposed for each plan year ending after Sept. 30, 2012, but before Oct. 1, 2019. This means that, if a self-insured health plan's plan year is the calendar year, the fee will be imposed for plan years 2012 through 2018.

The amount of the fee is one dollar for plan years ending before Oct. 1, 2013 multiplied by the average number of lives covered under the plan. For plan years ending after Oct. 1, 2013, the amount of the fee is two dollars multiplied by the average number of lives covered under the plan. The "plan sponsor" of the applicable self-insured health plan is responsible for paying the fee. For a multiemployer plan, the Code defines "plan sponsor" as the association, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the plan. The National Coordinating Committee for Multiemployer Plans has requested clarification from the IRS that plan sponsors can use plan assets to pay the required fee, and the IRS has yet to issue guidance answering that request. However, the DOL has advised the Treasury Department and the IRS that it is considering what sources of funds are permissible for paying the fee.

Earlier this year, the IRS issued proposed rules outlining these fees, including three safe harbor methods for determining the number of covered lives under the plan. Under the "actual count" method, the plan sponsor of a self-insured health plan can comply with this requirement by calculating the sum of the lives covered for each day of the plan year and divide that amount by the number of days in the plan year. Under the "snapshot" method, the plan sponsor can add the total of lives covered on one date in each quarter, or an equal number of dates for each quarter, to each other and divide the total by the number of dates on which a count was made (i.e., "4" if one date was used for each quarter). Under the "Form 5500" method, a plan sponsor can use a formula that includes the number of participants reported on Form 5500 for the plan for the plan year.

Plan sponsors of applicable self-insured health plans can use only one method in determining the number of covered lives per plan year, though the proposed rules permit plan sponsors to vary the method from one plan year to the next.

Plan sponsors of applicable self-insured health plans must report and pay the fee annually on Form 720 (Quarterly Federal Excise Tax Return) by July 31 of each year. This means that the first due date for the return will be July 31, 2013.

HIPAA Audits

The Office of Civil Rights at HHS has issued its audit guidelines to monitor compliance with HIPAA's privacy and security standards. Though insurance carriers will handle most of the compliance responsibilities for insured plans, plan sponsors should review and update their HIPAA policies and procedures to ensure compliance with HIPAA's rules to avoid potential penalties on audit. For example, plan sponsors should review, at a minimum, their business associate agreements to ensure that they are up-to-date and remind participants about their privacy notice at least once every three years. Plan sponsors should also be aware that there are ongoing requirements to train employees on the HIPAA requirements. We are available to assist you with your compliance efforts, including training employees and reappointing a privacy officer, if necessary.

Medicare Part D Notice

As a reminder, plan sponsors of group health plans that offer prescription drug benefits must distribute a notice to all Medicare-eligible participants each year that explains whether the prescription drug benefits offered under the plan are at least as good as those offered under a Medicare Part D Plan. Only those employers that offer their own Part D plan, or contract with a Medicare Part D Plan, are exempt from this requirement.

Plan sponsors should review their administrative services agreements and ensure that their service providers are updating and distributing all necessary participant communications, including the Medicare Part D notice, where applicable.

PPACA in 2014 and Beyond

Employers that sponsor group health plans should be aware of the following provisions of PPACA set to take effect in 2014 and beyond:

Individual Mandate

Earlier this year, the Supreme Court upheld PPACA's "individual mandate," which requires applicable individuals who fail to maintain "minimum essential coverage" for themselves and their applicable dependents to pay a penalty, included with their tax returns, for any month beginning after 2013 (for more information, please see our July 10, 2012 *Alert, Supreme Court Upholds Landmark Health Care Reform as a Tax*).

The amount of the monthly individual penalty depends in part on the year in which it is assessed.

Year	Monthly Penalty Amount
2014	The greater of: (i) 1/12 of $95 (the "applicable dollar amount"); or (ii) 1 percent of the individual's household income
2015	The greater of: (i) 1/12 of $325; or (ii) 2 percent of the individual's household income
2016 and Beyond	The greater of: (i) 1/12 of $695; or (ii) 2.5 percent of the individual's household income

For applicable individuals under the age of 18, the applicable dollar amount will be reduced by 1/2 for the calendar year in which the month occurs. The total family penalty is capped at 300 percent of the applicable dollar amount for the calendar year (i.e., $285 in 2014, $975 in 2015 and $2,085 in 2016).

Premium Tax Credits & Cost-Sharing Reductions

Effective in 2014, individuals whose household income for the taxable year equals or exceeds 100 percent of the Federal Poverty Level ("FPL," $23,050 for a family of four in 2012) but does not exceed 400 percent of the FPL ($92,200) will be eligible for a premium tax credit towards their purchase of health insurance (for more information, please see our Winter 2012 *Employment & Employee Benefits Developments Health Care Reform Highlights* newsletter). Generally, the amount of the credit will be

based on both the premium of the second lowest cost "silver" plan available to the individual that is offered through an Exchange, as well as the individual's household income. For reference, a "silver" plan is a plan that provides benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

To be eligible for the credit, applicable individuals must be enrolled in a plan offered through an Exchange and must be lawful residents of the state offering the Exchange. In addition, applicable individuals generally cannot be eligible for other minimum essential coverage and receive the premium tax credit. However, individuals eligible for, but not enrolled in, employer-sponsored health coverage may be eligible for the credit if the employer-sponsored health coverage is not affordable or does not provide "minimum value." Employer-sponsored coverage is not affordable if the employee's required contribution with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income. Employer-sponsored coverage does not provide minimum value if the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

Individuals who qualify for a premium tax credit and are enrolled in a "silver" plan offered through an Exchange will be eligible for further cost-sharing reductions, or subsidies. The subsidies are expected to reduce eligible individuals' out-of-pocket maximums by 2/3 for individuals with household incomes between 101 percent and 200 percent of the FPL; by 1/2 for individuals with household incomes between 201 percent and 300 percent of the FPL; and by 1/3 for individuals with household incomes between 301 percent and 400 percent of the FPL.

Employer Penalty

Effective in 2014, "large" employers may face a penalty if they do not offer a health plan for their employees, or if they offer a health plan that either does not provide minimum value or is "unaffordable" (for more information, please see our Winter 2012 *Employment & Employee Benefits Developments* Health Care Reform Highlights newsletter). A "large" employer is an employer with 50 or more full-time equivalent employees. Employers that sponsor group health plans should begin to determine whether they are "large" employers for purposes of the penalty. To help employers with this determination, the Departments have issued guidance on a safe harbor employers can use to determine whether they meet the 50-employee threshold. Generally, for "ongoing employees," an employer can determine each employee's full-time status by looking back at a standard measurement period of not less than three but no more than 12 consecutive months, as determined by the employer. An "ongoing employee" is any employee who has been employed by the employer for at least one standard measurement period. If an employee averaged at least 30 hours per week during this period, the employer will treat the employee as a full-time employee during the next period of time, or the "stability period," regardless of the number of hours the employee actually works during the stability period. The stability period must be at least six consecutive calendar months but cannot be shorter than the standard measurement period, and must begin within 90 days of the standard measurement period.

"New hires" (i.e., employees who have not been employed by the employer for at least one standard measurement period) will be considered full-time employees if it is reasonably expected that the employee will work an average of at least 30 hours per week. If so, the employer must treat the employee as a full-time employee immediately (though, to coordinate with PPACA's 90-day waiting limit, the employer does not have to offer the employee coverage during the employee's first three months of employment).

Essential Health Benefits

Effective Jan. 1, 2014, fully insured group health plans and health plans offered through state Exchanges must offer the "essential health benefits package." The essential health benefits package limits cost-sharing and provides certain levels of coverage.

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The Departments gave states the responsibility of defining the specific benefits that will constitute essential health benefits, and further guidance from each state is expected in the future.

Essential Health Benefit Categories
At a minimum, essential health benefits must include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

90-Day Waiting Periods

Effective for plan years beginning on or after Jan. 1, 2014, group health plans cannot apply "waiting periods" in excess of 90 days. A "waiting period" is defined as the period of time that must pass before coverage for an eligible employee or dependent becomes effective. Earlier this year, the Departments issued guidance as to how to apply the 90-day limit to variable-hour employees if the plan conditions eligibility on hours of service. Here, an employer-plan sponsor will still be considered to have complied with the 90-day limit if coverage for an eligible employee becomes effective within 13 months of the employee's date of hire, plus the remainder of the month until the first day of the next calendar month if the date of hire does not fall on the first of a month. This guidance will remain in effect at least through 2014.

Wellness Incentives

Effective Jan. 1, 2014, group health plans can increase their wellness incentives from the current level of 20 percent of premium costs to 30 percent of premium costs.

Pre-Existing Condition Exclusions

Effective Jan. 1, 2014, group health plans and group and individual health insurance coverage cannot impose any pre-existing condition exclusions. Currently, group health plans and group and individual health insurance coverage cannot impose pre-existing condition exclusions on individuals under age 19.

Nondiscrimination for Fully Insured Health Plans

PPACA extends the current requirement that self-insured plans not discriminate in favor of highly compensated individuals to fully insured plans. This requirement, however, has been delayed pending further regulations from the IRS which will detail the specifics of the rule. The rule is expected to become effective beginning the first plan year after such regulations are issued.

Excise Tax on Cadillac Plans

Effective Jan. 1, 2018, high-cost, or "Cadillac," health plans will be assessed a 40 percent non-deductible excise tax on the value of health coverage that exceeds $10,200 for an individual and $27,500 for a family, indexed for inflation. Insurers of fully insured plans will be responsible for the payment of the tax.

How to Prepare

Plan sponsors of group health plans must be aware of, and in some cases take action on, numerous statutory and regulatory requirements that have recently become effective. These sponsors should pay special attention to the provisions of PPACA set to take effect in 2014 and should continue planning for the administrative and financial implications these changes will have on their plans. Please contact your attorney at Schulte Roth & Zabel for more information on how to prepare.

Schulte Roth & Zabel Contacts

For additional information on the reminders and highlights in this newsletter, or if you would like assistance with implementing any of the requirements and recommendations or preparing participant communications, amendments or other plan materials, please contact your Schulte Roth & Zabel attorney or one of the following authors:

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