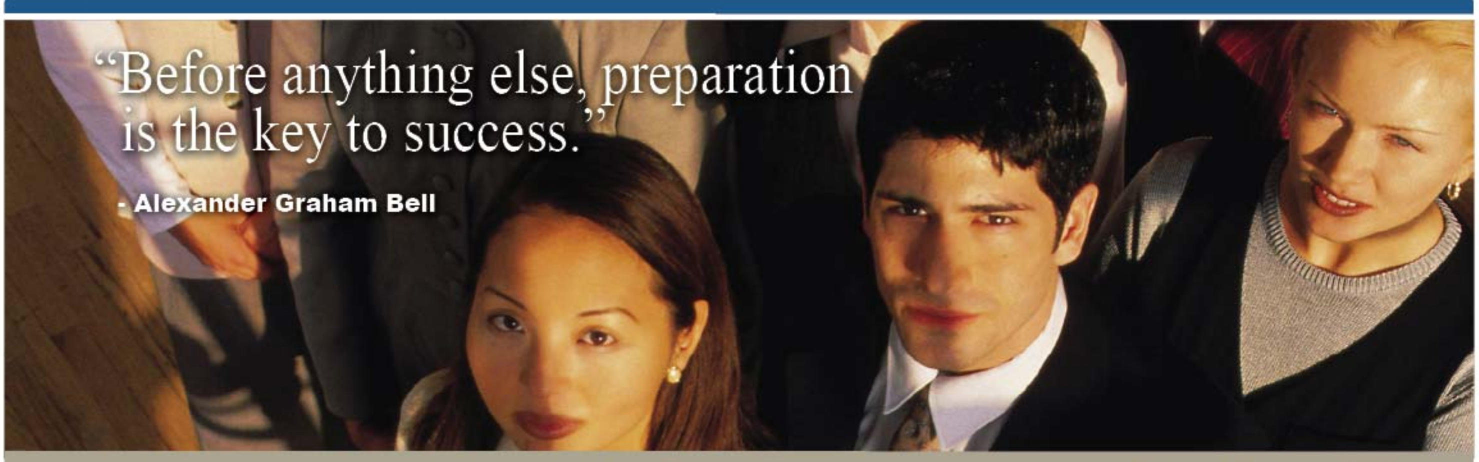
Benefits and Employment Briefing



A quarterly newsletter about employee benefits and current issues Second Quarter 2010

HEALTH CARE REFORM: THE NEAR TERM

Congressional passage of comprehensive health care reform legislation means that employers and other health plan sponsors can no longer take a wait-and-see approach to this subject. Like it or not, change is coming. And while many key provisions do not take effect until 2014, a surprising number of changes will apply to employer-based health coverage well before then. **We are therefore devoting this entire issue of our quarterly newsletter to a discussion of several significant short-term changes.**

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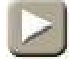

NEW REPORTING AND DISCLOSURE REQUIREMENTS

In addition to transforming the rules governing the *benefits* that health plans must offer, the Affordable Care Act substantially alters the way that plan sponsors and health insurers must *describe* and *report*

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HEALTH CARE REFORM: THE NEAR TERM

Congressional passage of comprehensive health care reform legislation means that employers and other health plan sponsors can no longer take a wait-and-see approach to this subject. Like it or not, change is coming. And while many key provisions do not take effect until 2014, a surprising number of changes will apply to employer-based health coverage well before then. We are therefore devoting this entire issue of our quarterly newsletter to a discussion of several significant short-term changes.

But first, some necessary background. For reasons that were widely reported in the popular media, this reform legislation was adopted in the form of two entirely separate bills. The Patient Protection and Affordable Care Act ("PPACA"), based on the Senate version of health care reform, was signed into law by President Obama on March 23, 2010. A week later, the President signed the Health Care and Education Reconciliation Act ("HCERA"), a package of changes to the PPACA insisted upon by the House of Representatives (but, for procedural reasons, limited to changes having a *revenue* effect). Because the Obama administration refers to these two Acts as the "Affordable Care Act," the articles in this newsletter will follow that same approach (often further abbreviating the name to simply the "Act").

When the Act becomes fully effective in 2014, a number of related provisions are designed to reduce the number of Americans without health coverage. These include an "individual mandate" (requiring that all legal residents have some type of health coverage – or pay a tax penalty for failing to do so), the establishment of statewide clearinghouses (known as "exchanges") as a way of connecting individuals and employers with health insurance policies, tax subsidies designed to assist individuals in obtaining health coverage through the exchanges, and penalties on larger employers (those with more than 50 full-time employees) that fail to offer their employees "affordable" health coverage.

But much will be happening in the next 3½ years. President Obama has directed the agencies responsible for administering the Act's provisions (the Department of Health and Human Services ["HHS"], the Department of Labor ["DOL"], and the Internal Revenue Services ["IRS"]) to give top priority to issuing necessary guidance. Those agencies have taken that directive to heart, having already started to issue substantive guidance. We expect to see more such guidance throughout the remainder of 2010.

The purpose of this newsletter is to lay out some of the more significant aspects of health care reform that employers and their

advisors should be considering right now. The members of Spencer Fane's Employee Benefits Practice Group would be pleased to assist in that process.

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SHORT-TERM INCENTIVES FOR EXPANSION OF HEALTH COVERAGE

Recognizing that the key provisions of the Affordable Care Act do not take effect until 2014, Congress included a number of short-term incentives for the expansion of health coverage during the intervening period. Three of these programs are as follows:

- "Reinsurance" for certain claims incurred by early retirees under an employer-sponsored plan;
- A tax credit for small employers with a low-paid workforce who pay a significant portion of their employees' health insurance premiums; and
- State-wide "high-risk pools" for individuals who are unable to obtain health coverage due to a preexisting condition.

Early Retiree Reinsurance Program

According to the Obama Administration, the percentage of large employers offering health coverage to early retirees (*i.e.*, those between age 55 and Medicare eligibility) has declined precipitously in recent years, from 66% in 1988 to 31% in 2008. As a way of stemming that slide, the Affordable Care Act allocates $5 billion to a program under which the federal government will reimburse employer health plans (whether insured or self-funded) for certain claims incurred by early retirees or their covered dependents. During 2010, this program will reimburse 80% of an individual's claims of more than $15,000 and less than $90,000. These two dollar amounts will be adjusted for inflation in later years.

To be eligible to participate in this reinsurance program, a health plan must submit an application to the Department of Health and Human Services ("HHS") demonstrating that the plan has implemented "programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions." As an example of such a cost-savings program, recent HHS regulations mention a diabetes management program that includes monitoring and behavioral counseling to prevent complications and

hospitalizations. Those regulations define a "high-cost condition" as one that is likely to result in claims of $15,000 or more during a plan year by any one participant.

Any reimbursements received under this program must be used by the plan to "lower costs for the plan." For example, these funds might be used to reduce retiree premiums, copayments, deductibles, coinsurance, or other out-of-pocket costs. Apparently, they could also be used to reduce any *employer* premiums for the retiree coverage. However, they could *not* be used as general revenues of the plan sponsor. HHS is required to audit this program on an annual basis to ensure the appropriate use of all reimbursements. These reimbursements will not be taxable to the plan sponsor.

This program is slated to end on January 1, 2014 – or *sooner*, if the $5 billion appropriation is exhausted before then. Applications to participate in the program will be available by the end of June. Because reimbursements will be made to qualifying plans on a first-come, first-served basis, any sponsor interested in participating in this program should plan to apply early.

Small-Employer Tax Credit

Beginning in 2010, small employers (those with fewer than 25 full-time employees, including full-time equivalents ["FTEs"]) with a relatively low-paid workforce (an average annual wage of less than $50,000) may qualify for a federal tax credit equal to a portion of the amounts the employer pays for its employees' health insurance. To receive the *full* credit, an employer must have 10 or fewer FTEs and an average annual wage of less than $25,000. The credit is phased out for employers with 10 to 25 employees or average annual wages of $25,000 to $50,000.

This tax credit is equal to a percentage of the total health insurance premiums paid by the employer. For 2010 through 2013, *taxable* employers may receive a credit of up to 35% of these premiums, while *tax-exempt* employers may receive a credit of up to 25%. Taxable employers will claim this amount as a general business credit, thereby allowing it to be carried back one year and forward for up to 20 years. The credit also applies to liability under the alternative minimum tax. Tax-exempt employers will claim the credit as an offset against their payroll tax liability. For such employers, the credit is limited to this annual amount.

Beginning in 2014, the program will be slightly modified. The maximum credit percentage will increase to 50% for taxable employers and 35% for tax-exempt employers. However, the credit will then apply only to coverage purchased through

one of the state-wide exchanges that are to be established under the Act. Moreover, the credit will then be available to an employer for only two consecutive years.

In order to qualify for this credit, an employer must pay at least 50% of the total insurance premiums charged to its employees. For 2010, the employer must simply pay the same dollar amount for each employee, regardless of whether an employee elects single or family coverage. Beginning in 2011, however, the employer must pay a uniform percentage of each employee's actual premium, even if an employee's premium is higher due to his or her election of family coverage.

A complicating factor stems from the fact that the credit is actually calculated on the basis of the *lesser* of (1) the employer's *actual* premiums paid on behalf of its employees, or (2) the amount that the employer *would* have paid (based on the same uniform percentage of the premium) if its employees had enrolled in a plan under which the premiums were equal to the average premiums charged in the small group market in the state where the insurance is purchased. In its recent Revenue Ruling 2010-13, the IRS has listed the dollar amounts of these "benchmark" employee and family premiums to be used during 2010. HHS will redetermine these state-wide benchmarks on an annual basis, and may also establish higher benchmarks for certain areas within a state.

In determining whether an employer meets the 25 FTE and $50,000 average wage thresholds, an employer may disregard any self-employed individuals, any 2% S-corporation shareholders, and any 5% owners of other entities. The number of FTEs is then determined by dividing the total number of hours worked by all employees by 2080. The applicable wage definition is the one used for FICA contribution purposes, but disregarding the annual FICA wage cap.

Any small employer that would qualify for this tax credit – or that would qualify by making only minor adjustments to the premium amounts it currently pays on behalf of its employees – should investigate the credit's availability. Claiming the credit may significantly ease the cost of maintaining the employee health plan. Moreover, although an employer may not deduct any premium payments that give rise to the credit, any *additional* employer premiums will still be deductible.

High-Risk Pools for Long-Term Uninsured

One of the programs included in the Affordable Care Act was proposed by congressional Republicans. It is designed to encourage states to establish temporary pools to provide health coverage to individuals who are otherwise unable to obtain such coverage due to a preexisting condition. To qualify for coverage through

one of these "high-risk pools," an individual must be lawfully in the United States, have a preexisting condition (as determined under guidance to be issued by HHS), and not have been covered under creditable coverage (as defined for HIPAA purposes) during the six months prior to applying.

This program is to be available starting on July 1, 2010. It will end on January 1, 2014, when coverage with no preexisting condition exclusions should be available through the exchanges. The Act appropriated $5 billion to support these high-risk pools, which are to be funded entirely by the federal government.

Each state may either establish its own high-risk pool or allow HHS to establish and maintain such a pool for its residents. As of May 3, thirty states had announced that they would maintain their own pools and 17 had elected to allow HHS to do so. The remaining four states were still considering their options.

Although employers will have no direct involvement with these high-risk pools, they should be aware of a provision in the Act that requires an insurer or self-funded plan to reimburse a pool if the insurer or plan sponsor is found to have encouraged an individual to disenroll from existing coverage in order to obtain coverage through a pool.

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GRANDFATHERED PLANS

In the weeks and months leading up to the enactment of the Affordable Care Act, one of the oft-repeated "campaign promises" made by promoters of the legislation was, "If you like your current health care coverage, you can keep it." In keeping with the spirit of that promise, the Act includes provisions that exempt so-called "grandfathered" plans from some, but not all, of the benefit mandates in the Act. Unfortunately, the Act leaves many questions unanswered with respect to the application of these grandfather rules.

Which Plans Are Grandfathered?

A grandfathered plan is any group health plan or health insurance coverage that was in existence on March 23, 2010, the date of enactment of the Act. It can be either fully insured or self-funded. The Act makes clear that adding new employees or enrolling additional dependents will not cause a plan to lose its grandfathered status. Because the Act refers only to *new* employees, however, some commentators have questioned whether *existing* employees – who might have previously opted out of the plan – can be allowed to enroll without undermining a plan's grandfathered status. Although further guidance on this point would be welcome, it seems unlikely that simply enrolling existing employees will have this result.

What is even *less* clear is whether, and to what extent, changes in the plan's design, insurance carrier, or eligibility rules will cause a plan to lose its grandfathered status. Some practitioners have speculated that *any* amendment to the plan will risk its grandfathered status. We think that such an interpretation is unlikely, because it would be inconsistent with the Act's intent. However, further guidance is needed as to whether more significant plan changes, such as might occur in the context of a corporate merger or acquisition, will cause a plan to lose its grandfathered status. Until such guidance is issued, plan sponsors should tread carefully in this area.

Mandates Applicable to All Plans

Even *grandfathered* plans must comply with the following benefit mandates, effective as of the first plan year beginning on or after September 23, 2010 (i.e., January 1, 2011, for calendar-year plans):

- A prohibition on lifetime limits for "essential" benefits;
- A prohibition on rescissions of coverage, except in the case of fraud or misrepresentation;
- Restrictions on "unreasonable" annual limits on "essential" benefits;
- The elimination of pre-existing condition exclusions for dependents under age 19; and
- Required coverage of dependent children to their 26th birthday (regardless of marital status), *unless* they have access to other employer coverage.

All employer plans (including grandfathered plans) must also comply with the following mandates, though not until the first plan year beginning on or after January 1, 2014:

- The elimination of *all* pre-existing condition exclusions;
- The elimination of *all* annual limits on "essential" benefits;
- Required coverage of dependent children to their 26th birthday (regardless of marital status), *even if* they have access to other employer coverage;
- A prohibition on excessive waiting periods (no more than 90 days); and
- "Automatic enrollment" of full-time employees (for employers with 200 or more full-time employees).

Mandates Applicable Only to Non - Grandfathered Plans

In addition to the requirements noted above, a plan established after March 23, 2010 (or a previously-established plan that loses its grandfathered plan status), must comply with the following mandates:

- Required coverage for emergency services at in-network levels;
- A prohibition on restrictions regarding designation of primary care providers;
- A prohibition on required referrals for OB/GYN services;
- Required first-dollar coverage for certain preventive services (immunizations and screenings), subject to no deductible;
- Enhanced claim appeal procedures, including implementation of an external appeals process;
- Required coverage of routine expenses for clinical trials; and
- A prohibition on discrimination in favor of highly compensated individuals in fully insured plans (the same prohibition to which self-funded plans are already subject).

Collectively Bargained Plans

The Act contains a special effective-date rule for collectively bargained plans. For health insurance coverage maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010, *none* of the mandates listed above will apply until the date on which the last of those collective bargaining agreements terminates.

The Act states that any voluntary amendments made pursuant to collective bargaining to comply with some or all of the Act's requirements *before* the expiration of the last collective bargaining agreement will not cause the plan to lose its grandfathered status.

Because the provision of the Act refers only to "health insurance coverage," a literal reading of the statute would suggest that the delayed effective date does not apply to self-funded plans. Additionally, some have speculated that, once the last collective bargaining agreement expires, a collectively bargained plan will lose its grandfathered status entirely.

Both of these interpretations would appear to be inconsistent with the spirit of the Act, particularly since *non*-collectively bargained plans are permitted to retain their grandfathered status indefinitely. More likely, upon the expiration of the last collective bargaining agreement, the "regular" grandfather rules (as described above) will then apply. Future guidance is expected to clarify these points, so stay tuned.

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DEPENDENT COVERAGE REQUIREMENTS (AND OPTIONS)

Under the Affordable Care Act, group health plans providing coverage to dependent children will soon be required to make coverage available to a covered employee's adult child until the child's 26th birthday, even if the child is no longer a full-time student and even if the child can no longer be claimed as the employee's "dependent" on the employee's federal income tax return. This requirement to extend group health plan coverage until an adult child's 26th birthday applies to both insured and self-insured plans (regardless of the plan's status as a "grandfathered" plan), and is effective for plan years beginning after September 23, 2010 (i.e., January 1, 2011, for calendar-year plans).

The Act also makes a conforming change to the Tax Code so that coverage and/or reimbursements for such adult children will not be included in the employee's gross income for federal income tax purposes. Although the requirement to extend group health coverage to adult children is not effective for many plans until 2011, the exclusion from income is already effective. It applies to coverage provided (or reimbursements of expenses incurred) on or after March 30, 2010.

As a result, plans that are already providing coverage to nondependent children under age 26 (either voluntarily or pursuant to a state law that requires insured plans to cover children to a later age) need not report the value of this coverage as taxable income for periods beginning on or after March 30, 2010. In addition, plans that voluntarily elect to comply with the new coverage requirement *before* 2011 may do so without adverse tax consequences to their employees (or additional reporting requirements by the plan sponsor).

Together, these two changes provide some significant new obligations (and opportunities) for sponsors of group health plans, health flexible spending accounts ("FSAs"), and health reimbursement accounts ("HRAs"). Fortunately, both the IRS and the DOL have already issued substantive guidance in this area, easing the task of complying with these new rules.

Requirement to Provide Coverage

The Act provides that any group health plan or health insurance issuer offering group or individual health insurance coverage for dependent children "must continue to make such coverage available for an adult child until the child turns 26 years of age." The Act specifically states, however, that a plan need not make coverage available to a child of a child receiving dependent coverage (i.e., an employee's grandchild). The DOL regulations make clear that a plan need not cover the *spouse* of an adult child, either.

As noted above, the requirement to extend group health coverage to adult children until their 26th birthday applies for plan years beginning on or after September 23, 2010. This means that most plans must offer this coverage beginning with the 2011 plan year. However, for plan years beginning before 2014, "grandfathered" plans (generally, those in existence on March 23, 2010) need not extend coverage to an adult child who is eligible for coverage under another group health plan – disregarding any coverage available to the child under a plan of the other parent's employer.

The DOL regulations address other key points, as well. For instance, the coverage provided to adult children under age 26 must be no less favorable than the coverage provided to other dependent children. This means that adult children may not be charged a higher premium than younger children, and they must be offered the same range of benefit options. An example in the regulations makes clear, however, that a plan charging an additional premium for each covered dependent *may* increase the total premium to reflect the coverage of an adult child.

Second, all plans that cover dependent children will be required to offer a one-time open-enrollment opportunity for children under age 26 – even if the plan normally offers no open-enrollment period. This open-enrollment period must begin no later than the first day of the first plan year to which this change applies, and it must remain open for at least 30 days. Notice of this open-enrollment opportunity that is provided to an employee will be considered sufficient notice to the employee's adult child. If a child chooses to take advantage of this open-enrollment opportunity, his or her coverage must be effective as of the first day of the first plan year beginning after September 23, 2010.

Finally, the DOL regulations make clear that this one-time enrollment opportunity must be treated as a "special enrollment" under HIPAA. This may have some surprising consequences. For instance, if a child qualifies for this open-enrollment opportunity, but his or her parent is not currently enrolled in the plan, the plan must provide an opportunity for both the parent *and* the child to enroll. Moreover, an adult child's enrollment may serve as an opportunity for his or her *parent* to change to a different benefit option. These alternatives should be explained in the notice that is required to be provided concerning this one-time enrollment opportunity.

Expansion of Income Tax Exclusion

Separately, the Act amends Section 105(b) of the Tax Code, the provision under which employees are allowed to exclude from their taxable income any benefits they receive under an employer-sponsored health plan.

Prior to this amendment, the exclusion from income under Section 105(b) applied only to medical benefits received by an employee, the employee's spouse, and the employee's "dependents" (as defined in Code Section 152). Under Section 152, a taxpayer's child will not qualify as a "dependent" unless the child (i) lived with the taxpayer for more than half of the year, (ii) did not provide over half of his or her own support for the year, and (iii) was either less than 19 for the entire year, or was a student who was less than 24 for the entire year.

The Act amends Section 105(b) to provide that the exclusion also applies to benefits received by an employee's "child" (as defined in Code Section 152(f)(1)) who, as of the end of the taxable year, has not yet attained age 27. Accordingly, the expanded income exclusion applies to any child, step-child, adopted child, or foster child who will not attain age 27 by the end of the year – regardless of the child's marital status, and regardless of whether the child meets the residency or support requirements to qualify as the employee's "dependent" for federal income tax purposes.

Note that the Act does *not* change the definition of "dependent" under Section 152, and therefore does not allow a taxpayer to claim an older child as a dependent for federal income tax purposes. It merely expands the category of individuals for whom medical expenses may be reimbursed without causing an employee to be taxed on those reimbursements.

According to the Act's legislative history, the Act also excludes from an employee's taxable income (under Code Section 106) the value of employer-provided health care *coverage* provided to the employee's adult children. Therefore, if an employer pays the premiums for its employees' adult children, those employees will no longer be taxed on those premiums. Moreover, an employer may now allow its employees to pay such premiums on a pre-tax basis (through a Section 125 cafeteria plan).

Differences Between Coverage Mandate and Tax Exclusion

There are some key differences between the two aspects of this change. First, the coverage mandate does not apply until the first plan year beginning on or after September 23, 2010, while the expansion of the income tax exclusion became effective on March 30, 2010. As a result, there is a period (between March 30, 2010, and the first day of the plan year that begins after September 23, 2010) in which plans have the "option" to extend coverage to adult children without causing the employee to incur additional taxable income. (Interestingly, Kathleen Sebelius, the Secretary of HHS, has already published a letter asking employers and insurers to voluntarily offer dependent health coverage through age 26 starting in May of 2010, when many college graduates will otherwise

lose coverage, and several key health insurers have already agreed to do so.)

Second, the coverage mandate applies until an "adult child" attains age 26 (i.e., until the child's 26th birthday), whereas the income tax exclusion applies to reimbursements (or coverage) provided to any child who has not yet attained age 27 by the last day of the calendar year. Therefore, although plans are only *required* to offer coverage until the child attains age 26, such coverage *may* be provided – on a tax-free basis – until the end of the year in which the child attains age 26.

IRS Guidance Regarding Tax Exclusion

The IRS has already issued guidance regarding the expansion of this tax exclusion. Notice 2010-38 makes clear that:

1. The exclusion from income applies to both reimbursements of health care *expenses* (under Section 105(b)) and the cost of employer-provided *coverage* (under Section 106);
2. The exclusion for reimbursements of medical expenses also applies to health FSAs and HRAs; and
3. Non-taxable coverage and reimbursements are also excluded from "wages" for purposes of FICA and FUTA taxes.

The Notice also includes some significant pronouncements with respect to Section 125 cafeteria plans and health FSAs. For instance, it provides a special "transition rule," whereby employers may permit their employees to immediately begin making pre-tax salary reduction contributions for health coverage through a cafeteria plan (i.e., to pay premiums for health coverage or to set aside dollars in a health FSA) for adult children under age 27, even if the plan has not yet been amended to cover those individuals. To take advantage of this rule, however, the employer must amend the plan to cover such adult children by December 31, 2010, *and* the amendment must be retroactively effective as of the first date that employees were permitted to make pre-tax salary reduction contributions on behalf of such children.

Second, the Notice states that the IRS intends to amend the Section 125 cafeteria plan regulations (effective as of March 30, 2010) to permit employees to make mid-year election changes on account of "change-in-status" events affecting nondependent children under age 27. Under the amended rules, an employee will be permitted to change premium conversion elections (or health FSA elections) if either (i) an adult child becomes newly eligible for coverage, or (ii) an adult child becomes eligible for coverage beyond the date on which the child otherwise would have lost coverage.

Questions for Plan Sponsors

Although group health plans that provide dependent coverage have until the first plan year that begins after September 23, 2010, in which to extend coverage through a child's 26th birthday, plan sponsors should

immediately consider the following questions:

- Should we extend group health coverage to adult children now, or should we wait until we are required to do so (in the first plan year after September 23, 2010)?
- If we voluntarily extend this coverage now, should this apply to all children under age 26, or only those who are still in school?
- If we extend this coverage now, will our stop-loss insurance carrier cover any catastrophic claims incurred by an adult child? And will our stop-loss insurance premiums increase as a result of this change?
- Should we amend our Section 125 plan to allow for health plan premiums on behalf of adult children to be paid on a pre-tax basis?
- Should we amend our Section 125 plan to allow for FSA reimbursements on behalf of such adult children?
- Should we allow employees to change their FSA contribution elections when an adult child becomes eligible for coverage under our group health plan?

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CAFETERIA PLAN CHANGES

While the focus of the Affordable Care Act is clearly on the nation's health insurance system, the Act does include several rifle-shot changes to the Tax Code's cafeteria plan rules. These include the following (listed in the order they become effective):

- **Restrictions on Reimbursements Under FSAs, HSAs, and HRAs.** Effective in 2011, expenses for non-prescription medications may be reimbursed from health flexible spending accounts ("FSAs"), health savings accounts ("HSAs"), and health reimbursement arrangements ("HRAs") *only* if those medications are prescribed by a physician. (Insulin will still be reimbursable without a prescription.)
- **Safe-Harbor Nondiscrimination Rule for "Simple Cafeteria Plans**." The Act creates a nondiscrimination safe harbor for "simple cafeteria plans." To be eligible to sponsor such a plan, an employer must have employed an average of 100 or fewer employees for each of the past two years. (This limit may be exceeded by a "growing employer," up to a limit of 200 employees.) If such an employer makes a minimum matching or non-elective contribution on behalf of each eligible employee, the plan will be treated as satisfying the nondiscrimination rules otherwise applicable to cafeteria plans.

It will also be deemed to satisfy the nondiscrimination rules applicable to certain *benefits* offered under the plan, including the rules that apply to group-term life insurance, self-insured medical coverage, and dependent care assistance. This option will be available as of January 1, 2011.

- **Increased Taxes on Nonqualified HSA Distributions**. Effective for distributions made on or after January 1, 2011, the tax on distributions from HSAs for anything other than qualified medical expenses will increase from 10% to 20%. The tax on such nonqualified distributions from Archer medical savings accounts will increase from 15% to 20%.

- **Limit on FSA Contributions**. Effective in 2013, annual salary-deferral contributions to health FSAs will be limited to $2,500. Starting in 2014, this amount will be adjusted for inflation. (Note that this cap will apparently not apply to true employer FSA contributions, such as “flex credits” or “flex dollars” that are not made available to employees in cash.)

- **Qualified Health Plans Offered Through Exchanges**. Finally, the Act creates statewide clearinghouses (known as “exchanges”) for “qualified health plans.” A qualified health plan offered through an exchange will generally *not* be a permissible pre-tax benefit under a cafeteria plan. There is an exception to this rule, however, for small employers that offer their employees the opportunity to enroll in a qualified health plan *through* an exchange. This rule becomes effective as of January 1, 2014, when the exchanges are scheduled to come online.

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INSURED HEALTH PLANS NOW SUBJECT TO NONDISCRIMINATION RULES

Prior to enactment of the Affordable Care Act, employee health benefits provided through an insurance contract (i.e., fully insured benefits) were not subject to any income-based nondiscrimination requirements under the Tax Code. Thus, an employer could provide more generous health insurance benefits to executives or other highly compensated individuals through the purchase of individual or group insurance policies.

By contrast, self-funded plans, sometimes referred to as "self-insured" or

"administrative-services-only" plans, were (and continue to be) subject to the nondiscrimination requirements of Code Section 105(h). Under that provision, if a self-funded health plan discriminates in favor of "highly compensated individuals" (or "HCIs") – generally, the owner(s) and the highest-paid 25 percent of all employees – all or a portion of the health care expenses paid or reimbursed under the plan on behalf of those HCIs will be taxable as ordinary income.

The Act generally extends these nondiscrimination requirements to *insured* health plans (other than "grandfathered" plans), but with an important twist. Under a new section of the Public Health Service Act ("PHSA"), as well as a new provision of the Tax Code making that PHSA provision applicable to all types of employers), insured plans must now satisfy the nondiscrimination requirements of Code Section 105(h) *as if* that section applied to those plans. However, these insured plans are not actually subject to Section 105(h).

This distinction is significant. If an insured plan violates the Section 105(h) requirements (by favoring HCIs in terms of either eligibility or benefits), the benefits provided under the plan will *not* be taxed to the HCIs. Instead, the plan administrator will be subject to a penalty (under the HIPAA provisions of the Code) equal to $100 per day per affected participant, up to an annual limit of $500,000 per year. With certain exceptions, small employers (those with 50 or fewer employees) are not subject to this penalty tax.

As noted above, this new provision applies to insured health plans *other* than those in existence on March 23, 2010 (i.e., "grandfathered" plans), and solely to plan years beginning on or after September 23, 2010. Consequently, plans that discriminate in favor of HCIs will now fall into one of the following three categories:

- Self-funded plans (regardless of their status as "grandfathered" plans) will continue to be subject to Code Section 105(h), under which discriminatory benefits are taxable to HCIs;

- Insured plans that are "grandfathered" may continue to discriminate in favor of HCIs without consequence; and

- Insured plans that are *not* "grandfathered" (and that are sponsored by employers with more than 50 employees) will be subject to a significant excise tax if they discriminate in favor of HCIs in any plan year beginning after September 23, 2010.

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NEW REPORTING AND DISCLOSURE REQUIREMENTS

In addition to transforming the rules governing the *benefits* that health plans must offer, the Affordable Care Act substantially alters the way that plan sponsors and health insurers must *describe* and *report* those benefits. From new claim appeal procedures to standardized benefit summaries to additional governmental reporting, the Act will almost certainly increase administrative costs and complexities for employers. And like many other aspects of the Act, determining precisely how – and even *when* – to comply with some of the new reporting and disclosure obligations will be difficult. Although regulations will likely answer some of these questions, plan sponsors should start revising many of their procedures immediately.

The following discussion summarizes seven of the Act's most significant reporting and disclosure changes. Unless otherwise noted, these changes will apply to *all* plans, whether grandfathered or not. The new requirements are summarized in the order in which they become effective.

Automatic Enrollment Notice

The Act amends the Fair Labor Standards Act to require that large employers maintaining one or more health plans automatically enroll any new, full-time employees in one of those plans. These employers must also automatically *continue* the enrollment of *current* employees. State wage withholding or other laws that would otherwise prevent automatic enrollment are preempted. These requirements apply to employers with more than 200 full-time employees, regardless of a plan's insured, self-funded, or grandfathered status.

Plan sponsors will obviously need to provide an explanation of the automatic enrollment rules to new and current employees, and how they may opt out of such coverage. Unfortunately, the effective date of this automatic enrollment requirement is unclear. The Act can be read to make it applicable only after the DOL has issued implementing regulations.

Claim Appeal Procedures

New plans – but *not* grandfathered plans – must also adopt enhanced procedures for handling appeals of denied claims. Claimants must be allowed to present evidence and testimony as part of the appeal process, coverage must be continued during the appeal, and plans must provide for an external review of the claim denial. To satisfy the external review requirement, insured plans must comply with state insurance regulations governing such reviews, and self-funded plans will be required to comply with standards to be established by HHS.

These enhanced appeal procedures must be described in plan documents and summary plan descriptions ("SPDs"). They are effective for plan years beginning on or after September 23, 2010 (*i.e.*, January 1, 2011, for calendar-year plans).

Transparency Disclosures

Also for plan years beginning on or after September 23, 2010, employers must comply with various "transparency" requirements. For instance, they must submit certain information about their health plans to HHS. These disclosures must include information concerning claim-payment policies, plan enrollment, denied claims, cost sharing and rating policies, out-of-network coverage, and participants' rights. This information must also be made available to the public.

Form W-2 Reporting

Employers must soon begin reporting the cost of health coverage on their employees' Forms W-2. Beginning in 2011, employers must include the aggregate cost of such coverage, determined in a manner similar to the way that COBRA premiums are calculated. Although regulations are to be issued in this area (which should be useful in the COBRA context, as well), the cost of coverage will include both employer and employee contributions, but will exclude pre-tax employee deferrals to health savings accounts, Archer medical savings accounts, and health flexible spending accounts. This information must first be provided on Forms W-2 for the 2011 tax year, which are to be issued by January 31, 2012.

Uniform Summary of Benefits and Coverage

Beginning generally in 2012, plan administrators and insurers must provide those who apply for coverage, and those who are enrolled, an additional disclosure document summarizing the plan's benefits and explaining its coverage. This "mini-SPD" must satisfy uniform standards for format and content. It is in addition to, and not in place of, the SPD required by ERISA.

The new summary must be provided (in either paper or electronic format) prior to the individual's initial enrollment, and then annually thereafter during open enrollment. This summary may be no longer than four pages, must use a minimum of 12-point font, and must be understandable by the average plan participant (written in a "culturally and linguistically appropriate manner"). Using uniform definitions to be established by regulations, the summary must contain information about cost sharing, continuation of coverage, and limitations on coverage.

The Secretary of HHS is to issue a model summary by March 23, 2011, with plan administrator compliance required by March 23, 2012. Penalties of up to $1,000 per enrollee may apply for each willful failure to provide this summary.

Notice of Plan Modifications

Under ERISA's current "summary of material reduction" standards, health plan administrators must notify participants of plan changes that "materially reduce" benefits within 60 days *after* the reductions become effective. Notice of changes that

enhance benefits (or that do not *materially* reduce them) need not be provided until 210 days after the close of the plan year in which the change was adopted. These rules have been changed by the Act.

All group health plans – whether insured, self-funded, grandfathered, or not even subject to ERISA – will now have to provide notice of any "material modifications" at least 60 days *before* they become effective. These modifications might include premium or cost-sharing increases or coverage changes. Failure to provide this notice may result in penalties of up to $1,000 per enrollee.

Although the effective date of this requirement is unclear, advance notice of material changes should be provided *at least* with respect to changes occurring on or after March 23, 2012. A safer approach would be to comply with this requirement immediately.

Notice Concerning Exchanges

Beginning March 1, 2013, employers must provide new and current employees with information about the statewide exchanges created by the Act. These notices must describe the exchanges, the federal premium assistance that may be available to purchase exchange-based coverage (if the employer's plan is not "affordable"), and information about "free-choice vouchers" and premium credits. Note that the deadline for providing this notice may be up to ten months before the exchanges are even to become effective.

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