To-Do List, Part 1

ACA requirements to consider for 2012 and 2013

In June, the U.S. Supreme Court found the Affordable Care Act (ACA) to be constitutional. This means that all of the ACA provisions already in place—such as the age-26 rule, preventive care requirements and restrictions on annual and lifetime limits—will continue. And, what is more, all the new and upcoming requirements will go into effect as planned. If they have not already, plan sponsors should review upcoming requirements and make sure to be prepared to comply. To that end, we provide a checklist of ACA requirements that apply to group health plans and plan sponsors for 2012 through 2013.

Except where noted, these requirements generally apply to all group health plan coverage—insured and self-funded—including grandfathered plans. However, each requirement may have its own set of exceptions for more limited benefits, such as those excepted under the Health Insurance Portability and Accountability Act (HIPAA) or retiree-only coverage. Plan sponsors should review this checklist and make sure they have a strategy for completing their own "to-do" lists.

2012 Checklist

■ **Increase in restricted annual limit allowed.** The ACA disallowed lifetime dollar limits on essential health benefits for plan years on or after September 23, 2010, but allowed a phase-in of the restrictions on annual dollar limits over a three-year period. For the 2011 plan year, plans were allowed to impose an annual limit of $750,000 on essential health benefits. For 2012, the limit is $1.25 million.

■ **W-2 reporting for value of health care.** Beginning with this current tax year, employers must report the aggregate cost of "applicable employer-sponsored coverage" in a new box on the W-2 (to be sent to employees in January 2013). The reporting is for informational purposes only. "Applicable employer-sponsored coverage" generally refers to coverage under any group health plan made available by an employer that is excludable from the employee's gross income under Code Section 106.

■ **Summary of benefits and coverage (SBC).** Plans must provide an SBC for any group health plan benefit option, including grandfathered plans, for enrollments and plan years beginning on or after September 23 of this year. Plans must follow a prescribed template from the U.S. Department of Health and Human Services (HHS) and must deliver the SBC to all enrollees. Plans also must notify all eligible individuals—even those not enrolled—about the availability of the SBCs, and provide SBCs upon request within seven business days.

■ **Medical loss ratio (MLR) rebates.** Insurers are required to determine an MLR based on the amount of premiums used to pay claims and related expenses. Some insurers will be required to pay a rebate if they fall short of a minimum MLR threshold. Plans should have started receiving these rebates in August. There are specific rules regarding how this rebate money may be spent, such as those found in the Employee Retirement Income Security Act (ERISA) and ACA, as well as restrictions. The MLR rules apply only to insured plans, including grandfathered plans.

■ **Women's preventive health.** The ACA already requires group health plans to cover certain preventive health services at 100% without cost-sharing. The required services are based on recommendations from several task forces listed in the ACA. This requirement went into effect for plan years starting on or after September 23, 2010. HHS adopted additional recommendations for women's preventive health, which must be covered for plan years starting on or after August 1, 2012. These include coverage for contraceptives, breastfeeding supplies and health screenings for women. This requirement does not apply to grandfathered plans.

2013 Checklist

■ **Increase in restricted annual limit allowed.** Under the phase-in of the restrictions on annual dollar limits on essential health benefits (discussed above), the restricted annual dollar limit for 2013 is increased to $2 million.

■ **Limit on health flexible spending account (FSA) contributions.** Starting January 1, 2013, the maximum amount an employee may contribute to an FSA is $2,500 (indexed for inflation).

■ **Exchange notices.** Employers must provide all employees with a notice about coverage available under the exchange by March 23, 2013. The notice must explain the availability of exchange coverage and how to access such coverage, as well as informing them that a premium credit may be available. This requirement applies to the employer, and the notice must go to all employees, not just health plan participants.

■ **Patient-centered outcomes research (PCOR) fee.** A fee to fund PCOR will be assessed on health insurers and sponsors of self-insured health plans. The fee generally is $1 per covered life, with respect to the 2012 plan year, and $2 per covered life thereafter. The fee must be paid on Internal Revenue Service (IRS) Form 720, which is due July 31 of the following year (meaning the 2012 fee will be payable by July 31, 2013).

■ **Elimination of the Medicare Part D retiree drug subsidy deduction.** Currently, employers that provide certain prescription drug coverage to Medicare-eligible retirees may apply for a retiree drug subsidy (RDS) under Medicare Part D. In the past, this RDS payment was not taxable to the employer, and the employer was still allowed to deduct the amounts paid for prescription drug claims. Starting January 1, 2013, the amount paid for claims will not be deductible to the extent that RDS money is received—removing some of the tax advantage of the RDS program.

■ **Medicare tax.** Starting January 1, 2013, there is an additional 0.9% increase in the employee Medicare tax for employees who earn more than $200,000 ($250,000 on a joint return) annually. This will affect withholding and W-2 reporting for employers. Plan sponsors may need to verify that their payroll departments or service providers are aware of this new requirement.

Although the next big push in health care reform is in 2014, when the exchanges are up and running, plan sponsors clearly have plenty on their checklists for the remainder of 2012 and 2013. Stay tuned for our next column, when we will continue this checklist, giving ACA requirements that plan sponsors must consider for 2014 and beyond.

This to-do checklist first appeared on www.plansponsor.com in September. Because health care law is evolving rapidly, there may have been further developments since the initial publication.

CONTRIBUTORS

Christy Tinnes is a principal in the Health and Welfare group of Groom Law Group in Washington, D.C. She is involved in all aspects of health and welfare plans, including ERISA, HIPAA portability, HIPAA privacy, COBRA and Medicare. She represents employers designing health plans, as well as insurers designing new products. Most recently, she has been extensively involved in the insurance market reform and employer mandate provisions of the health care reform legislation.

Brigen Winters is a principal at Groom Law Group, Chartered, where he co-chairs the firm's Policy and Legislation group. He counsels plan sponsors, insurers and other financial institutions regarding health and welfare, executive compensation and tax-qualified arrangements, and advises clients on legislative and regulatory matters, with a particular focus on the recently enacted health care reform legislation.

PLEASE NOTE: This feature is intended to provide general information only, does not constitute legal counsel and cannot be used or substituted for legal or tax advice.

Got a health care reform question? You can ask *your* health care reform legislation question online at www.surveymonkey.com/s/second_opinions.

You can find a handy list of **Key Provisions of the Patient Protection and Affordable Care Act** and their effective dates at www.groom.com/HCR-Chart.html.

