ISLER DARE RAY RADCLIFFE & CONNOLLY, P.C.

EMPLOYEE BENEFITS UPDATE

October 24, 2012

Health Plan Checklist for Open Enrollment Season and Beyond

For HR professionals, October and November usually mean open enrollment season for health and welfare benefit plans for the upcoming year. The following compliance checklist is provided to assist you with those efforts.

√ **New Summary of Benefits and Coverage Must Be Provided**

Federal health reform added a new four-page disclosure requirement, known as the "Summary of Benefits and Coverage" or "SBC". As described in earlier issues of our Employee Benefits Updates, the goal behind the SBC is to provide consistent information for each health plan in a prescribed format, in order to enhance consumer knowledge and facilitate comparisons of different health coverage options so that employees can make well-informed decisions about their health coverage.

- SBCs must be provided as part of all open enrollment periods beginning on or after September 23, 2012.

- For individuals who enroll in coverage other than through an annual open enrollment period—such as new hires or those with special enrollment rights—the requirement to provide an SBC starts on the first day of the plan year beginning on or after September 23, 2012 (which translates into January 1, 2013 for calendar year plans).

- An SBC must be provided for each medical option that is offered—including plans that are considered "grandfathered" from other requirements of Federal health reform—although there are some limited exceptions for stand-alone retiree-only plans, employee assistance plans, wellness programs, and disease management plans.

√ **Required Annual Notices**

Various Federal laws require annual notices to employees or plan participants for which the government has, in many cases, provided model language. Because Summary Plan Descriptions or plan booklets are not always updated annually, it is advisable to provide the following notices as part of your open enrollment package.

- *Medicare Part D Notice*

  This notice, which should have been provided by October 15th to all employees and dependents participating in your group health, provides information about whether the prescription drug coverage offered under your plan is considered "creditable coverage" or "non-creditable coverage" under Medicare's prescription drug plan known as Medicare Part D.

- *Women's Health and Cancer Rights Act*

  This notice summarizes your plan's coverage for mastectomies and reconstructive breast surgeries.

- *Children's Health Insurance Program*

  This notice should be provided to all employees, advising them of the special enrollment rights that may be available to them if they are low-income individuals who qualify for a state premium assistance subsidy under Medicaid or CHIP.

- *HIPAA Privacy*

  Open enrollment materials should either reproduce the plan's HIPAA privacy notice in its entirety or provide a statement that a copy of the HIPAA privacy notice is available at any time, upon request.

- *Grandfathered Status under Health Reform*

  Plans in effect prior to the enactment of the Federal health reform law on March 23, 2010, which are "grandfathered" from complying with many of that law's changes because they have continued to satisfy certain restrictions on benefit changes and cost-sharing features, must continue to disclose their grandfathered status in open enrollment booklets and other plan materials.

√ **Design Changes in Plan Terms and Benefits**

- *$2,500 Limit on Employee Contributions to Health FSAs*

  Effective for plan years beginning on or after January 1, 2013, the maximum amount that an employee will be able to contribute to a health flexible spending account (through salary reduction contributions) will be $2,500. The $2,500 limit does not apply to employer credits or contributions. Although this change must be incorporated into your 2013 election forms and be implemented operationally by your FSA

recordkeeper as of January 1, 2013, your plan documents do not need to be amended to reflect this change until December 31, 2014.

- *Increase in annual limits on essential health benefits*

  For 2013, annual dollar limits on essential health benefits that are provided under a non-grandfathered plan must be increased from $1.25 million to $2.0 million. For these purposes, "essential health benefits" consist of minimum benefits in ten broad categories such as ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services.

- *Expanded preventive care services for women without cost-sharing*

  Effective for all plan years beginning after August 1, 2012, non-grandfathered health plans must provide expanded preventive care services for women, covering 100% of the costs of these services. Included in these changes are well-woman visits; screenings for gestational diabetes; testing for HPV; counseling for sexually-transmitted infections; counseling and screening for HIV; counseling and coverage for FDA-approved contraceptive methods; breastfeeding support, supplies and counseling; and screening and counseling for interpersonal and domestic violence. Certain religious employers may qualify for an exemption from providing such contraceptive coverage, and other religious-based organizations who object may also qualify for a one-year non-enforcement period.

√ **Additional Reporting, Fees and Notice Requirements Coming in 2013**

And, because there is no rest for the weary when it comes to implementing the requirements of Federal health reform, we wanted to highlight for you a few requirements that will take effect in early 2013.

- *W-2 Reporting on Value of Coverage*

  The W-2 forms for calendar year 2012, which are required to be issued by January 31, 2013, must include (for the first time) the value of health benefits provided by your employer's group health plan to your employees.

- *New Fee to Fund Patient-Centered Outcomes Research*

  In order to fund the new Patient-Centered Outcomes Research Institute that will provide clinical effectiveness research, insurers and sponsors of self-funded plans will be required to pay a new fee. For plan years ending between October 1, 2012 and

September 30, 2013, the fee is $1.00 times the average number of covered lives under the plan; for the 2nd year, the fee will increase to $2.00 per covered life; and thereafter, until 2019, the fee will be increased by an inflation adjustment. Certain plans are exempt from this fee—such as health flexible spending accounts, limited dental and vision plans, employee assistance plans and wellness programs—but retiree-only plans are subject to this fee even though they may be exempt from other Federal health reform requirements. These new fees will be reported on IRS Form 720, and payments for calendar year plans will generally be due by the following July 31st (i.e., calendar year plans ending December 31, 2012 will have their first report and payment due by July 31, 2013).

- *New Notices About Health Exchanges Required by March 1, 2013*

  By March 1, 2013, employers will need to provide all employees with a notice providing information about the health insurance exchanges; about the premium tax-credits and premium subsidies that may be available if the employer does not offer "affordable" health care; and about the potential loss of employer contributions to their coverage if they purchase coverage through an exchange, so that they understand the trade-off involved in giving up employer-provided coverage. The government has indicated that it plans to issue model notices which can be used in order to meet this notification requirement.

If you have any questions about your open enrollment materials, or if we can assist you in any way regarding your health benefit plans, please let us know.

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