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Health Reform Considerations for Employers Preparing for Open Enrollment

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Now that the Supreme Court has upheld the Patient Protection and Affordable Care Act (the "Affordable Care Act"), employers who have been waiting to implement certain health care reform requirements should be aware of approaching effective dates that will impact upcoming open enrollments for their group health plans. Many group health plans will have to make changes in their benefit plan coverage and communications for plan years beginning as early as August 1, 2012.

Additionally, employers whose group health plans are fully insured may be receiving rebate checks from their insurers this week if the benefit payments made by the insurers last year did not meet the required percentage payout of 80 percent or 85 percent of premiums, depending on the size of the insured group. Employers who receive rebate checks must use the payments for the benefit of the participants in the group health plan, such as applying the monies towards lowering premiums, increasing benefits or even declaring a "premium holiday." Participant benefit elections for the upcoming plan year may be impacted based on the decisions employers make regarding how to apply these rebates. Regulations and guidance from the Departments of the Treasury, Labor, and Health and Human Services (the "Departments") provide more details for employers receiving the rebates.

Summary of Benefits and Coverage

All group health plans (whether insured or self-insured or grandfathered or non-grandfathered) must provide a Summary of Benefits and Coverage ("SBC") and Uniform Glossary to participants and beneficiaries who enroll or re-enroll in group health coverage beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For new hires and special enrollees, the disclosure requirements apply beginning on the first day of the first plan year that begins on or after September 23, 2012.

The SBC does not replace a group health plan's summary plan description, but rather, provides participants with a brief summary of key terms of the health plan in question and answer and table format to quickly explain provisions such as the plan's deductible or limits on benefits. It also must provide examples of common benefit scenarios such as a visit to a primary care physician, hospital stays, or diagnostic testing and explain the cost-sharing (co-payments or co-insurance) under the plan that are applicable to the services and any limitations or exceptions.

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The Departments have published final regulations setting forth the requirements for providing a SBC and a Uniform Glossary to group health plan participants and beneficiaries. An initial SBC template and instructions can be found on www.dol.gov/ebsa/healthreform. Employers with calendar year plans should begin preparing the SBC and Uniform Glossary and decide how they will be distributed. Inclusion in the summary plan description is permissible, provided that the SBC and Uniform Glossary are prominently displayed at the beginning and the summary plan description is delivered in accordance with the timing requirements for providing a SBC.

Employers must use the template and adapt it only as needed to correctly reflect the actual coverage and benefits under the plan. There is only limited guidance regarding how to reflect EAP and wellness programs.

Changes to Benefits and Limits

New Women's Health Preventive Services

Interim final regulations issued by the Departments require that certain preventive services be covered with no deductibles or co-payments for non-grandfathered group health plans. New preventive services for women that include benefits with no cost-sharing for all contraceptives approved by the Food and Drug Administration are effective for plan years beginning on and after August 1, 2012. There are limited exceptions for religious-based employers, as well as a one-year enforcement safe harbor for other qualifying employers with religious objections.

Annual Limit on Benefits

For plan years beginning on or after September 23, 2012, but before January 1, 2014, unless a waiver applies, a group health plan, including a grandfathered plan, is restricted to an annual limit on "essential health benefits" that is no less than $2 million. Beginning in 2014, group health plans may not impose annual limits on essential health benefits.

FSA Limits

Effective with plan years beginning on or after January 1, 2013, employees may not contribute more than $2,500 annually to a health flexible spending account. New guidance from the IRS further addresses the implementation of the new limit.

As the provisions of the Affordable Care Act continue to roll out, employer-sponsored group health plans will be impacted in both subtle and more noticeable ways, particularly in the communication of benefit coverages and the types of coverage options that will be increasingly available.

For more information on the matters discussed in this *Locke Lord QuickStudy*, please contact the authors:

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