HEALTH CARE REFORM –
What You Must Do This Year

In light of the Supreme Court’s June 28, 2012 decision to uphold the Affordable Care Act (the “Act”), employers and plan sponsors must continue to implement the Act’s various mandates for health coverage. Here are six actions that covered employers and plan sponsors must take this year:

1. Determine whether you are a covered employer or plan sponsor and what employer-sponsored health benefits that you offer that may be subject to some or all of the requirements under the Act.

2. Provide a four-page (double-sided) Summary of Benefits and Coverage (SBC) to plan participants for initial and open enrollment for plan years commencing on or after September 23, 2012.


4. Ensure that your Form W-2 reporting system has changed to include the value of 2012 health coverage.

5. Ensure that your tax withholding system has changed to collect additional Medicare tax for high wage earners starting January 1, 2013.

6. Ensure that employee Health Flexible Spending Account (FSA) salary reduction contributions are limited to $2,500 for plan years beginning on or after January 1, 2013.

1. **Who is a covered employer and what benefits are covered?**

As a general matter, employers that provide “applicable employer-sponsored coverage” under a group health plan will be subject to new requirements under the Act. This includes federal, state and local government entities, churches and other religious organizations, as well as employers that
are not subject to the COBRA continuation coverage requirements. However, certain exemptions may be applicable to any new requirement under the Act so you should always consider whether any such exemptions will apply to you.

The requirements under the Act generally apply to all fully insured and self-insured group health plans including certain FSAs and stand-alone health reimbursement arrangements (HRAs). The Act generally does not apply to health savings accounts (HSAs) or HIPAA-excepted benefits, which include "retiree-only" plans, certain stand-alone dental or vision plans, and most FSAs. Whether a particular arrangement constitutes a group health plan for purposes of the Act or is otherwise exempt from the Act requires a review of the relevant facts and circumstances. Grandfathered plans are exempt from some of the Acts requirements. The requirements discussed in this communication, however, apply to group health plans regardless of grandfathered-plan status.

2. **Provide a Summary of Benefits and Coverage**

The SBC is a new health plan disclosure. You are required to provide SBCs to participants (including eligible employees and enrolled beneficiaries) beginning with the first open enrollment or plan year on or after September 23, 2012 (i.e., January 1, 2013 for calendar year plans). For plan participants who enroll or re-enroll through an open enrollment period, the SBC must be provided beginning on the first day of the open enrollment period. For plan participants who initially enroll in coverage other than through an open enrollment period (e.g., newly eligible participants or those eligible for special enrollment), the requirement to provide an SBC starts on the first day of the plan year beginning on or after September 23, 2012 (i.e., January 1, 2013 for calendar year plans).

**Insured Plans** – The insurer is responsible for developing the SBC and delivering it to you. However, the insurer is not responsible for distributing the SBC to participants. You should contact your insurer immediately and agree on a timetable for them to provide you with the SBC. Arrange for distribution to

**Self-Funded Plans** – You are responsible for both the preparation and distribution of the SBC to plan participants. Guidance for preparing the SBC, as well as model templates and instructions, can be found on the U.S. Department of Labor’s website.1 If you have outsourced your health plan administration to a third party administrator (TPA), they should be prepared to provide the SBC for you. Contact them as soon as possible to coordinate timely preparation and distribution of the SBC.

3. **Collect The Value of 2012 Health Care Coverage for Every Employee**

You must add to the 2012 Forms W-2 for employees the total cost of health care coverage,2 if any, received by the employee and his/her dependents covered under applicable plans. Even if the employee paid for part or all of the cost of coverage (on either a pre-tax or after-tax basis), the total cost of the coverage still must be reported on the Form W-2. This rule presents a recordkeeping challenge. Our experience is that it can be more difficult than it might seem at first because it requires an individual-by-individual record of coverage for every plan during the year. For example, if an employee changes coverage or carrier mid-year, the value of coverage may change and these changes in cost must be taken into account when reporting the total cost of coverage.

Generally, all plans must comply with this requirement. However, there is some transition relief for certain employers provided by IRS Notice 2011-28, e.g., small employers that issue fewer than 250 Forms W-2. Additionally, certain costs are excluded from this reporting requirement, including contributions to HSAs and salary reduction contributions to FSAs, costs of

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1 See http://www.dol.gov/ebsa/healthreform/

2 You will need to select one of three different methodologies for valuing the cost of health coverage – the COBRA premium method, the premium charged method or the modified COBRA premium method. More information on the methods for calculating the cost of group health plan coverage can be found in IRS Notice 2012-9, Q&A’s 24-27.
coverage under stand-alone dental or vision plans, long-term care coverage, stand-alone coverage for specified disease or fixed indemnity plans, accident and disability benefit-only insurance, self-insured coverage that is not subject to COBRA, and employer contributions to multiemployer plans.

4. **Ensure that your Form W-2 Reporting System is Changed for 2012 Reports**

System changes take time. If your Form W-2 production is outsourced, check to be sure that the vendor is implementing the required changes and agree on a timetable for the vendor to demonstrate that the changes have been made. If your Form W-2 production is not outsourced, be sure that the appropriate steps are taken internally for timely action and testing. You may want to alert your IT department that if the changes are not timely implemented, your organization faces IRS penalties.

5. **Ensure that your Tax Withholding System is Changed for 2013**

Starting January 1, 2013, the Medicare tax increases by 0.9% to 2.35% of annual wage or self-employed income over $200,000 (filing single) or $250,000 (filing joint). You are required to withhold the additional 0.9% Medicare tax on an employee’s wages that exceed $200,000 even though an employee may not actually be liable for the additional tax (e.g., when the employee’s wages combined with his/her spouse’s wages do not exceed the threshold when filing a joint return). Any over-withholding or under-withholding of Medicare tax based on the employee’s personal circumstances will be settled on the employee’s individual income tax return.

Again, if your payroll system is outsourced, check to be sure that the vendor is implementing these changes and agree on a timetable to demonstrate that the changes are done. If not outsourced, work with your IT department to get the changes in place.

6. **Ensure that employee contributions to health FSA’s are limited to $2,500 for plan years commencing on or after January 1, 2013**

A health flexible spending arrangement ("FSA") is a type of benefit offered under a cafeteria (or "125") plan. Under the Act, employee salary reduction contributions to health FSAs are limited to $2,500 for plan years commencing on or after January 1, 2013. You should be sure that your communication and enrollment materials for plan years commencing on or after January 1, 2013 (distributed in 2012 for calendar year plans) reflect this limit.

Also, the IRS requires that you follow the terms of your benefit plans and that benefit plan documents accurately reflect plan rules. Therefore, it is important to modify the terms of your FSA plan document to apply the 2013 $2,500 limit. The IRS has provided transitional relief in IRS Notice 2012-40, however, that allows plans to adopt the required amendments to reflect this limit at any time through the end of calendar year 2014.
Hanson Bridgett’s Employee Benefits Practice

Employee benefits and compensation issues can be complicated and costly for retirement systems, employers and employees. Our Employee Benefits Group is a recognized leader in public employee benefits matters. We represent many public retirement system boards as well as public plan sponsors in matters ranging from negotiating investment contracts to advising on benefits, tax and fiduciary duty questions. We have created innovative programs to solve public agency benefits issues, including obtaining IRS approval for several innovative ways to fund retiree health benefits. The Employee Benefits Group relies on its depth and diversity of experience to work closely with our clients to develop creative and practical solutions.

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