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The Benefits Brief…

PPACA Mysteries Solved: SBC And CER Fee Requirements Revealed

The "Who Done It" of The Patient Protection and Affordable Care Act of 2010 is more of a "Who Does What and How," as benefit professionals race to make sense of the disclosure requirements for group health plans.

One of these disclosure requirements is the summary of benefits and coverage (SBC) for medical plans, including health reimbursement arrangements (HRAs) and health care flexible spending accounts (health FSAs). Another directive requires certain health insurance carriers and sponsors to pay a fee, based on covered lives, for comparative effectiveness research (CER).

SBCs do not affect a health FSA if that health FSA is an excepted benefit or if an HRA can be classified as an FSA and thus, an excepted benefit. So first, we are going to walk through a short discussion of SBCs and CER fees and then delve into what is an excepted benefit and see how this rule applies to SBCs.

SBCs for HRAs

SBCs are required for all participants and beneficiaries enrolling or re-enrolling in group health plans, including HRAs and health FSAs on or after September 23, 2012. For participants joining the plan after open enrollment, the requirement to provide an SBC is effective the first day of the plan year following September 23, 2012. An SBC may be provided in paper format (or electronically under certain circumstances).

The Department of Health and Human Services (HHS) has created an SBC template that must be completed and distributed using specific terms and conditions for HRAs. While HRAs qualify as health plans, this SBC template does not fit the unique circumstances of most HRAs, so information may be confusing to participants. Thus, when distributing SBCs to participants, a cover letter of explanation may be helpful.

Another important note is that employees may receive multiple SBCs for various plans and coverage. For example, they might receive one or more SBC for health insurance coverage and an additional SBC for their HRA (if the HRA is not integrated with their health insurance policy or considered standalone).

In the future, quite a bit of guidance regarding HRAs is expected. For example, HRAs providing medical coverage that are not integrated with an underlying medical plan must meet several PPACA requirements beginning in 2014. Also beginning in 2014, integrated HRAs must provide one consolidated SBC that covers both medical and HRA coverage.

Comparative Effectiveness Research (CER)

PPACA Section 6301 created a new nonprofit corporation to assist in clinical effectiveness research. To aid in the financial support for this endeavor, certain health insurance carriers and health plan sponsors will pay fees based on the average number of lives covered by these welfare benefit plans. These fees go into effect for plan years ending on or after October 1, 2012.

The fee for the initial plan year is $1 per average covered life, and $2 per average covered life for the following year. Indexed each year thereafter, the fee will be determined by the value of national health expenditures. However, this fee does phase out and will not apply to plan years ending before October 1, 2019.

Which plans are required to pay fees? CER fees are required for all group health plans including HRAs and health FSAs, unless a plan consists solely of excepted benefits such as those that cover only vision or dental expenses. HRAs exempt from other regula-

tions would be subject to the CER fee. For instance, an HRA that covered only retirees would be subject to this fee.

How are fees calculated? Fees may be calculated for nonexempt HRAs and health FSAs by counting each participant without regard to spouses and dependents also covered by the plans, if the plan sponsor has no other relevant self-insured plans. Also, if employers have more than one qualifying self-insured plan, these plans may be considered one, as long as they all have the same plan year.

Relying on the "one plan" method does have its drawbacks, however. Let's say an employer sponsors a self-insured health plan and a nonexempt health FSA. For CER fee purposes, the count would start with the health plan and include all covered lives including employees, spouses and dependents. Anyone not enrolled in the employer's health plan, but participating in HRAs or health FSAs, would be counted as one additional covered life.

Who pays the fees? For self-insured plans the plan sponsor would be liable for the fees. Generally, the plan sponsor will be the employer. For fully-insured plans, the insurance carrier will need to pay the fees.

Fees are reported and paid once a year by submitting Form 720 by July 31 of the year following the end of the plan year.

So now that you know about SBCs and CER fees, let's take a look at excepted health FSA plans where the SBC rules do not apply.

What is an "excepted" health FSA? "Excepted" benefit language goes way back in the annals of FSAs. Generally, for plan years beginning after June 30, 1997, health and welfare plans were subject to Health Insurance Portability and Accountability Act (HIPAA) certification requirements. This required plan sponsors to issue certificates of credible coverage to participants who lost coverage in health plans.

Certificates verify that a participant had creditable coverage from a previous plan or employer that would offset any pre-existing condition limitation periods in new health plans. Losing coverage could include termination of employment or dropping health insurance coverage.

A health FSA within a cafeteria plan is considered a welfare benefit plan and therefore must comply with the HIPAA certification requirement, unless the health FSA has a specific exception that exempts it from issuing the certification. So how is that accomplished?

On December 29, 1997, the IRS, Department of Labor (DOL) and the Health Care Financing Administration published "Clarification of Regulations." This publication specified circumstances under which a health FSA would be excepted.

So what are the requirements that will exempt a health FSA from HIPAA certification and in turn exempt health FSAs from providing SBCs at enrollment time?

Two-Part Test

In order for a health FSA to be an excepted benefit, it must pass two tests:

1. The employer must provide another health insurance plan that does not offer just excepted benefits. In other words, it must provide health benefits that are not limited to just vision or dental expenses.

2. The maximum reimbursement under the health FSA cannot be greater than two times the employee's salary reduction. Or, if the maximum reimbursement is greater than two times an employee's salary reduction, it cannot be greater than an employee's salary reduction election plus $500.

Let's look at an example of this exception. But first, the short answer is—the health FSA is an excepted benefit if the employer provides another health insurance plan and the cafeteria plan does not include employer flex credits.

Let's work through an example if there are employer flex credits in a cafeteria plan. In this cafeteria plan the employer supplies everyone in the plan with $400 that could be used toward any benefit in the plan. The maximum limit for the health FSA is $1,200 and the employer provides another health insurance plan to all employees. Is this health FSA exempt from providing an SBC at enrollment time? Two times the employee annual salary reduction election is $1,600. This means that the health FSA is exempt from HIPAA certification requirements and, therefore, exempt from providing an SBC.

Another example for consideration would be a health FSA that provides a maximum limit of $800 with employer flex credits in the amount of $450. This employer also provides another health insurance plan to all employees. The health FSA is also exempt from providing an SBC. Two times the employee annual salary reduction election would be $700, which makes the maximum limit of $800 greater than two times the employee's salary reduction. However, when we add $500 to the maximum amount of employee salary reductions, which would be $350, we end up with an amount ($850) that is greater than the annual salary limit of $800. This health FSA would also be exempt from proving an SBC.

Now that we are talking about employer flex credits, what exactly are employer flex credits within a cafeteria plan? Well, you are probably familiar with cafeteria plans in general that allow employees to make an annual election to pay certain expenses with pre-tax dollars, which in turn reduces their taxable salary.

Employer flex-credits are non-elective employer contributions made available for every employee eligible to participate in a cafeteria plan and to be used at the employee's election for one or more qualified benefits. However, cash or other taxable benefits may also be an option for those employer flex-credits, at the employer's discretion. The amount of employer flex-credits available in cash need not be equal to the amount of the non-elective employer flex-credits that could be used for qualified benefits within the cafeteria plan.

In other words, a participant in a cafeteria plan may estimate health FSA expenses to be $2,000 for the plan year. If the employer supplies flex-credits in the amount of $500, the employee would have to deduct only $1,500 from her salary to pay all her estimated expenses with pre-tax money. And, of course, there are other considerations surrounding employer flex-credits such as nondiscrimination rules, but you get the idea.

Keep in mind that HHS required a "good faith effort" this first year in providing SBCs. And I'm sure we'll receive additional information in 2013 concerning the questions we have about SBCs and CER fees.

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