



## Health Care Reform

In our efforts to keep you updated on the status of the Health Care initiatives taking place in our government, we are taking a look forward to 2012 to summarize upcoming legislation and developments expected for the new year. The following review has been prepared using information provided by US Department of Labor, Practical Law Publishing Limited, Practical Law Company, Inc. and Group Insurance Services.

## HEALTH CARE REFORM: 2012

Key provisions requiring attention in 2012 relate to the following:

- Benefit summaries
- 60-day notice of plan changes
- Comparative effectiveness fees
- Quality of care reporting
- W-2 reporting
- Women's preventive care guidelines
- Medical Loss Ratio (MLR) rebates
- Tax changes for age 26 coverage
- Small business tax credit

### Benefit Summaries

The US Department of Health and Human Services (HHS) is required by the Patient Protection and Affordable Care Act to develop standards for a Summary of Benefits and Coverages (SBC) document to be provided to all employees. The SBC must provide easy to understand and consistent information about health plan benefits and coverage. There are specific guidelines that must be followed in preparing these summaries.

The proposed deadline for providing the SBC was March 23, 2012. On November 17, 2011, this deadline was extended; employers and carriers now have until after final regulations are issued to begin providing the SBC. It is unknown as to when the final regulations will be issued, but sufficient time should be provided to prepare the SBC once issued.

**The SBC requirements will apply to:**

- Insured and self-insured group health plans under ERISA, including grandfathered plans.
- Non-ERISA group health plans
- Individual health insurance coverage

**The SBC must include the following:**

- Uniform definitions
- Description of coverage
- Description of the plan's exceptions, reductions and limitations
- Plan's cost-sharing provisions, including deductibles, coinsurance, and copayments
- Provisions for renewing and continuation of coverage
- Statement advising the SBC is a summary only and the plan document or policy should be consulted to determine governing provisions
- Contact information (phone, web address, etc.) for questions or to obtain a copy of the plan or policy
- Internet address or contact information for obtaining list of network providers
- Internet address or contact information for obtaining prescription drug coverage information, if applicable
- Internet address for requesting a uniform glossary
- Premium information for insured coverages or cost of coverage for self-funded coverage

Coverage examples for common benefits scenarios (pregnancy, breast cancer treatment, diabetes) based on criteria provided by HHS that all plans must include (type of treatment, dates of service, etc.). Examples must include whether the service would be covered and at what level of cost-sharing. Failure to provide an SBC will be subject to fines of up to \$1,000 for each failure, excise tax reporting requirements for group health plans, and possibly separate penalties under the Department of Labor.

**60-Day Notice of Plan Changes**

Once the SBC requirement becomes effective, and irrespective of renewal date, employers and carriers must provide **60 days' notice** of any **material modifications** to the plan that are **not** related to renewals of coverage. Notice can be provided in an updated SBC or a separate summary of material modifications.

Changes that must be disclosed include: any material modifications in plan terms or coverage that are not reflected in the most recent SBC; any change not already included in the most recently provided SBC; and any mid-plan year change that does not occur in connection with a renewal of coverage.

Plans must provide the SBC before the beginning of each plan year. Changes that occur in connection with a new plan year should be described in an updated SBC provided before the beginning of the plan year.

### Comparative Effectiveness Fee

For policy and plan years ending after September 30, 2012, and before October 1, 2013, health insurers and self-insured health plans must pay an annual fee of **\$1 per covered life** (average number of active and retired employees, spouses, and dependents). The fee will go towards research to determine the effectiveness of various forms of medical treatment. The fee will increase to \$2 after September 30, 2013, and indexed thereafter for inflation. The fee is scheduled to end for plan years ending after September 30, 2019.

The IRS is in the process of determining data to be used for calculating the fee as well as creating exceptions for certain types of arrangements (flexible spending accounts, health reimbursement accounts, etc.)

### Quality of Care Reporting

HHS must develop reporting requirements for all non-grandfathered health plans and healthcare provider reimbursement structures that affect quality of care by March 23, 2012. Plans that are subject to these requirements will have to report on efforts to:

- Improve health outcomes through implementation of activities including: quality reporting, effective case management, chronic disease management, and medications and care compliance initiatives
- Prevent hospital readmissions
- Improve patient safety and reduce medical errors
- Implement wellness programs and health promotion activities

The report must be submitted annually by health plans and insurance issuers to HHS and provided to participants at each open enrollment period. The reports will be publicly available online where participants may compare and contrast their plans with other employers' plans, with no restriction as to size of employer group.

### W-2 Reporting

Beginning with the 2012 W-2 Form, issued in January 2013, employers that are required to issue 250 or more W-2 Forms must report the aggregate cost of **employer-sponsored group health coverage** on the W-2 Forms. The amount reported will include both the portion paid by the employer and by the employee. The reporting is for informational purposes only and will not affect the taxability of benefits.

### Women's Preventive Care Guidelines

Effective for plan years starting on or after August 1, 2012, non-grandfathered plans must cover specific preventive health services for women with no cost sharing. These services include well-woman visits, gestational diabetes screening, HPV DNA testing, STD/HIV screening and counseling, breastfeeding support, supplies, and counseling, domestic violence screening, and contraceptives. [See HARDEN 8/3/11 Legislative Update]

### Medical Loss Ratio (MLR) Rebates

MLR rules require insurance carriers to spend a certain percentage of premium dollars on health care. Insurers will make this determination based on an established formula. Amounts in excess of this percentage are to be returned to the employer in the form of a rebate. Employers qualifying for a rebate from their insurance carrier due to medical loss ratio rules may need to distribute rebates to enrollees in August 2012.

### Tax Changes for Age 26 Coverage

If your state previously required you to **impute income** for covering **dependents up to age 26**, there may be changes to the State tax code. All states that impose an income tax should now be in conformity with federal tax law, which permits this coverage to be provided on a tax-free basis.

### Small Business Tax Credit

Small employers that qualify for the tax credit provided by the health care reform law can claim the tax credit by filing **Form 8941** with their annual tax filings.

To qualify for the tax credit, an employer must have fewer than 25 employees and pay average annual wages of less than \$50,000.

### Supreme Court Will Hear PPACA Challenges

The U.S. Supreme Court announced on November 14, 2011, that, during its 2012 term, it will review the health care reform law. The Supreme Court will decide whether or not the law is constitutional, which is significant to the implementation of the health care reform law. A decision is expected from the Supreme Court by June 2012

As always, we'll keep you posted of significant developments as they occur.

***If you have any questions, please contact your HARDEN Employee Benefits Account Manager.***

*Resources: Department of Health and Human Services Federal Register 45 CFR Part 158; Practical Law Publishing Limited and Practical Law Company, Inc., October 2011, Zywave, 2011; 2011 National Association of Insurance Commissioners, Patient Protection and Affordable Care Act Section-by-Section Analysis; Blue Cross Blue Shield Association, Detailed Summary 4/22/10.*