Kelley Drye

Health Care Reform - What You Need to Know for 2012

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This Advisory supplements our Advisory of October 15, 2010 addressing the requirements of the Patient Protection and Affordable Care Act (commonly referred to as "Health Care Reform"). The provisions of Health Care Reform become effective at varying times between 2010 and 2018; this Advisory provides an overview of the provisions that become effective in 2012 and require decisions or actions by employers who sponsor group health plans.

If your plan was previously "grandfathered" and has lost its grandfathered status, additional requirements may apply. To determine whether your plan is still grandfathered and the requirements of Health Care Reform that already apply to non-grandfathered plans, please refer to the related sections in our previous Advisory -- *Is Your Plan a "Grandfathered" One?* and *What Changes Are Required for New and Non-Grandfathered Plans Only?* If your plan will remain grandfathered for the 2012 plan year, you must provide notice of the plan's grandfathered status in any materials describing the plan's benefits. We are available to assist you in analyzing these issues in the context of your plan(s).

W-2 Reporting. Employers with 250 or more employees must report on 2012 W-2s (generally issued in January 2013) the aggregate cost of health benefits provided to each employee.[1] All employers that provide "applicable employer-sponsored coverage" under a "group health plan" are subject to the reporting, including government entities and most churches and other religious organizations. Employers required to file fewer than 250 W-2s for 2011 are not required to start reporting until 2013. The reporting requirement does not apply to certain types of health plans, including health FSAs, HRAs, HSAs, long-term care plans, and "excepted" benefit plans such as stand-alone dental and vision plans. The reporting is for informational purposes only and does not change the taxation of employer-sponsored health coverage.

The portions of the cost paid by the employer and the employee for employer-sponsored coverage must each be reported, regardless of whether the employee paid for that cost through before-tax or after-tax contributions or whether a portion of the cost is taxable to the employee (i.e., plans that cover non-dependent same-sex spouses and/or domestic partners). In general, the costs are to be calculated in the same fashion as full COBRA premiums (excluding the allowable 2% COBRA administration fee), i.e., for insured plans, the reported cost is the premium charged by the insurer for employees' coverage; and for self-insured plans, the employer must calculate the COBRA applicable premium in a manner that satisfies the requirements under COBRA.

New Claims and Appeals Procedures. Non-grandfathered group health plans are subject to enhanced internal claims and appeals requirements and external review procedures. Although these new requirements were originally scheduled to go into effect for plan years beginning on and after September 23, 2010, the Department of Labor (DOL) extended certain deadlines until January 1,

2012. The enhanced procedures require existing summary plan descriptions (SPD) and plan communications to be updated. Although the DOL indicated that it will release model SPD language, none has been issued to date. If you have any questions, we can assist you in updating any existing procedures pending such guidance.

- **Internal Claims and Appeals**. Non-grandfathered group health plans and insurers must implement an effective internal claims and appeals process, taking into account the following requirements:
    - Definition of "adverse benefit determination" must include coverage rescissions.
    - Deadline for urgent claim decisions is 72 hours (the 24-hour deadline in prior guidance was not retained).
    - Expanded requirements for a full and fair review of denied claims.
    - Notices of adverse benefit determinations must include additional content (e.g., information sufficient to identify a claim and diagnosis and treatment codes upon request).
    - Process must avoid conflicts of interest.
    - Continued coverage for certain treatments pending the outcome of an appeal must be provided.
- **External Review Procedures.** External review requirements must be performed under either a state or federal external review process. Insurers subject to state insurance law must comply with the state provisions or, if external review procedures do not exist for a particular state, the insurer must comply with the interim federal procedure. The DOL has provided an interim enforcement safe harbor for non-grandfathered, self-insured group health plans that are not subject to a state external review process. To qualify for the safe harbor, plans must have contracts in place with at least two independent review organizations (IROs) by January 1, 2012 and at least one additional organization by July 1, 2012. Once an IRO has rendered a final decision, a plan must provide benefits to the claimant in accordance with that decision regardless of whether they intend to seek judicial review. Under the current rules, only claims involving medical judgment and rescissions are subject to federal external review.

New Fees on Group Health Plans. An annual fee will be assessed on all fully insured and self-insured health plans, for plan years ending after September 30, 2012, to help fund the Patient-Centered Outcomes Research Institute, a not-for-profit organized to conduct and promote clinical effectiveness research. For the first year, the fee equals $1 multiplied by the average number of covered lives (e.g., employee plus spouse and dependents). The fee increases to $2 times the number of lives for the next year and is indexed thereafter. The fee for fully insured plans will be paid by the health insurance carrier; the fee for self-funded plans must be paid by the plan sponsor.

The fee does not apply to "excepted" benefits (e.g., stand-alone dental and vision plans), but does apply to retiree-only plans. Health FSAs should generally be exempt so long as the employer provides other group health plan coverage and the maximum benefit payable does not exceed two times participants' salary reduction amounts. We are awaiting further guidance from the IRS on how the fee will be determined and paid, how to determine the average number of lives covered under

the plan, whether a safe harbor will be available to allow employers to avoid having to determine the number of dependents covered under a plan, and whether HRAs will be exempt.

Summary of Benefits and Coverage. A summary of benefits and coverage (SBC) must be provided by group health plans, including grandfathered plans, to applicants and enrollees before enrollment or re-enrollment. The SBC is intended to help participants better understand the coverage they have and allow them to easily compare different coverage options. The proposed regulations require that the SBC not exceed four-pages (double-sided) or have print smaller than 12-point font, and that it be presented in a manner that will be understood by the average plan participant. The SBC must include an internet address where individuals can access a uniform glossary of terms commonly used in health coverage such as "co-pay" and "deductible". See a proposed template for the SBC here. Any material modifications to the SBC must be provided no later than 60 days prior to the effective date of the change. A plan sponsor/insurer will be subject to penalties for willful failure to timely provide an SBC. ***On November 17, 2011, the original applicability date of March 23, 2012 was delayed until final regulations are issued and applicable. No specific date was given, but the government anticipates that the final regulations will give plans "sufficient time to comply."***

Much of the IRS guidance with respect to these provisions is not final; therefore, we will continue to monitor for further guidance. In the meantime, please do not hesitate to contact any of us with questions or if we can assist you in any way with implementing any of the requirements of Health Care Reform.

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[1] Employers will not need to report the cost of health benefits provided to retirees, if the employer is not otherwise required to issue the individual a W-2 form.