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Health Care Reform: 2012 Compliance Checklist

Health care reform brings a number of changes for employers and health plans in 2012. As employers prepare to comply with new requirements, they need to be aware of how health care reform will affect them in the coming year.

This Clarke & Company Benefits, LLC Legislative Brief provides a compliance checklist for employers for 2012. Please contact your Clarke & Company Benefits, LLC representative for assistance or if you have questions about changes that were required in previous years.

GRANDFATHERED PLAN STATUS

A grandfathered health plan is one that was in existence when health care reform was enacted on March 23, 2010. Grandfathered plans are exempt from some of the health care reform requirements. A plan's grandfathered status will continue to affect its compliance obligations from year to year.

- ☐ Determine if you have a **grandfathered plan**. Contact your Clarke & Company Benefits, LLC representative if you have questions about whether your plan is grandfathered or not.
- ☐ Determine whether your plan will **maintain its grandfathered status**. If you make certain changes to your plan that go beyond permitted guidelines, your plan is no longer grandfathered. Contact your Clarke & Company Benefits, LLC representative if you have questions about changes you have made, or are considering making, to your plan.
- ☐ If you move to a **non-grandfathered plan**, make sure the plan includes all the additional participant rights and benefits required by health care reform. These rules include first-dollar coverage of preventive care services, an enhanced claim and appeal process, and non-discrimination requirements for insured plans.

ANNUAL LIMITS

Beginning January 1, 2014, group health plans will no longer be able to impose annual limits on the value of essential health benefits. However, until then, certain minimum annual limits are permitted. Unless your plan received a waiver of the annual limit requirements, you should confirm that any annual limit included in your plan is set at least as high as the following amounts for each applicable plan year:

- ☐ **$750,000** for plan years beginning on or after Sept. 23, 2010, but before Sept. 23, 2011;
- ☐ **$1.25 million** for plan years beginning on or after Sept. 23, 2011, but before Sept. 23, 2012; and
- ☐ **$2 million** for plan years beginning on or after Sept. 23, 2012, but before Jan. 1, 2014.

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SUMMARY OF BENEFITS AND COVERAGE

- ☐ Plans and insurance issuers must provide a **Summary of Benefits and Coverage** (SBC) to participants and beneficiaries.
  - The SBC is a concise document – no more than four double-sided pages - providing simple and consistent information about health plan benefits and coverage in plain language.
  - A proposed template for the SBC is available, along with proposed instructions for completing the proposed template and a uniform glossary of terms.

- ☐ The proposed deadline for providing the SBC was March 23, 2012. This deadline has been extended, however. Plans and issuers now have **until after final regulations are issued** to begin providing the SBC. It is unknown when the final regulations will be issued, but plans and issuers should have sufficient time after they are issued to prepare the SBC.

60-DAY NOTICE OF PLAN CHANGES

- ☐ When the SBC requirement becomes effective, plans and issuers 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.

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, STD screening and contraceptives.

MEDICAL LOSS RATIO (MLR) REBATES

- ☐ Fully insured plans may receive **rebates** in **August 2012** if they qualify for a rebate from their issuers due to the medical loss ratio (MLR) rules requiring insurance companies to spend a certain percentage of premium dollars on health care. The rebates must be used for the benefit of the plan's enrollees, which may include reducing enrollees' premium payments.

W-2 REPORTING

- ☐ Beginning with the **2012 tax year**, employers that are required to issue 250 or more W-2 Forms must report the aggregate cost of **employer-sponsored group health coverage** on employees' **W-2 Forms.**
  - The cost must be reported beginning with the 2012 W-2 Forms, which are issued in Jan. 2013.
  - This requirement is optional for smaller employers for the 2012 tax year – and until further guidance is issued.
  - Reporting is for informational purposes only – it does not affect the taxability of benefits.

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TAX CHANGES FOR AGE 26 COVERAGE

☐ If your state previously required you to **impute income** for covering **dependents up to age 26**, check on changes to your state's 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.

COMPARATIVE EFFECTIVENESS RESEARCH FEES

☐ Self-funded plans must pay a **$1 per covered life fee** for comparative effectiveness research. Fees are effective with the first renewal **after October 1, 2012**. Fees increase to $2 the next year and will be indexed for inflation after that.

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** (Credit for Small Employer Health Insurance Premiums) with their annual tax filings.

- To qualify, employers must have fewer than 25 employees and pay average annual wages of less than $50,000**.**

If you need more information on any of the health care reform topics addressed above, please contact your Clarke & Company Benefits, LLC representative.

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