HEALTHCARE REFORM COMPLIANCE UPDATE

New Requirements for 2012

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Four (4) New Requirements affecting Health Plans in 2012

- **W-2 Reporting**
- **Summary of Coverage and Benefits**
- **Notice of Modification**
- **Comparative Effectiveness Research Fee**

New Requirements for 2012

W-2 Reporting

W-2 Reporting Requirements

- Most employers will be required to report the aggregate cost of employer sponsored health coverage starting with the 2012 Tax Year for covered employees
  - Reported in **Box 12** of the W-2 using **code DD**
  - Costs to be reported **include both the employer and employee paid portions**, regardless of whether the contribution was made on a pre-tax basis through a cafeteria plan
  - Costs **include the level of coverage elected by the employee** (i.e., single, family, single plus spouse, or single plus children)
  - Costs also **include coverage that is taxable to the employee for non-tax dependent domestic partners or children over age 26**
  - Employers do not need to report with respect to former employees (i.e. retirees) who may still be on the health plan, but who will not be getting a W2
- Issuance of W-2s will not take place until January 2013

Action Steps Checklist

- ☐ **Have a process in place to track the costs of health care on an employee basis**
  - *Employers will need to keep accurate records with regard to the coverage levels elected by each of its employees throughout the tax year. For example, an employee may have had singlecoverage for a portion of the year and family coverage for the rest of the year.*
- ☐ **Work with external or internal payroll staff to assure that information can be captured and properly reported**

New Requirements for 2012

Summary of Coverage and Benefits

Summary of Coverage & Benefits

- Group health plans must a uniform Summary of Benefits with the following requirements:
  - A maximum of **four pages**
  - **12-point font**
  - Use of **plain English**
  - Provide **uniform definition of insurance** and **medical terms**
  - Description of **benefit cost sharing, limitations** and **exclusions**
- The final Summary recommended by the National Association of Insurance Commissioners (NAIC) work group has three parts:
  1. A four page Summary of Benefits and Coverage
  2. A two-page attachment to the Summary providing coverage examples
  3. A four page Glossary of Health Insurance and Medical Terms
- Must be provided to employees starting **March 23, 2012**
- Must be provided **in addition to the Summary Plan Description** (SPD) required by ERISA

Action Steps Checklist

- ☐ **EPD (Executive Plan Designs) will provide notification of when the model notice is issued by HHS**
- ☐ **Consider the design and the glossary when creating other plan materials such as an annual enrollment newsletter relating to the health plans**
- ☐ **Work with Carrier & EPD to assure that this notice is properly completed and issued to employees**

New Requirements for 2012

Notice of Modification

Notice of Modification

- Group health plans must provide a notice of material modification **at least 60 days prior to the effective date** unless the change is already stated in the most recent Summary of Coverage and Benefits
- This requirement was actually effective when the law was enacted (3.23.2010), however, **implementation is not required until March 23, 2012**, along with the Summary of Coverage and Benefits

Action Steps Checklist

- ☐ **Be cognizant that material changes to plan benefits will require a 2-month lead time to implement.**
- ☐ **Work with Carrier & EPD to assure your organization has adequate time to provide this notification of changes that are being implemented for upcoming plan years**

New Requirements for 2012

Comparative Effectiveness Research Fee

Comparative Effectiveness Research Fee

- The purpose of this fee is to fund, in part, the new *Patient-Centered Outcomes Research Institute* created under PPACA, which will conduct comparative research relating to patient outcomes to assist patients, clinicians, purchases and policy makers in making informed health decisions
- Starting with plan years ending after 9.30.2012, group health plans will be assessed **a fee of $1 per participant the first year**, **then $2 per participant the second year**
- This fee wil be indexed annually and **will end beginning after 9.30.2019**
  - For Calendar Year Plans, the fee applies to calendar policy years 2012 through 2018
- This fee will be **paid by insurers for insured plans** and by **plan sponsors for self-funded plans**
- This fee will be **based on the average number of lives covered under the plan for the year**

Action Steps Checklist

- ☐ **IRS is currently seekign public comments on this fee until 9.6.2011**
- ☐ **EPD will provide additional guidance on how this fee is to be calculated and remitted**

Disclaimer

The intent of this analysis is to provide general information regarding the provisions of current healthcare reform legislation. It does not fully address all of your organization's specific issues. It should not be construed as, nor is intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice should address questions regarding specific issues.