2012 Health Care Reform Compliance Checklist

A New Year means new requirements under Health Care Reform. The following checklist is designed to help employers who sponsor group health plans review their plan's compliance with the major provisions of Health Care Reform that may impact their companies in 2012.

Please Note: This list is for general reference purposes only and is not all-inclusive. The information is subject to change based on new requirements or amendments to the law. Additionally, your group plan may be exempt from certain requirements described below. If you have any questions regarding your obligations with respect to Health Care Reform, you should consult with a knowledgeable employment law attorney and your carrier.

1. Evaluate Grandfathered or Non-Grandfathered Status of Plan

A grandfathered plan is one that was in effect on March 23, 2010. If a plan loses its grandfathered status, it may no longer be exempt from certain requirements under Health Care Reform.

- Determine whether any changes to the plan with respect to benefits, costs, or other changes result in a loss of grandfathered status.
- To maintain grandfathered status, provide a statement indicating the plan believes it is a grandfathered health plan, along with contact information for questions and complaints, whenever a summary of benefits under the plan is provided to participants and beneficiaries (model notice available here).

2. Review Plan Documents for Required Changes to Plan Benefits

Plan documents should be amended to reflect changes as of the effective dates noted below. Please contact your carrier or employment law attorney for additional details or if you have questions regarding these amendments.

- Annual limits on "essential health benefits" are being phased out according to the limits set by law (no lower than $1.25 million for plan years starting on or after September 23, 2011).
    - Note: Certain limited benefit or "mini-med" plans that received temporary waivers from the rules concerning annual dollar limits, as well as stand-alone HRAs in effect prior to September 23, 2010 which are automatically exempt until January 2014, must distribute an annual notice to participants and subscribers stating that the plan has restrictive coverage and includes low annual limits (required language for the notice is available for both limited benefits plans and stand-alone HRAs).

- Except for grandfathered plans, expanded coverage of women's preventive services must be provided with no cost-sharing requirements effective for plan years beginning on or after August 1, 2012.
- Except for grandfathered plans, new standards for claims and review processes that were previously delayed until plan years beginning on or after July 1, 2011 or January 1, 2012 (such as the requirement to provide notices to claimants in a culturally and linguistically appropriate manner) are now in place.

3. Report Employer-Provided Health Plan Coverage on Forms W-2

This requirement does not apply to employers that were required to file fewer than 250 Forms W-2 for the preceding calendar year, unless and until the

IRS publishes further guidance giving at least 6 months' advance notice of any changes. However, employers should check with their state revenue department for any reporting requirements related to coverage for adult children that may apply for state income tax purposes.

- Beginning with calendar year 2012 Forms W-2 (required to be furnished to employees in January 2013), employers that provide a group health plan to their employees are generally required to report the cost of the coverage provided to each employee annually.

4. Provide Summary of Benefits and Coverage (SBC)—Effective Date for Compliance To Be Determined*The U.S. Department of Labor (DOL) has advised that group health plans are not required to comply with the requirement to provide the SBC and uniform glossary until final regulations are issued. Under the proposed rules, compliance would have been required beginning March 23, 2012.*

- Check for new updates as the original March 23 deadline approaches. Proposed templates for the summary of benefits and coverage and the uniform glossary are currently available.
- While the requirements to provide these materials will vary depending on the event, generally the information will need to be distributed to participants and beneficiaries:
  - Prior to initial enrollment in the plan;
  - Upon annual renewal of coverage;
  - At least 60 days prior to a material change in the terms of coverage;
  - Within 7 days of a request for special enrollment; and
  - Within 7 days of a participant or beneficiary's request.

5. Other Considerations for 2012

The following additional items may be of significance depending on your specific plan and the benefits offered.

- **Small Business Health Care Tax Credit**. Determine whether your company qualifies for the small business health care tax credit. For tax years 2010 through 2013, the maximum credit is 35 percent for small business employers.
- **Changes to Flexible Spending Accounts (FSAs)**. Confirm that your plan documents reflect the new restrictions on reimbursement of costs for over-the-counter drugs for FSAs and other tax-favored accounts that took effect in 2011. Keep in mind that beginning in 2013, the law also limits the amount of contributions to a health FSA to $2,500 (to be adjusted for inflation thereafter).
- **Simple Cafeteria Plans**. If eligible, consider whether your company could benefit from establishing a simple cafeteria plan. Simple cafeteria plans are treated as meeting the nondiscrimination requirements of a cafeteria plan and certain benefits under a cafeteria plan.
- **Medical Loss Ratio (MLR) Rebates**. Beginning in 2012, insurance issuers that do not meet certain standards relating to premiums are required to provide rebates to enrollees. Where the rebate goes to the employer-policyholder that paid the premium on the enrollee's behalf, the employer may be responsible for distributing the rebates to eligible plan enrollees. Rebates must be provided by August 1 of each year. The DOL's Employee Benefits Security Administration has released technical guidance on how to handle rebates paid pursuant to the medical loss ratio requirements.

Be prepared for compliance requirements to change. Stay up-to-date on the latest information by visiting our section on Health Care Reform.

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