Begley Insurance Group

LEGISLATIVE BRIEFING

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.

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 affect its compliance obligations every year.

- Determine if you have a grandfathered plan. Contact your BIG 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 BIG 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 Jan. 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.
- $2 million for plan years beginning on or after Sept. 23, 2012, but before Jan. 1, 2014.

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 template for the SBC is available, along with instructions and examples for completing the template and a uniform glossary of terms.

- The final SBC regulations provide that plans and issuers must start providing the SBC as follows:

  • Issuers must provide the SBC to health plans effective Sept. 23, 2012.

  • Plans and issuers must provide the SBC to participants and beneficiaries who enroll or re-enroll during an open enrollment period beginning with the first day of the first open enrollment period that begins on or after Sept. 23, 2012.

  • For participants who enroll in coverage other than through an open enrollment period (for example, newly eligible individuals and special enrollees), plans and issuers must provide the SBC beginning on the first day of the first plan year that begins on or after Sept. 23, 2012.

60-Day Notice of Plan Changes

- 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 Aug. 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. Exceptions to contraceptive requirements apply to religious employers.

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 January 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.

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 Oct. 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.

This article is for informational purposes only and does not constitute a legal opinion. Contact your legal representative for information specific to your needs.