2012

Special Update: U.S. Supreme Court Upholds Health Care Reform Law

The U.S. Supreme Court upheld the key provisions of Health Care Reform in a decision issued in June. Key highlights of the decision include:

- The individual mandate, which requires most individuals to maintain a minimum level of health insurance or pay a penalty beginning in 2014, is upheld as constitutional under Congress's power to tax.
- The portion of the law which threatens states' existing Medicaid funding for failure to comply with the requirements related to expanding the scope of Medicaid coverage is unconstitutional.
- The remaining provisions of the Health Care Reform law are not affected and remain intact.

Community Living Assistance Services and Supports: See Special Update Below

The law creates a voluntary long-term care insurance program called Community Living Assistance Services and Supports (CLASS), through which eligible enrollees would receive benefits to purchase long-term care services and supports necessary to live independently in the community. The program is expected to be available after October 2012. **Special Update:** The HHS Secretary has announced that there is currently no viable path forward for implementation of the CLASS program.

Expanded Coverage of Preventive Services for Women

For insurance policies with plan years beginning on or after August 1, 2012, non-grandfathered health plans will need to include coverage of additional women's preventive services without cost sharing, such as well-woman visits, breastfeeding support, domestic violence screening, and contraception. Click here for more.

Medical Loss Ratio (MLR) Rebates

Insurance companies are required to spend at least 80% (in the individual and small group markets) or 85% (in the large group market) of the premium dollars they collect on medical care and quality improvement activities. Issuers that do not meet these standards must provide rebates to enrollees, beginning in 2012, by August 1 each year. Rebates are based upon aggregated market data in each state and not upon a particular group health plan's experience.

In order to reduce burdens on issuers and to minimize the tax impacts on participants in and sponsors of group health plans, thefinal rule directs issuers to pay to the policyholder (usually the employer) any rebates owed to persons covered under a group health plan, through lower premiums or in other ways that are not taxable. According to Technical Release 2011-04, any portion of a rebate constituting plan assets must be handled in accordance with the fiduciary responsibility provisions of ERISA. For guidance on how to handle rebates paid pursuant to the medical loss ratio requirements, please click here.

Issuers that do not owe rebates for 2011 are required, under a separate final rule issued by HHS, to provide a notice to their policyholders and subscribers that they have met or exceeded the MLR standards. The notice is required for the 2011 MLR reporting year only and must be provided with the first plan document that the issuer provides to enrollees on or after July 1, 2012.

Reporting Costs of Employer-Provided Health Coverage on Forms W-2

Beginning with the calendar year 2012 Forms W-2 (required to be furnished to employees in January 2013), employers that provide applicable employer-sponsored coverage under a group health plan and **who have not been granted transitional relief**by the IRS will be required to report the cost of the coverage provided to each employee annually. Notice 2012-9 includes information on how to report, what coverage to include and how to determine the cost of the coverage.

Note: Notice 2012-9 continues to grant transitional relief to employers that were required to file **fewer than 250 Forms W-2** for the preceding calendar year. For such employers, the requirement to report the value of coverage will **not apply for the 2012 Forms W-2** (the forms required for the calendar year 2012 that employers generally are required to provide employees in January 2013) and will not apply for future calendar years until the IRS publishes guidance giving at least 6 months of advance notice of any change to the transition relief.

Summary of Benefits and Coverage: See Special Update Below

Group health plans and health insurance issuers offering group health insurance coverage are required to provide participants and beneficiaries, without charge, a summary of benefits and coverage (SBC) containing specific information about the plan and coverage, as well as a uniform glossary of terms commonly used in health insurance coverage, at several points during the enrollment process and upon request. Both documents must comply with certain appearance and format requirements and must utilize terminology understandable by the average plan enrollee.

Additionally, notice of any material modification in any of the terms of the plan or coverage that is not reflected in the most recently provided SBC generally must be provided to enrollees at least 60 days before the effective date of the change.

Special Update: Final rules have been issued which require compliance with the new notice requirements for plan years and open enrollment periods beginning on or after Sept. 23, 2012. Click here for more information, including downloadable templates that may be used to satisfy the notice requirements for the first year of compliance. FAQs are also available which address a number of issues related to the SBC requirements.

Fees on Issuers of Certain Health Insurance Policies and Plan Sponsors of Certain Self-Insured Health Plans

The IRS has issued final regulations implementing and providing guidance on the fees imposed by the Affordable Care Act on issuers of certain health insurance policies and plan sponsors of certain self-insured health plans to fund the Patient-Centered Outcomes Research Trust Fund, which is the funding source for the Patient-Centered Outcomes Research Institute. The Institute was established by the Affordable Care Act to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing the quality and relevance of evidence-based medicine through research.

The final regulations require an issuer of a specified health insurance policy and plan sponsor of an applicable self-insured health plan to report and pay the fee for a policy or plan year no later than July 31 of the year following the last day of the policy or plan year. The regulations apply to policy and plan years ending on or after October 1, 2012, and before October 1, 2019.