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Healthcare Reform: What to Expect in 2012

by Jill Bergman, CEBS and Kevin Quinn

After passage of the Affordable Care Act ("ACA" or "the Act") in March 2010, employers and plan sponsors scrambled to understand the implementation timeline and swiftly turned their attention to the initial mandates contained in the Act. Fully insured and self-funded plans have extended coverage to young adult dependents up to age 26, removed lifetime limits on essential benefits, began to cover required preventive services with no member cost sharing, and wrestled with the concept of grandfathered plans and what benefit that status might offer.

While the initial ACA frenzy has calmed (somewhat), healthcare reform continues to proceed, but not without a few diversions along the way. Some portions of the law have already been repealed, such as the enhanced 1099 reporting requirement. In this article, we will highlight what plan sponsors can expect in 2012 and summarize what ACA issues the Supreme Court may decide on this term.

W-2 Reporting Requirements

Employers will need to report the cost of healthcare coverage for each participating employee on employees' 2012 W-2 statements. Interim guidance eased the overall compliance burden and granted exemptions to smaller employers (those who issued less than 250 W-2 statements in 2011) and employers who contribute to a multiemployer plan.

In general, only annual medical plan costs will need to be reported on the W-2 statement (Box 12, Code DD) as the interim rules allow employers to disregard amounts contributed to stand-alone dental and vision plans and health reimbursement arrangements ("HRA"). Amounts contributed to health savings accounts ("HSA"), accident or disability insurance, or salary reduction elections to a healthcare flexible spending account (unless optional employer flex credits are offered) are also excluded from the determination.

The Uniform Summary of Benefits and Coverage ("SBC")

Beginning September 23, 2012, all fully insured and self-funded plans will be required to provide summaries of benefit plan information along with a glossary of common insurance and medical terms in a format and manner prescribed by law and implementing regulations. The SBCs must include specified coverage information as well as two examples illustrating how the plan may cover the costs for "having a baby" and "managing Type II diabetes." The SBCs generally must be distributed with group plan enrollment materials as stand-alone documents, or may be included with the Summary Plan descriptions if prominently featured. The SBCs must be no longer than four double-sided pages, use 12-point font, and precisely replicate all symbols, formatting, bolding, shading, and page breaks as described in the SBC Instruction Guide.

Employers to Help Fund the Patient-Centered Outcomes Research Fund

The Patient-Centered Outcomes Research Fund was established to evaluate outcomes and the effectiveness of healthcare services in order to identify and recommend the best course of action to treat and prevent disease. The ACA imposes a fee on self-funded and fully insured plans to help support this effort. For plan or policy years that end after September 30, 2012 (stated another way—plan or policy years that begin after October 1, 2011), the fee is equal to the product of $1 multiplied by the average number of lives covered under the plan. The annual fee, which will increase to $2 (also multiplied by the average number of lives covered under the plan) the following year, can be increased in the future and is scheduled to end in September 2019.

Wellness Reporting

By March 2012 the Department of Health and Human Services ("HHS") must develop wellness reporting requirements for insurers and group health plan sponsors. Insurers will be required to report on such activities as case management, care coordination, chronic disease management, preventing hospital readmissions, and improving patient safety. Employers may need to provide details regarding efforts to implement wellness and health promotion activities in the workplace. Plan sponsors will provide annual reports to HHS and to plan participants at open enrollment. HHS has the authority to impose penalties for noncompliance.

Medical Loss Ratio Rules

Beginning with the 2011 calendar year, insurance carriers in the small group market must spend at least 80 percent (85 percent in the large group market) of the premiums they collect on medical services (such as claim payments) and on activities that improve healthcare quality. Carriers will report the aggregate Medical Loss Ratio ("MLR") results by state with respect to the policies they issue separately in the large group, small group, and individual markets. Carriers that fail to meet these targets must issue a rebate to plan sponsors by August 1 of the following calendar year.

In general, employer-sponsored plans may need to treat the portion of the rebate attributable to employee contributions as plan assets subject to ERISA fiduciary provisions, unless plan documents state otherwise, the employer paid the full cost of coverage, or the plan is not subject to ERISA. The plan sponsor needs to ensure that the rebate is used to benefit covered employees such as reducing employee contributions, providing benefit enhancements, or paying individual rebates.

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Coverage of Additional Preventive Services for Women

Non-grandfathered, fully insured, and self-funded plans will be required to cover the following women's preventive services as of the first plan year that begins on or after August 1, 2012, with no member cost sharing (deductible, copayment, or coinsurance payments) as follows:

- Annual well-woman visits for preventive care services that are age and developmentally appropriate;
- Gestational diabetes screening for women 24 – 28 weeks pregnant and women at high risk for developing gestational diabetes;
- Family planning services, including Food and Drug Administration-approved contraceptives, sterilization procedures, and education and counseling services;*
- High-risk human papillomavirus DNA testing every three years for women age 30 and older, regardless of Pap smear test results;
- Annual HIV and sexually transmitted disease screenings;
- Breastfeeding support and counseling services as well as lactation supplies and devices; and
- Domestic violence screening and counseling.

CLASS Dismissed

The long-term care Community Living Assistance Services and Supports ("CLASS") program included in the ACA will not proceed at this time due to concerns about the program's financial soundness. CLASS was intended to provide a minimum $50 lifetime daily benefit to individuals having difficulty with activities of daily living such as eating, bathing, and dressing. Enrollees would be required to pay premiums for at least five years before becoming eligible to receive benefits.

The Road to the Supreme Court

Since it was signed into law, numerous challenges to the ACA have been brought by individuals, states, and a variety of business groups. One of the central issues the Court will decide is whether Congress has the authority under the Constitution's commerce clause to require all Americans to buy health insurance or pay a penalty (individual mandate). Opponents argue that Congress cannot regulate inactivity (such as a decision not to purchase health insurance) as commerce. Lower court rulings have been mixed on this issue.

The United States Supreme Court has agreed to hear an unprecedented six hours of oral arguments on March 26 – March 28, 2012. The Supreme Court will review four key ACA issues as follows:

- **Anti-Injunction Act** — A lower court ruled that the constitutionality of the individual mandate cannot be considered until after the mandate takes effect in 2014 and tax liabilities

**This provision (with modification) is delayed until August 1, 2013 for certain religious institutions.*

are imposed (April 2015), as no individual has yet been harmed by the individual mandate.

- **Individual mandate** — Does Congress have the power to require individuals to purchase a product (i.e., insurance) in the private marketplace or be subject to a penalty?
- **Severability** — The Court must decide if the remainder of the ACA will be allowed to stand should the Court declare the individual mandate to be unconstitutional. Many believe that if the individual mandate is struck down, the entire law will be compromised as premiums (or tax penalties) must be collected from everyone in order to spread the risk and costs among the entire population. Others suggest many facets of the law are not intertwined with the individual mandate (such as extending coverage to adult children up to age 26) and that alternative options are possible if the individual mandate is struck down.
- **Medicaid** — The states argue that the ACA's expansion of Medicaid should be struck down on the ground that it unconstitutionally "coerces" state governments to expand the program in order to continue to receive Federal funding for the Medicaid program. Lower courts have allowed this provision to stand.

The Supreme Court is expected to rule on the issues by the end of June 2012. The timing will no doubt play a role in the 2012 elections and presidential race.

More information about the various ACA provisions can be found on the DOL website, located at www.dol.gov/ebsa/healthreform/. ■

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