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# WELCOME TO THE NEW YEAR FOR HEALTH CARE REFORM!

In 2010 and 2011, a number of actions have been taken by plan sponsors and insurers of group health plans to comply with the first round of health care reform changes. Plans were required to extend coverage to children until they turn twenty-six (26). Insurance companies were prohibited from rescinding coverage, except in limited circumstances. Most plans had to provide first dollar coverage for preventive care. Lifetime limits on "essential health benefits" were eliminated and annual limits on benefits were restricted. A second round of health care reform initiatives are required in 2012 under the Patient Protection and Affordable Care Act ("PPACA"). This Alert will briefly summarize what plan sponsors and insurers can expect for 2012.

## 1. Rebates Associated With Medical Loss Ratio.

Health insurers are required to spend at least 80 to 85 percent of their premium dollars on medical care and health quality improvement activities, or provide rebates to policyholders for their failure to do so. Rebates, based on the insurer's financial data for 2011, are first due by August 1, 2012. The DOL has recently issued Technical Release 2011-04, providing guidance on how the rebates should be handled by ERISA group health plans. Policyholders for group health plans (*e.g.*, employers, plans or trusts) that are informed of their entitlement to a rebate will need to review Technical Release 2011-04 and determine how the rebates will be allocated between participants and the plan sponsor and if and how rebates will be distributed to participants. The guidance affords plan sponsors some flexibility to not distribute rebates to participants, but instead apply the amounts received against future contributions. Decisions regarding the allocation and distribution of rebates are fiduciary decisions (if participants contribute to the plan) and need to be documented.

## 2. Summary of Benefits and Coverage.

On August 21, 2011, the Department of Health and Human Services ("HHS"), the Department of Labor ("DOL") and the Department of Treasury ("Treasury") (jointly, the "Departments") issued proposed regulations and proposed templates in connection with the PPACA's requirement that plans issue a summary to applicants and enrollees that describes their benefits and coverage in a uniform manner. The initial distribution date for the Summary of Benefits and Coverage ("SBC") was supposed to be March 23, 2012. The Departments recently announced that the distribution requirement has been delayed until the promulgation of final regulations that will include a new effective date, giving plan sponsors and insurers sufficient time to comply.

3. W-2 Reporting.

Beginning for the 2012 year, large employers are required to provide information of the cost of their employees' group health plan coverage on the Form W-2s. Large employers are those filing 250 or more W-2s for the previous year. The IRS, in Notice 2011-28, recently provided guidance on how to determine reportable costs. Smaller employers will not be required to report the costs of health coverage until additional guidance is issued by IRS.

4. Quality of Care Reporting.

PPACA requires that, by March 23, 2012, HHS develop guidance on the new "quality of care" reports that health plans (both insured and self-funded) must provide annually to HHS and to participants upon open enrollment. The statute requires that plans report on their efforts to: (i) improve health outcomes through implementation of activities, such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives; (ii) prevent hospital readmissions; (iii) improve patient safety and reduce medical errors; and (iv) implement wellness and health promotion activities. Once these reporting requirements are established, health plans will have to comply with them for plan years beginning on or after March 23, 2012 (unless HHS extends the compliance date in regulations or other guidance).

5. Comparative Effectiveness Research Fee.

PPACA required the establishment of a new Patient-Centered Outcomes Research Institute ("Institute") to advance comparative clinical effectiveness research. The Institute is to be funded by fees paid by plan sponsors for self-funded plans and by insurers for insured plans. The fees are treated as taxes. For plan and policy years ending after September 30, 2012, and before October 1, 2013, plans and insurers must pay an annual fee of $1 multiplied by the average number of lives covered by the plan or policy. The fee increases to $2 multiplied by the average number of lives per year for plan and policy years ending after September 30, 2013. Thereafter, the fee will be increased annually based on the National Health Expenditures Index published by HHS. The fee is set to expire for plan and policy years after September 30, 2018. The IRS issued Notice 2011-35, requesting comments on the implementation of these fees. Proposed regulations are anticipated in the near future.

6. Nondiscrimination Rules for Insured Health Plans.

PPACA extended the non-discrimination rules under Code § 105(h), applicable to self-funded health plans, to insured plans effective for policy years on or after September 23, 2010. In Notice 2011-1, the IRS delayed the implementation of this rule until after the Departments issue regulations. The Notice also indicated that compliance will not be required until plan years beginning after a specified period contained in the regulations. It is anticipated that proposed regulations will be issued in 2012.

7. Sixty (60) –Days Advance Notice of Plan Benefit Changes.

PPACA requires sixty (60)-days advance written notice of any material modification to health benefit information. "Material modification" is any change that would be considered by the average participant to be an important change to covered benefits or other terms of coverage. The proposed regulations on the Summary of Benefits and Coverage ("SBC") clarify that the advance notice requirement only applies to mid-year changes to the information provided in the SBC. New changes to benefits that are effective for the new policy or plan year will not be subject to the sixty (60)-day advance notice requirement. Rather, the new changes need to be disclosed in the SBC, which must be provided to participants at least thirty (30) days before the new policy or plan year.

8. Claims and Appeal Regulations.

PPACA added additional requirements for the internal claims and appeal processes, including a requirement for an independent external review, for group and individual health plans. These changes do not apply to grandfathered plans. Interim final regulations were issued by the Department on July 23, 2010 and provided guidance on seven (7) new requirements effective for plan or policy years beginning on or after September 23, 2010. In Technical Release 2010-02, the Departments granted an enforcement grace period for four (4) of the new rules until plan or policy years on or after July 1, 2011. The Departments again on March 18, 2011 issued another Technical Release 2011-01, which further extended the enforcement grace period until plan or policy years beginning on or after January 1, 2012 with respect to the four (4) requirements. On June 24, 2011, the Departments issued amendments to the interim final regulations with respect to the four (4) requirements subject to the extended enforcement grace period. The amendments to the interim regulations are effective for plan or policy years on or after January 1, 2012.

PPACA and the regulations (as amended) require substantial changes to the claims and review processes of self-funded and insured plans. Some of these changes may have already been implemented, some not. The serial extensions of the non-enforcement grace periods (applying to only a select number changes), as well as the amendments to the initial interim regulations, have caused a great deal of confusion among plan sponsors and insurers. The regulations also provide three (3) different options for external review: (i) a state external review process (but only if it meets certain standards) for insured plans; (ii) a federal external review process administered by the Office of Personnel Management ("OPM") for insured plans in states that do not have an existing review law or have a law that does not meet federal standards; and (iii) a private contract regime (plans contract with three (3) accredited independent review organizations ("IROs")) for self-insured group health plans.

Plan sponsors and insurers need to review the claims and appeals procedures in their summary plan descriptions and plan documents to make sure that they contain all the changes in the interim final regulations (as amended) by the first date of plan or policy year beginning on or after January 1, 2012. Moreover, plan sponsors and insurers must make sure that the new content requirements of the initial notice of adverse benefit determinations and the final internal adverse benefit determinations will be satisfied. Plan sponsors and insurers also need to be prepared to provide the relevant notices required under the claims and appeals processes "in a

culturally and linguistically appropriate manner" required under the amended final interim regulations. The regulations require plans and insurers to be able to provide adverse benefit determination notices in a non-English language if 10% or more of the population residing in the claimant's county, as determined by the data provided in the American Community Survey data published by the U.S. Census Bureau. Finally, for plans that are subject to the private contract external review process, they must contract with at least two (2) IROs by January 1, 2012 and with at least three (3) IROs by July 1, 2012.

9. Loss of Grandfathered Status.

PPACA grandfathered certain health plans that were in effect the day the Act was signed on March 23, 2010, and exempted them from many of the required changes. For example, grandfathered plans are not subject to: (i) the new claims and appeals rules; (ii) the requirement to cover specified preventive services without cost sharing; (iii) the requirement to offer a comprehensive "essential benefits package"; (iv) the nondiscrimination requirement imposed on insured plans; and (v) a number of other requirements. (The DOL has a chart detailing what PPACA rules do not apply to grandfathered plans on its website at http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf.)

The Departments published an interim final rule on June 14, 2010, describing the type of plan changes that would cause the loss of the plan's grandfathered status. An amendment to those interim final rules was published on November 15, 2010. The amended interim final rules are very detailed and need to be reviewed each time there is a renewal, a change in benefits, an increase in co-insurance, co-payments or other cost-sharing requirements, a change in annual limits, or change in employer contribution rates. If indeed there is a loss of grandfathered status at renewal or mid-year, the plan must be amended to include all the new rules which apply to non-grandfathered plans.

We hope you find this Alert helpful. If you have any questions or need assistance in complying with these new requirements, feel free to contact Terry Connerton at (412) 918-1160 or e-mail her at tconnerton@metzlewis.com.

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