Getting It Straight

Your 2012 PPACA Checklist

AS WE ALL KNOW, there was a big push under PPACA for plan sponsors to amend health plans for the 2011 plan year. While there are not as many changes to be made in 2012, there is still work to do to ensure you are in compliance for the year.

Make sure these "to dos" are on your 2012 checklist.

What Plan Amendments Are Required?

Change to Annual Limit Amount: If your plan adopted the restricted annual limits until 2014 (when annual limits on essential health benefits no longer are permitted), the annual limit amount for the 2012 plan year must be increased to $1.25 million.

What Changes Are Required to Claims Procedures?

There have been a number of changes to appeals requirements over the last year, with grace periods and delayed effective dates, but these changes finally will be applicable in 2012. (These requirements do not apply to grandfathered plans.)

Foreign Language Requirement: For plan years starting on or after 1/1/12, plans must start providing explanations of benefits (EOBs) in foreign languages if sent to an address listed in guidance as having a certain threshold of foreign language speakers. This guidance is found in the Preamble to the appeals amendment (see www.dol.gov/ebsa). Plans also must be able to provide claims assistance in these languages if requested.

EOB Content: Also for plan years starting on or after 1/1/12, EOBs must contain additional content, including denial codes and additional information to identify claims. Plans also must provide diagnosis and treatment codes and their meanings to claimants upon request.

External Review: With respect to external review, self-funded plans must have contracted with at least two Independent Review Organizations by 1/1/12 in order to meet the non-enforcement safe harbor and must contract with three by 7/1/12.

Are There New Notice Requirements?

Summary of Benefits: Plans will be required to issue a four-page (front and back) Summary of Benefits and Coverage (SBC) notice by 3/23/12. The SBC is required to follow the template set out in regulations and be delivered at enrollment, renewal, and upon request. If there is a plan change that would trigger a change to the SBC, the plan is required to give at least 60 days' advance notice. So far, the agencies have issued only proposed regulations and have adopted an effective date of 3/23/12. We have heard that this date may be delayed, most likely through some type of informal guidance or Q&A, but until that time, plans should keep it on their lists.

Are There New Reporting Requirements?

There are a few new reporting requirements, and we are still waiting for guidance on all three.

W-2 Reporting: Plans will be required to report the value of certain health benefits on employees' W-2s for the 2012 tax year (to be issued in January 2013). The IRS has issued Notice 2011-28, which provides several Q&As about what types of benefits are to be included and how to calculate their values. We are expecting more guidance this year. Even though this reporting is not required until the W-2 issued in January 2013, plans must be able to track these costs throughout the 2012 tax year.

Comparative Effectiveness Fee: For plan years ending after 9/30/12, health plans (both insured and self-funded) will be required to pay an annual fee of $1 multiplied by the average number of covered lives under the plan, including active employees, retirees, and dependents. This amount will be increased to $2 the following year and is intended to be used to fund centers to study clinical effectiveness, risk, and benefits of various treatments. The IRS has requested comments regarding how plans should determine the average number of covered lives and report this information.

Quality of Care: The Department of Health and Human Services (HHS) is required to develop reporting requirements regarding quality of care by 3/23/12 (although it is unclear when plans must comply). This reporting is expected to address efforts plans are making to improve health outcomes through activities such as case management and wellness programs. The report must be submitted annually to HHS, posted online, and provided to participants at annual enrollment. (This requirement does not apply to grandfathered plans.) —*PS*

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