

Client Alert

January 2012

Health Care Reform - Important Developments for Employers

Despite the on-going litigation and Republican opposition in Congress, the Administration continues to work on implementing the Patient Protection and Affordability Care Act of 2010, as amended (the "Act"). Set out below is a brief review of the following important developments from the past 12 months --

- the postponement of the March 2012 uniform benefit summary requirements;
- the delay of the new W-2 reporting requirements for group health coverage costs to 2012 and issuance of additional guidance on what must be reported;
- further guidance on (and some narrowing of) the internal/external claims process for "non-grandfathered" plans;
- the closing of the retiree reinsurance program at the end of 2011; and
- state action on the tax treatment of adult child coverage required under the Act.

Deadline for Uniform Benefit Summaries Postponed

The Act provides that insurers and group health plans must, beginning March 23, 2012, provide a summary of benefits and coverage to plan enrollees (containing uniform terms in a specified format) upon initial enrollment and annually thereafter. While the government issued proposed regulations in August, it recognized that the proposed format -- which was designed for individual insurance policies -- may not be a good fit for group health plans. As a result, the government asked for comments on how the summary requirements should be applied to such programs (on which it has received numerous comments). At the same time, the general consensus among employers and insurers was that the March 23rd deadline was too ambitious and would not provide sufficient time to develop the required summaries once final regulations came out.

In response to these concerns, the government issued guidance on November 19, 2011 providing that group health plans and insurers will not be required to comply with the summary rules until final regulations are issued. See the [Department of Labor FAQs About Affordable Care Act Implementation: Part VII](#) (Q1). In addition, in recognition of the time and effort it will take to develop the summaries, the Department also announced that it will provide a delayed effective date to give employers and insurers ample time to develop the required summaries once the final rules are out.

W-2 Reporting of Health Care Coverage Costs Delayed to 2012 and Additional Guidance Issued

As covered in a prior client alert, the Internal Revenue Service ("IRS") postponed the W-2 reporting of group health plan costs to 2012. See [Health Care Reform: Recent Legislative Developments and Guidance on Grandfather Rules and New W-2 Reporting Rules](#) (issued April 2011). As pointed out in that alert, the IRS also provided that 2012 reporting only had to be done for W-2s due in 2013. Thus, reporting of 2012 healthcare costs need not be done on any 2012 W-2s that must be issued during 2012, which gives employers most of 2012 to make any needed payroll system adjustments to implement the new requirements.

The IRS recently issued additional guidance on the W-2 reporting requirements in [Notice 2012-9](#), which provides the following:

Application of Small Employer Exception -- The W-2 reporting requirement does not apply to employers who issued less than 250 W-2s in the prior year. The Notice clarifies that this is to be determined based on the total W-2s the employer was required to file in the prior year (including any done by an agent).

Work for Related Employers -- If an employee works for related employers during the same year and the employers use a common paymaster, the common paymaster must comply with the group health plan cost reporting. However, if they do not use a common paymaster, it is permissible to report the total health plan costs on one W-2 or allocate those costs among the employers in any reasonable manner.

Dental and Vision Benefits -- The Notice clarifies that dental and vision benefits do not have to be reported IF they are otherwise exempt from the Act. In general, these benefits are so exempt only if they are offered under a separate insurance policy or participants must pay an additional premium for any such benefits they elect.

EAPs, Wellness Programs and On-Site Medical Clinics -- The recent guidance provides that employee assistance programs (EAPs), wellness programs and on-site medical clinics do not have to be reported if either --

- such coverage is not subject to the COBRA continuation health care coverage rules, or
- a separate premium is not charged for any such coverage that must be provided under COBRA.

Keep in mind, though, that it is okay to report on the W-2 the cost of these or any other excludable health benefits (e.g., long-term care coverage, health care reimbursement arrangements and exempt dental/vision benefits) as long as the benefits otherwise constitute employer-sponsored coverage and a permissible method for calculating cost is used.

Special Reporting Issues --

- **Non-Calendar Coverage Periods** -- For any reportable benefit which is provided on a non-calendar year basis, the coverage cost can be reported by allocating the cost on a uniform basis:
 - to either the calendar year in which the coverage period begins or the year in which it ends, or
 - among the two calendar years in a reasonable manner.
- **Post-Year Employee Status Changes** -- The Notice provides that the reportable cost for a calendar year may be based on information that the employer has of year-end. Thus, post-year elections or notifications that could have retroactive effect (e.g., birth of a child or divorce) do not have to be taken into account in calculating cost.
- **Indemnity Plans** -- The cost for any hospital or other fixed indemnity insurance (including coverage for a specified disease or illness) must be reported only if it is paid for (by either the employer or employee) on a pre-tax basis. Thus, any such coverage that is provided on an after tax basis does not have to be reported.

- *Third-Party Sick Pay Providers* -- The guidance provides that third-party sick pay providers who are required to provide W-2s to employers do not have to report any applicable group plan costs for affected employees. However, the employer must still include that cost on any W-2 it is required to issue to those employees.

Internal/External Claims Review Procedures Clarified

As described in a prior client alert, one of the key components of the Act, applicable to *non-grandfathered plans*, is the requirement to adopt expanded internal claims review procedures and an independent external review process. See [Health Care Reform - Regulations Issued on Expanded Internal/External Claims Review Process for Nongrandfathered Group Health Plans](#). These new and expanded claims review requirements substantially expand and increase the long-standing “full and fair review” process requirements of ERISA. Under the initial regulations issued on July 19, 2010, the additional internal claims review requirements included: (i) a reduction in the timeframe to review an urgent claim from 72 hours to 24 hours; (ii) expanded notice requirements for claims denials, including such information as the diagnosis code, treatment code and denial code among other information describing the claim; and (iii) a requirement that notices be provided in a “culturally and linguistically appropriate” manner. Failure to *strictly adhere* to any of the requirements would result in a deemed denial of the claim permitting the claimant to proceed to court on a *de novo* review basis.

The regulations also established required procedures, including strict timing requirements, for an independent, external review of any denied claims. These rules require group health plans to contract with independent review organizations in order to permit plan participants with an avenue, short of litigation, to have their denied claims reviewed by an independent third party. The cost of the external review process is borne almost exclusively by the plan sponsor and decisions of the independent review organization are binding on the plan but not the participant.

Although the internal and external claims review procedures were originally scheduled to become effective beginning with plan years on and after January 1, 2011, an enforcement grace period for most of the requirements was established until January 1, 2012, through a series of guidance in 2010 and 2011. Additionally, in June 2011, as part of this guidance, the DOL, IRS and HHS issued amendments to the original regulations which modified certain of the requirements. The key modifications include:

- Elimination of the 24-hour review requirement for urgent claims. Urgent claims must now be reviewed as soon as possible but no more than 72 hours after receipt of the claim.
- Elimination of the requirement to provide the diagnosis and treatment codes in benefit denial notices. Such notices must include a statement describing the opportunity to request the diagnosis and treatment codes. Upon request, the codes must be provided as soon as possible.
- Clarification of when plans must provide notices in a non-English language. Basically, the requirement to provide notices, on request, in a non-English language, is triggered if 10% or more of the population residing in the claimant’s county (based on the U.S. Census Bureau) are literate in the same non-English language.
- A limited exception to the strict compliance requirement for *de minimis*, non-prejudicial failures, which are beyond the plan’s control.
- A narrowing of the types of claims that are subject to external review during a suspension period to claims involving “medical judgment” (as determined by the external reviewer) or coverage rescission.

Although the 2011 guidance provided some welcomed relief from certain of the internal and external claims review process requirements, the rules, as modified, continue in effect beginning in 2012 for non-grandfathered plans.

Closure of Temporary Retiree Reinsurance Program

The Act established a temporary “early retiree” reinsurance program, which became effective in June of 2010. See [Health Care Reform - The Retiree Reinsurance Program](#) (issued June 2010). This program consisted of a \$5 billion reinsurance fund that was set up to reimburse employment-based plans for covered health expenses of retirees between the ages of 55 and 65 (and their dependents). The program is scheduled to end as of 2014 (or, if earlier, the date the fund is exhausted).

Because both governmental and private employers are eligible, it was thought that the fund would be exhausted well before 2014. As expected, HHS has recently announced that the program will not accept any reimbursement requests for claims incurred after December 31, 2011. See [December 9, 2011 Notice](#). However, claims incurred before 2011 year-end may still be submitted, even if they are paid in 2012.

State Taxation of Adult Child Coverage

As group health plans began implementing the new adult child coverage requirements, state income tax treatment of that coverage came to the fore. At the beginning of 2011, a number of states had not yet amended their income tax laws to adopt the Federal income tax exclusion for that coverage. This meant that until the state legislature or tax authorities took action, the cost of coverage for nondependent child was arguably taxable wages for state income tax purposes (and possibly subject to state income tax withholding requirements).

Fortunately, all affected states adopted conforming legislation (or their tax departments announced that the state would follow the Federal tax rules) by the Fall of 2011. Thus, adult child coverage is nontaxable in all states which generally follow the Federal tax code.

We welcome the opportunity to respond to any questions you may have regarding these or any other aspects of the Health Care Reform Act.

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