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2012 PPACA CHECKLIST

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While most of the design changes required for group health plans under the Patient Protection and Affordable Care Act, as amended ("PPACA"), became effective in 2010 or 2011, some additional requirements must be implemented for 2012.

All group health plans subject to PPACA must comply with the following requirements, regardless of its status as a "grandfathered health plan":

- **Provision of a Summary of Benefits**. The summary must include the information specified in the regulations but cannot exceed four double-sided pages. A summary must be provided to participants and beneficiaries as part of any written enrollment materials and a summary must be included for each benefit package offered for which the participant or beneficiary is eligible. However, upon renewal, only the summary for the benefit package in which the participant is enrolled needs to be furnished, unless the participant or beneficiary requests a summary for another benefit package. Unless an extension is granted, summaries must be issued no later than March 23, 2012. Instructions and a template of a draft summary of benefits is published in the Federal Register and can be viewed at http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21192.pdf.
- **W-2 Reporting Obligation**. Employers must begin reporting the aggregate cost of applicable employer-sponsored coverage on an employee's Form W-2 beginning with the Form W-2 issued in January 2013 for the 2012 tax year. Make sure that you have appropriate systems in place to collect and determine the value that must be reported. IRS Notice 2011-28, available at http://www.irs.gov/pub/irs-drop/n-11-28.pdf, provides interim guidance on the reporting requirements (including information on how and what to report).

If your group health plan is not grandfathered, the following additional requirements will also apply beginning in 2012:

- **Expanded Preventive Services**. PPACA requires plans to cover preventive services without any cost-sharing when delivered by in-network providers. New and revised services have been added to the Grade A and B Recommendations of the U.S. Preventive Task Force since September 23, 2009. A plan has up to the first plan year that begins on or after the one-year

anniversary of the effective date of the new or revised service to comply. Accordingly, calendar year plans will need to be in compliance with the recommendations that went into effect in 2010 beginning January 1, 2012. For more information about the preventive services that must be covered, visit http://www.healthcare.gov/center/regulations/prevention/recommendations.html.

Note that there will be new preventive care items required to be provided at no cost to women, including contraceptive methods and counseling, beginning in the first plan year that begins on or after August 1, 2012 (January 1, 2013 for calendar year plans).

- **Claims, Appeals and External Reviews**. The enforcement grace period for the internal claims and appeals and external review required under health care reform was extended only until plan years beginning on or after January 1, 2012. Therefore, plan sponsors will need to ensure that the appropriate arrangements have been taken for their plan to comply with such requirements, including updating existing summary plan descriptions to describe the new internal claims and appeals and external review procedures reflected in the interim final regulations issued in July 2010, as subsequently amended this past June.

Note that the amended appeals regulations require that a plan sending a notice to an address in a county in which at least 10% of its population is literate only in the same non-English language (based on data maintained by the U.S. Census Bureau) must:

- include a one-sentence statement in the English versions of all notices prominently displayed in the non-English language clearly indicating how to access the language services provided by the plan. Sample language appears in the DOL model notice of adverse benefit determination, which is available at http://www.dol.gov/ebsa/IABDModelNotice2.doc;
- provide oral language services (such as a telephone customer assistance hotline) that include answering questions in the applicable non-English language and providing assistance with filing claims and appeals (including external review) in the non-English language; and
- provide, upon request, a notice in any applicable non-English language.

The preamble of the amended appeals regulations (http://www.gpo.gov/fdsys/pkg/FR-2011-06-24/pdf/2011-15890.pdf) includes a chart of 255 counties in the United States and Puerto Rico that currently meet the 10% threshold. This information will be updated annually and posted on the websites of the U.S. Departments of Labor and Health and Human Services.

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