A look at the changes coming in 2012, 2013 & 2014.

Companies sponsoring group health plans should be aware of the changes coming to the health insurance industry as part of the “second stage” of health care reform. These major and minor adjustments should be kept on your radar.

What’s new for 2012? Insurers that issue group health plans will have to abide by some new requirements.

- Should plan benefits materially change, the plan issuer will have to provide notice in writing at least 6o days beforehand to plan sponsors and participants.
- Health care plan summaries will have to meet new formatting and content guidelines for clarity, and in the case of fully insured plans, the plan issuer must provide electronic or hard-copy summaries at designated times during the enrollment process.
- Group health plan participants could actually get rebates in 2012 under certain conditions. In 2011, insurers had to start notifying the Department of Health and Human Services of their medical loss ratios – that is, the percentage of premiums that they spend on clinical services and efforts to improve health care quality as opposed to administrative overhead. The minimum medical loss ratio is 80% for individual and small group insurers and 85% for large group insurers. If a plan issuer doesn’t meet this medical loss ratio test for 2011, it must issue rebates to enrollees beginning on August 1, 2012. [1,2]

What happens in 2013? There are four important changes scheduled for 2013 that employers

must recognize and publicize.

- Companies will have to disclose the value of employer-sponsored health insurance coverage to employees on W-2 forms for the 2013 tax year. (Big businesses are already doing this, but the IRS allowed a grace period for companies with less than 250 W-2 employees.)

- Companies will also be required to inform their workers about health care insurance exchanges, health care premium subsidies and free choice vouchers.
- There will be a $2,500 cap placed on annual flexible spending account (FSA) contributions, with COLAs in future years.
- Either the plan issuer or the plan sponsor must pay an annual per-member fee to the Patient-Centered Outcomes Research Institute for fiscal year 2013 (which starts October 1, 2012) and subsequent fiscal years. This annual fee equals $1 x the number of covered lives; in fiscal year 2014, it will double to $2 per covered life. [1,2]

What is scheduled to happen in 2014? The second stage of health care reform wraps up with a flourish in this year, with 10 significant changes. By this time, a whole new health insurance market is supposed to be in place and businesses will step into the “new world” of health care insurance.

- In 2014, firms with 50 or more employees will be required to offer a minimum level of health care coverage to active employees. So what exactly is minimum coverage? The federal government defines it using two criteria: the health plan chosen has to cover at least 60% of covered health care costs, and the plan can’t cost a worker more than 9.5% of his or her household income.
- If firms with 50 or more employees can’t meet this test, they will pay a penalty of $2,000-3,000 per employee. (Some companies may elect to do this.)
- New reporting requirements start for businesses. Employers will annually have to inform the IRS if they are offering minimum health care coverage or not, the duration of any waiting period, the number of FTEs per month covered and their names, addresses and taxpayer ID #s.

They will also have to report the monthly premium for the cheapest coverage option in each enrollment category and the employer's percentage of the total allowed cost of benefits under the plan.

- Your company might be eligible for the Small Business Health Care Tax Credit if a) it employs 25 or fewer FTEs (apart from owners or family members) whose annual wages are $50,000 or less and b) you pay 50% or more of the health care coverage for single workers.

- Also, the wellness program incentives cap rises from 20% to 30%, so here's another reason to encourage your workers to participate in wellness program (and to seek federal grant funding for said programs).
- Businesses with 200+ employees will be asked to automatically enroll all FTE and PTE into group health plans. (Employees may opt out.)
- As state health insurance exchanges are supposed to be up and running, you must provide a free choice voucher to qualifying employees in 2014.
- Employers cannot make employees wait more than 90 days for health insurance coverage in 2014, and non-grandfathered plans must also provide coverage for clinical trials related to life-threatening illnesses.
- The retiree reinsurance program reimbursing firms for up to 80% of qualifying retiree medical expenses will be gone in 2014 (and maybe before then if its funding runs out). [1,3,4]

Prepare yourself – and your business. You, your employees and whoever handles your payroll will have much to keep up with in the near future. So confer periodically with your group health plan adviser to stay up to speed.