Sterling Benefits, LLC

PREMIER PROVIDER OF EMPLOYEE & EXECUTIVE BENEFITS

Health Care Reform News ~ 2012

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Overview

The year 2012 is relatively light on reforms — apart from the legal battle — and several provisions have been delayed.

Much of the bill's main elements are still on pace to be implemented in 2014, including the creation of state-run health exchanges.

As changes and clarification become available, we will continue to update you with information and the implications of the state and federal mandates.

Some key provisions for Health Care Reform in 2012 include:

- W-2 reporting,
- Small Business Health Care Tax Credit—available through 2013,
- Uniform Summary of Benefits and Coverage (SBC) Forms and Notice of Material Modifications—DELAYED,
- Medical Loss Ratio Rebate,
- Quality of Care Reporting,
- Comparative Effectiveness Research Plan Fees, and
- Women's Preventive Services.

W-2 Reporting

Starting in tax year 2012 (for employers that issue over 250 W-2s), employers are required to report the value of applicable employer-sponsored health insurance coverage they provide employees on each employee's annual Form W-2. For those that issue less than 250 W-2s, reporting is optional until the 2013 tax year.

The amount reported does not affect tax liability, as the value of the employer contribution to health coverage is for informational purposes only and continues to be excludible from an employee's income, and it is not taxable.

The revised **Form W-2 for 2011** is now available for viewing online. The cost of employer-sponsored health coverage will be reported in Box 12, using Code DD.

IMPORTANT: This document is designed to provide a general overview of the new health reform law. It does NOT attempt to cover all of the law's provisions.

Small Business Health Care Tax Credit

In general, the Small Business Health Care Tax Credit is available to small employers that pay at least half the cost of single coverage for their employees. Eligible small businesses can claim the credit as part of the general business credit starting with the 2010 income tax return filed in 2011.

For tax years 2010 to 2013, the maximum credit is 35 percent of premiums paid by eligible small business employers and 25 percent of premiums paid by eligible employers that are tax-exempt organizations. The maximum credit goes to smaller employers — those with 10 or fewer full-time equivalent (FTE) employees — paying annual average wages of $25,000 or less. The credit is completely phased out for employers that have 25 FTEs or more or that pay average wages of $50,000 per year or more.

Small employers, whether businesses or tax-exempt organizations, will use IRS **Form 8941**, Credit for Small Employer Health Insurance Premiums, to calculate the small business health care tax credit.

Uniform Summary of Benefits and Coverage Forms & Notice of Material Modifications

PPACA will require health plans and health insurance issuers to begin providing a summary of benefits and Uniform Summary of Benefits and Coverage (SBC) or be subject to financial penalties. The health insurance carrier will provide the eight-page (four pages front & back) summary, but the employer will be required to provide the summary to eligible employees and their beneficiaries at initial enrollment, open enrollment, special enrollment, and upon request.

If a plan or insurer makes a mid-year material modification to coverage the plan or insurer must provide Notice of Material Modifications to enrollees no later than 60 days before the modification becomes effective. The notice requirement does not apply to modifications made in connection with a renewal of coverage. This new 60-day requirement does not mean that all plan amendments require advance notice (only those plan amendments that would cause a corresponding change to the SBC).

The original compliance deadline of March 23, 2012, has been delayed until after the Department of Labor (DOL) releases its final regulations.

DOL stated that "until final regulations are issued and applicable, plans and issuers are not required to comply with section 2715 of the Public Service Act." The final rule will be issued "as soon as possible." The DOL also noted that the final regulations, once issued, will take into consideration the timing required to comply.

For more information visit the DOL website **http://www.dol.gov/**.

Medical Loss Ratio Rebate

Beginning in 2011, the law required insurance companies in the individual and small group markets to spend at least 80 percent of the premium dollars they collect on medical care and quality improvement activities. Insurance companies in the large group market must spend at least 85 percent of premium dollars on medical care and quality improvement activities. Insurance companies must report their Medical Loss Ratio (MLR) data to HHS on an annual basis so that residents of every State will have information on the value of health plans offered by different insurance companies in their State.

Issuers that don't meet the minimum MLR (80% for small group) during the calendar year will need to pay rebates by August 1 of the following year. The first rebate payments, if any, must be made by August 1, 2012. The final rule directs issuers to provide rebates to the group policyholder (usually the employer) through lower premiums or in other ways that are not taxable. This process will vary by plan type. Policyholders must ensure that the rebate is used for the benefit of subscribers. The final rule also requires that issuers provide notice of rebates to enrollees and the group policyholder. All enrollees must be given information about the MLR and its purpose, the MLR standard, the issuer's MLR, and the rebate provided.

Quality of Care Reporting

Not later than March 23, 2012, HHS is required to develop reporting requirements for all non-grandfathered health plans and healthcare provider reimbursement structures that affect the quality of care. Group health plans and health insurance issuers will submit an annual report to HHS and will be provided to participants at the time of each open enrollment period.

This reporting is to include information relating to improving health outcomes through "quality reporting," effective case management, care coordination, chronic disease management, and medication and care compliance initiatives; activities to prevent hospital readmissions (including through education and counseling); activities to improve patient safety and reduce medical errors through use of best clinical practices, evidence based medicine, and health information technology; and wellness and health promotion activities.

The reporting requirements are still being developed and may be later enforced by "appropriate penalties" developed by HHS.

Comparative Effectiveness Research Plan Fees

For plan/policy years ending after September 30, 2012, and before October 1, 2019, the plan issuer or sponsor will pay a fee to partially support the Patient-Centered Outcomes Research Institute. In the first year, the annual fee will be $1 multiplied by the average number of covered lives. In the second year, it will increase to $2 multiplied by the average number of covered lives.

Women's Preventive Services

Under the Affordable Care Act, women's preventive health care – such as mammograms, screenings for cervical cancer, prenatal care, and other services – is covered with no cost sharing for new health plans.

On August 1, 2011, the Department of Health and Human Services (HHS) adopted additional Guidelines for Women's Preventive Services recommended by the independent Institute of Medicine (IOM) and based on scientific evidence that will be covered without cost sharing in plan years starting on or after August 1, 2012.

Additional women's preventive services that will be covered without cost sharing requirements include:

- **Well-woman visits:** This would include an annual well-woman preventive care visit for adult women to obtain the recommended preventive services, and additional visits if women and their providers determine they are necessary.
- **Gestational diabetes screening:** This screening is for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
- **HPV DNA testing:** Women who are 30 or older will have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of pap smear results.
- **STI counseling, and HIV screening and counseling:** Sexually-active women will have access to annual counseling on HIV and sexually transmitted infections (STIs).
- **Contraception and contraceptive counseling:** Women will have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. These recommendations do not include abortifacient drugs. *Group health plans sponsored by certain religious employers may be exempt from the requirement to cover contraceptive services.*
- **Breastfeeding support, supplies, and counseling:** Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment.
- **Domestic violence screening:** Screening and counseling for interpersonal and domestic violence should be provided for all women.

Plans will retain the flexibility to control costs and promote efficient delivery of care by, for example, continuing to charge cost sharing for branded drugs if a generic version is available and just as effective and safe.

The full list of covered preventive services can be found online at **www.healthcare.gov**.

HealthCare Reform Lawsuits & Decisions

On November 14, 2011, the United States Supreme Court announced that it will hear arguments relating to various constitutional challenges to the Patient Protection and Affordable Care Act (PPACA). A decision will be issued before its term ends in June 2012, in the middle of a Presidential election year.

The Court has agreed to review four questions that were raised in various lower court challenges to the PPACA (*National Federation of Independent Business, et al., v. Sebelius; U.S. Dept of Health and Human Services, et al., v. Florida; et al., Florida, et al., v. HHS*)

- **Individual Mandate:** Did Congress exceed its authority under the Commerce Clause of the Constitution in requiring that individuals maintain "minimum essential coverage" beginning in 2014, or pay a tax assessment?
- **Severability:** If the individual mandate provision is nullified as unconstitutional, is it "severable" from the rest of the legislation, or will some or all or the other PPACA provisions also be nullified?
- **Anti-injunction Act**: Are private individuals and states procedurally barred from challenging the constitutionality of the individual mandate by the Anti-Injunction Act, which prohibits legal challenges to taxes until after the tax is collected?
- **Medicaid**: Did Congress exceed its constitutional authority in expanding the Medicaid program

The *Commonwealth of Virginia, et al., v. Sebelius* petition was not before the Justices. (On September 8, 2011, the U.S. Court of Appeals for the Fourth Circuit in Richmond, Virginia sided with the federal health reform law on procedural grounds, dismissing or "vacating" two separate earlier District Court cases where the district judge ruled that the individual mandate is unconstitutional, but severable from the rest of the law, which could stand. Virginia Attorney General Kenneth Cuccinelli announced on September 8 that he would appeal to the U.S. Supreme Court.)

Virginia's Health Reform Initiative

Every Virginian needs access to appropriate and affordable health care. The challenge the Commonwealth faces is how to provide that access in an economically responsible manner. The purpose of the Virginia Health Reform Initiative is to go beyond federal health reform and recommend other innovative healthcare solutions that meet the needs of Virginia's citizens and government.

To read more about Virginia's Health Reform Initiative, please visit:
http://www.hhr.virginia.gov/Initiatives/HealthReform/index.cfm.

Required PPACA Grandfathered Notice

For groups with plan years or policy years beginning on or after September 23, 2011, only Grandfathered groups are required to distribute the PPACA Grandfathered Notice. (No other notices are required at this time.) Grandfathered status can be lost when there is significant reduction of benefits, increased out-of-pocket spending for employees, and changing from insurance carriers.

You can obtain and modify the notice on the **Department of Labor Website** or as a **Sample Notice** on our website.

Model Language Notice Grandfathered Health Plan

This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

The Pre-Existing Condition Insurance Plan

For those that have had a hard time finding health insurance because of a pre-existing condition or if they've been turned down for insurance coverage may be eligible for the Pre-Existing Condition Insurance Plan.

This program is available for children and adults who have been locked out of the health insurance market because of a pre-existing condition. To qualify, you must: be a citizen of the United States or residing here legally, have been uninsured for at least 6 months, and have a pre-existing condition or have been denied insurance coverage because of a medical condition.

The insurance coverage will provide a wide range of medical benefits including physician's services, hospital care, and prescription drugs. Like standard health insurance plans, there will be a monthly premium, a deductible, and some cost-sharing expenses. Pre-existing conditions will be covered, higher premiums will not be charged because of a medical condition, and eligibility is not based on income.

To learn more about this program, including how to apply, go to "Find Your State" at **www.pcip.gov**.

Key Provisions in 2013 & 2014

2013

- W-2 Reporting mandatory for all employers
- Prohibition on insured plans discriminating in favor of highly compensated individuals
- Health Flexible Spending Accounts - $2,500 limit
- Additional Medicare Tax on wages that exceed a threshold amount and on Unearned Income
- Itemized Deductions for Medical Expenses Increased to 10%
- Employers to provide Notice of Exchange and Notices of Premium Subsidies

2014

- Individual Mandate - Individuals will be required to obtain minimum essential coverage, with the penalty for noncompliance being the greater of $95 per individual or 1% of household income over the filing threshold (will rise to $695 or 2.5% in 2016).
- Individual subsidies will be made available.
- A plan must not apply a waiting period that exceeds 90 days
- A plan may not impose any pre-existing condition exclusion
- Employers with 50 or more full-time employees must offer minimum coverage to active employees and will be subject to penalties if they don't provide minimum coverage or if they provide coverage that is not "affordable".
- Employers will be required to report coverage information to the IRS annually. Reporting employers must also provide a related written statement to their full-time employees.
- Employers with more than 200 full-time employees must automatically enroll new full-time employees in health insurance plans
- The small group market must use the modified community rating. Rates are based on these factors only - Age (rates for highest age band no more than 3 times rates for lowest age band), Tobacco use (rates for tobacco users no more than 1.5 times rates for nontobacco users), Geography, Family tier.
- Cost-sharing limits on deductibles, co-insurance, copayments or similar charges, and any other required expenditure which is a qualified medical expense with respect to essential health benefits covered under the plan.
- Each health insurance issuer that offers health insurance coverage in the individual or group market is required to accept every employer and individual in the state that applies for such coverage.
- Insurers are permitted to impose employer contribution and minimum participation requirements within certain limitations.
- States will begin to operate health insurance exchanges. Small employer tax credits will be available only in the exchanges. Employers will also be able to purchase coverage outside of the exchanges .

Sterling Benefits, LLC

PREMIER PROVIDER OF EMPLOYEE & EXECUTIVE BENEFITS

4356 Bonney Road
Building 2, Suite 101
Virginia Beach, VA 23452-1200

Phone: 757-624-5200
Fax: 757-624-5215

Visit us online:
www.SterlingBenefit.com

IMPORTANT: This document has been compiled from numerous sources and is designed to provide a general overview of the new health reform law. It does NOT attempt to cover all of the law's provisions and should NOT be used as legal advice for implementation activities.

We encourage you to seek any professional advice, including legal counsel, regarding how the new requirements will affect your specific plan.

Links - Further Reading

HR 3590 – Patient Protection and Affordable Care Act.

HR 4872 – Health Care and Education Reconciliation Act.

HealthCare.gov

HHS – The U.S. Department of Health and Human Services.

IRS – The federal Internal Revenue Service.

White House Fact Sheets

Healthcare Reform Website

www.healthreform.gov has been archived. The new website is:

HealthCare.gov