Sterling Benefits, LLC

PREMIER PROVIDER OF EMPLOYEE & EXECUTIVE BENEFITS

Health Care Reform News ~ 2013

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Overview

With the Supreme Court Ruling and the Elections behind us, the majority of the obstacles to the implementation of the Affordable Care Act (ACA) have been cleared. The question is no longer if, but when and how ACA will be established in each state.

The main provisions of ACA, Exchanges and Subsidies, are **scheduled** to go into effect January 1, 2014.

Some key provisions for Health Care Reform new in 2013 and provisions from prior years impacting 2013 include:

- Exchange/Marketplace Creation,
- Employer Exchange Notices—DELAYED,
- New Taxes, Limits, and Fees,
- Uniform Summary of Benefits and Coverage (SBC) Forms and Notice of Material Modifications,
- Women's Preventive Services,
- Medical Loss Ratio Rebate,
- W-2 Reporting, and
- Small Business Health Care Tax Credit—available through 2013.

As changes and clarification become available, we will continue to update you with information and the implications of the state and federal mandates. In 2013, we anticipate a lot of communications from various Government Agencies regarding intent, interpretation, and guidance of the ACA regulations.

As part of our ongoing commitment to keep you informed, Sterling Benefits has added a resource to release the latest updates in a timely manner without inundating you with emails. We encourage you to read our **News Feed** at your leisure or you may subscribe to the "blog" to receive a weekly digest of any communications.

Sterling Benefits Reform News Feed

http://sterlinghcr.blogspot.com/

PCIP Enrollment Suspension

On February 16, 2013, the federally-run Pre-Existing Condition Insurance Plan (PCIP) suspended acceptance of new enrollment applications until further notice. State-based PCIPs may continue accepting enrollment applications through March 2, and will then suspend acceptance of new enrollment applications until further notice. PCIP will continue providing coverage to more than 100,000 people currently enrolled nationwide.

This suspension will help ensure that funds are available through 2013 to continuously cover people currently enrolled in PCIP.

Exchanges – Online Insurance Marketplace

The ACA requires Public Exchanges, referred to as Marketplaces, to be established in each state by January 1, 2014. Exchanges may be operated by the state or federal government or as a partnership between a state and the federal government. Virginia has opted for the Federal Exchange.

Exchanges will open beginning October 1, 2013, offering coverage beginning January 1, 2014. Between 2014 through 2016, only individuals and employers in the small group market are eligible to participate in an Exchange. Small groups will be defined as businesses with up to 100 employees, although until 2016 a state may choose to limit the definition to businesses of up to 50 employees. The definition for large groups will remain as businesses with more than 100 employees.

Employees meeting certain requirements who cannot afford the coverage provided by their employer may purchase a plan in the Exchange. Employers with at least 50 full-time employees who decide not to offer a health benefit plan to their employees, and instead leverage the Exchange, are subject to penalties referred to as the employer mandate.

The scheduled implementation of Exchanges next year has been called into doubt because of the complexity of the law and opposition in some states. Many provisions remain unclear at this time as various government agencies are working to provide interpretations and guidance on the law.

Exchange Notice—2013

The deadline for employers to notify employees of the availability of Exchanges has been **delayed** from March 1, 2013, to late summer or fall of 2013. The Department of Labor is considering providing model, generic language that could be used to satisfy the notice requirement. Future guidance on complying with the notice requirement under the Fair Labor Standards Act (FLSA) section 18B is expected to provide flexibility and adequate time to comply.

Health FSAs—2013

For plan years starting in 2013, Health FSAs have a $2,500 salary reduction contribution limit. This limit is indexed for inflation. Plan documents and Summary Plan Descriptions must be revised.

Medicare Tax—2013

Starting in 2013, employers must withhold an additional 0.9% FICA tax on wages above $200,000 ($250,000 if married). There is an additional 3.8% surtax of certain investment income for high income taxpayers.

Itemized Deduction for Medical Expenses—2013

Starting with the year 2013, the 7.5% threshold for the itemized deductions of health expenses will increase to 10% of adjusted gross income. If age 65 or older in 2013, the threshold remains at 7.5% through 2016.

Comparative Effectiveness Research Plan Fees—2013

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 Patient-Centered Outcomes Research (PCOR) fee will be $1 multiplied by the average number of covered lives. In 2013, the fee increases to $2 per member per year and will increase annually through 2019.

The insurer pays the fee for insured group health plans and individual health insurance policies. The plan sponsor (i.e., generally the employer) pays the fee for self-insured group health plans. Insurers and plan sponsors must use IRS Form 720 to report the fee and must pay the fee annually by July 31 for all plan years ending in the preceding calendar year.

Transitional Reinsurance Contribution—2013

This is a fund for state-based non-profit reinsurance entities that will administer a high-risk pool for the individual market beginning 2014 and ending 2016. The fee for 2013 is $63 per member per year, prorated for every month a group plan extends into 2014 and will decrease annually through 2016.

Health Insurer Fee—2013

This fee subsidizes PPACA costs. It is based on a percentage of premiums and begins in 2014. The fee will be prorated for every month a group plan extends into 2014. The 2013 assessment is anticipated to be .60% of the HMO premium and 1.40% of the PPO premium. It's a permanent fee that will increase annually.

ACA Already in Effect

2012 Provisions that impact 2013 group renewals

- **Summary of Benefits and Coverage Forms and Notices of Material Modifications**—SBCs must be provided for affected plans, effective for Open Enrollment periods starting on or after September 23, 2012. SBCs must be provided to applicants and enrollees by the employer before enrollment or re- enrollment or be subject to financial penalties. The SBC must accurately describe the benefits and coverage under the applicable plan or coverage. Notices of Material Modifications must be provided 60 days prior to any mid-year plan changes. **Hot Topic**

- **Women's Preventive Services**—Expanded women's preventive services that will be covered in plan years starting on or after August 1, 2012 without cost sharing requirements include: Well-woman visits; Gestational diabetes screening; HPV DNA testing; STI counseling, and HIV screening and counseling; Contraception and contraceptive counseling; Breastfeeding support, supplies, and counseling; and Domestic violence screening. **Newsletter**

Past Provisions that impact groups on an ongoing basis

- **Medical Loss Ratio Rebate**—If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality during the calendar year, the insurer must rebate the difference (rebate) by August 1 of the following year. Carriers are required to provide notice of rebate to the enrollees and the group policyholder. Employers receiving rebates can use the rebates to lower future premium rates or give each enrollee a portion of the rebate amount. **Newsletter**

- **Patient protections—**Preventive care, adult child coverage, prohibitions on rescissions of coverage, gradual elimination of annual and lifetime limits, and the Pre-existing Condition Insurance Plan. **Newsletter**

- **W-2 Reporting—**Large businesses required to track the cost of health care coverage on Form W-2, starting with the 2012 tax year. Businesses that filed fewer than 250 W-2s for the 2011 tax year are currently exempt until the IRS indicates otherwise. **Newsletter**

- **Benefits—**Flexible benefits (FSAs and HSAs) require a prescription on over-the-counter drugs and medicine for tax-free reimbursement. The HSA excise tax is still 20 percent for non-qualifying distributions. **Newsletter**

- **Small Business Tax Credit—**The tax credits are still available; they are worth up to 35% of employer contribution. These credits increase in 2014 to 50%. **Hot Topic**
    - ***Update***—Due to sequestration, the IRS announced on 3/6/2013, that the refundable portion will be reduced by 8.7% until Congressional action or the end of the Fiscal Year.

Key Provisions in 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.
- Pay or Play Mandate—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

SterlingHCR.blogspot.com NEW

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