Sterling Benefits, LLC

PREMIER PROVIDER OF EMPLOYEE & EXECUTIVE BENEFITS

Health Care Reform Update ~ 2012

Issued: 7/20/2012

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Overview—Supreme Court Ruling

On June 28, 2012, The Supreme Court upheld the constitutionality of President Barack Obama's Patient Protection and Affordable Care Act (ACA), including the most disputed part: the mandate that virtually all Americans have health insurance or pay a fine. **The mandate was upheld under the federal government's power to levy taxes under Article 1 of the Constitution.**

Chief Justice John Roberts sided with the court's four liberal justices — Stephen Breyer, Ruth Bader Ginsburg, Elena Kagan and Sonia Sotomayor — to form the 5-4 majority. Chief Roberts indicated in the majority opinion that since the mandate requires individuals to purchase health insurance or make a shared responsibility payment, it does not regulate existing commercial activity, but instead compels individuals to become active in commerce by purchasing a product. He reasoned that Congress is not permitted to regulate such inactivity, but only commercial activity. If Congress could regulate inactivity, it would justify a mandatory purchase to solve any problem.

In another part of the decision, the Supreme Court held that the Act's Medicaid eligibility expansion provisions were unconstitutional because the government cannot coerce states to expand Medicaid by threatening to withhold existing federal Medicaid funds. As a result of this decision, even non-participating states must still receive existing Medicaid funding. The Supreme Court also decided that the unconstitutional part of the Medicaid provisions could be severed and remedied, leaving the remainder of the statute fully operable.

The 2010 health care law will continue phasing in as planned. Some parts are already in effect: Young adults can stay on their parents' insurance up to age 26; Insurers can't deny coverage to children with health problems; Limits on how much policies will pay out to each person over a lifetime are eliminated; Seniors have improved Medicare prescription benefits; and co-payments for preventive care have been eliminated.

Much of the Act'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.

Politics & Ongoing Issues

An estimated 26 million people will remain without health coverage once the law is fully implemented, including illegal immigrants, people who don't sign up and elect to face the "tax" instead, and those who can't afford it even with the subsidies. (The first-year Individual Mandate tax is 1% (approximately $95 per person) the Employer penalty is $2,000 annually per employee for groups with over 50 employees.)

In 2009, President Obama and Democrats predicted the ACA to cost $900 billion over 10 years. Republicans recently released an estimated cost of $2.6 trillion over 10 years. (Senate Republican Committee on the Budget Press Release.)

On July 11, 2012, House Republicans voted for the 33rd time to dismantle ACA. The vote passed 244 to 185, with five Democrats breaking ranks. The Bill will likely be blocked in the Democrat-controlled Senate.

Some States want to opt out of the Medicaid expansion (Colorado, Florida, Indiana, Iowa, Louisiana, Maine, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, Ohio, Pennsylvania, South Carolina, Texas, Virginia, and Wisconsin)—due to the uncertainty about startup and future costs.

Some States are opting out of or delaying implementing State health insurance exchanges. Sen. Jim DeMint (R-S.C.) and Rep. Michele Bachmann (R-Minn.) sent a letter to all 50 governors urging states to oppose the creation of the health insurance exchanges. The letter tells governors, "By refusing to create an exchange, you will assist us in Congress to repeal this violation which will help lower the costs of doing business in your state". Twelve Republican senators and more than 60 GOP House members signed the letter ahead of the House vote on July 11. Sixteen states have committed to creating an exchange.

Expect November Elections to be interesting with Romney and Republican congressional candidates campaigning on promises to repeal ACA within their first 100 days of office if elected.

ACA Already in Effect

- **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.
- **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.
- **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.
- **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%.

Medical Loss Ratio Rebate—2012

The Affordable Care Act requires health insurers in the individual and small group markets (2 to 50 employees) to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market (51+ employees), this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. 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, the insurer must rebate the difference.

In Virginia here are the carriers giving rebates: Aetna - Small and Large group, Anthem - Individual and Small group PPO plans (No HMO rebates), CareFirst - Small and Large group, Guardian - Small and Large group, Optima - Individual only, Southern Health - Small group only, United Healthcare MidAtlantic - Small and Large group.

Carriers will send the required notification and rebate check (if applicable) as required by law. Enrollees in the employer health plans will also receive a notification. Under ACA, employers must use any rebate they receive to benefit those subscribers covered during the MLR reporting year on which the rebate is based. Generally, employers can use rebates to reduce future premiums or issue a payment to their employees. Employer groups that decide to pay rebates directly to their employees (subscribers) should base their payment on the percentage of total premium that was paid by the employee, prorated for the period of time the employee was covered under the plan. For example, a full-time employee covered throughout 2011 who contributes 20% of the premium for her coverage would receive 20% of the rebate due on her portion of the total premium (and rebate) paid.

You should consult with your tax adviser as to whether there are any tax implications in receiving a rebate. The IRS has recently issued an article with scenarios http://www.irs.gov/newsroom/article/0,,id=256167,00.html.

For more information on the MLR please visit www.HealthCare.gov.

Women's Preventive Services—2012

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.

Additional 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.

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

Summary of Benefits and Coverage Forms—2012

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 Summary of Benefits and Coverage must be provided for affected plans, effective for open enrollment periods starting on or after September 23, 2012. The SBC applies to fully insured and self-insured medical plans, including stand-alone HRAs. It does not apply to Health FSAs, HSAs or other HIPAA-excepted benefits (e.g., stand-alone dental or vision). This requirement is in addition to the Summary Plan Description (SPD).

The health insurance carrier will provide the eight-page (four pages front & back) summary (Sample SBC), but the employer will be required to provide the summary to eligible employees and their beneficiaries:

- Within seven business days of a request or application.
- As part of enrollment materials—the plan must provide the SBC no later than the first day on which the individual is eligible to enroll.
- As part of renewal / open enrollment materials—the SBC must be provided no later than 30 days prior to the first day of the new plan year.
- Upon a material modification during the policy period (i.e., not at renewal).

The SBC may be provided electronically if: The format is readily accessible; The SBC is provided in paper form free of charge on request; The electronic form is an Internet posting; and the insurer or group health plan: Timely notifies the pre-enrollee in paper form (such as a postcard) or email that the documents are available on the Internet, Provides the Internet address to the pre-enrollee, and Notifies the pre-enrollee that the documents are available in paper form on request.

There is a fine of up to $1,000 per consumer where the issuer or plan willfully fails to provide the SBC. In addition, the SBC regulations explicitly authorize the state department of insurance to impose fines in accordance with that state's regulatory framework. If the state fails to act, then HHS or the DOL can step in and issue a fine of $100 per day per affected individual (this fine is in addition to the fine referenced above for willful conduct) until the SBCs are properly issued.

We will pass along carrier specific details as they become available.

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 percent FICA tax on wages above $200,000. There is an additional 3.8 percent FICA tax on unearned 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.

Exchange Notice—2013

No later than March 1, 2013, employers must notify all current employees about state exchanges, including the right to purchase coverage through the exchange and their possible eligibility for subsidies. This notice must also be provided to new employees hired after that date. Guidance from the U.S. Department of Health and Human Services is still pending.

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 the second year, it will increase to $2 multiplied by the average number of covered lives.

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.

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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