SIHO INSURANCE SERVICES

Health Care Reform Update

December 31, 2012

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As you know, the Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. Since that time SIHO has been sending periodic e-news regarding the provisions of the bill. In order to provide structure, the following timeline will be included with each newsletter; In addition, each newsletter will provide clear and pertinent information about a selected few topics from this timeline **and will be highlighted in red.**

Immediately

- Grandfather Status
- Small Business Health Insurance Tax Credit
- Reinsurance Program for Early Retiree Health Coverage (June 1, 2010)
- High-Risk Pool Coverage (July 1, 2010)
- Health Insurance Informational Portals (July 1, 2010)

Plan Years Starting on or after September 23, 2010

- Dependent Coverage through Age 26
- No Pre-Existing Condition Exclusions for Children
- No Lifetime Benefit Limits and "Restricted" Annual Limits
- No Rescissions (except Fraud)
- All Emergency Services Covered In-Network*
- No Cost Sharing for Specific Preventive Services*

Note: *Indicates provision does not immediately apply to Grandfathered Group Health Plans.

2011-2013

- Increased tax on HSA and MSA Withdrawals not used for Medical Expenses
- Public Long-Term Care Program
- Medical Loss Ratio (MLR) Requirements
- **Comparative Effectiveness Studies Begin**
- **All Group Plans Must Report Benefits to HHS**
- Additional Medicare Tax Levied onto High Income Individuals

2014 and Beyond

- Exchanges
- Annual Taxes on Private Health Insurers
- Monetary Penalties for any Individual Failing to Purchase Coverage
- Expanded Medicaid and Tax Credits for Low Income Individuals
- Employer Responsibility Requirements and Free Choice Vouchers
- Guarantee Issue and Guarantee Renewal
- Pre-Existing Exclusions, Annual Limits, and Lifetime Limits Eliminated
- Restricted Underwriting Factors
- Wellness Program Changes
- Excise Tax (2018)

Patient-Centered Outcomes Research Institute (PCORI) Fee

The Patient-Centered Outcomes Research Institute was established as part of the Affordable Care Act (ACA) to assess fees to fund research for self-insured groups. Plans ending on or after October 1, 2012 are required to pay one dollar multiplied by the average number of covered lives on the plan for the plan year. The fee increases to two dollars multiplied by the average number of covered lives on the plan during that plan year for all self-insured plan years ending on or after October 1, 2013 through October 1, 2014.

If your 2012 plan ends on December 31, your first return will not be filed until July 31, 2012, according to IRS.gov. Different methods can be used to calculate the average number of covered lives on your plan and include the actual count method, the snapshot method and the member months method.

"First, an issuer may determine the average number of lives covered under a policy for a policy year by calculating the sum of lives covered for each day of the policy year and dividing that sum by the number of days in the policy year (the actual count method)," according to IRS.gov. "Second, an issuer may determine the average number of lives covered under a policy for a policy year by adding the total number of lives covered on one date in each quarter of the policy year, or an equal number of dates for each quarter, and dividing the total by the number of dates on which a count was made (the snapshot method). Third, as an alternative to determining the average number of lives covered under each individual policy for its respective policy year, an issuer may determine the average number of lives covered under all policies in effect for a calendar year based on the "member months" reported on the Exhibit divided by 12 (the member months method)."

Click on the links below for more information.

IRS Interim Final Rule
Comparative Effectiveness Intent

W-2 Reporting of Aggregate Employer Cost of Health Care Coverage

The Affordable Care Act (ACA) established new requirements for reporting employer-provided health care coverage on Form W-2. New guidance, Notice 2012-9, has been issued and provides updates and clarifies information about the requirements, restating and superseding the information previously provided in Notice 2011-28, according to irs.gov.

"Reporting the cost of health care coverage on the Form W-2 does not mean that the coverage is taxable. The amount reported does not affect tax liability," according to irs.gov. "The value of the employer's excludable contribution to health coverage continues to be excludable from the employee's income. The new reporting requirement is for informational purposes only and will provide employees useful and comparable consumer information on the cost of their health care coverage.

W-2 forms must be provided to employees for the 2012 calendar year, which will typically be provided in January 2013.

According to irs.gov, employers will not be required to issue this form to retirees or any other former employees to whom the employer does not otherwise issue the W-2 form.

More information, including the IRS interim guidance, is provided in the links below.

IRS Notice 2012-09
Additional W-2 Information

Summary of Benefits and Coverage (SBC)

Health insurance issuers and group health plans are required to provide an easy-to-understand summary about a health plan's benefits and coverage. The new regulation is designed to aid consumers to better understanding and evaluate health insurance choices.

The new forms include:

- A short, plain language Summary of Benefits and Coverage (SBC)
- A uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment"

All insurance companies and group health plans must use the same standard SBC form to assist in comparing health plans. The SBC form also includes "coverage examples", which are comparison tools that allow an individual to see what the plan would generally cover in two common medical situations. The SBC must be provided when shopping for or enrolling in coverage and a copy must be provided if requested from an issuer or group health plan. The Uniform Glossary of Terms must be provided with the SBC by the health insurance company or group health plan.

Additional information is available by clicking on the link below.

SBC Information

Flexible Spending Account (FSA) Limit

The Internal Revenue Service (IRS) issued FSA guidance on the new $2,500 limit on pretax employee contributions to health care flexible spending accounts beginning on January 1, 2013. The regulation, which only applies to salary reduction contributions, will take effect for new plan years beginning on or after January 1.

The Patient Protection and Affordable Care Act (PPACA) currently requires a doctor's prescription or a letter of medical necessity from a physician in order to use FSA money for Over-The-Counter (OTC) medications. Congress is considering legislation that would reverse the ban on OTC items including aspirin, acid reflux medication and allergy medications.

Click on the link below for additional information.

2013 Flexible Spending Accounts

Please be advised that some regulations surrounding this legislation have not yet been finalized. The advice found within this newsletter should never be interpreted as legal advice.

You are receiving this message as courtesy of the SIHO Insurance Services Communications Team. If you have questions or comments specific to newsletter distribution, please contact Debbie Holman (Debbie.Holman@siho.org). If you wish to be removed from this newsletter, please reply directly to this message asking to 'unsubscribe'

For past issues and more on health care reform: http://www.siho.org/en/HCR/