Sterling Benefits, LLC

PREMIER PROVIDER OF EMPLOYEE & EXECUTIVE BENEFITS

Health Care Reform News ~ 2011

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Overview

Twenty-one new provisions of the national health reform law take effect in the coming year, ranging from extra money for wellness programs to subsidies for creative attempts at tort reform.

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 coming online in 2011 include:

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 in 2010. The credit is specifically targeted to help small businesses and tax-exempt organizations that primarily employ low- and moderate-income workers. 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.

Health Coverage for Older Children

Health coverage for an employee's children under 27 years of age is now generally tax-free to the employee. These changes immediately allow employers with cafeteria plans — plans that allow employees to choose from a menu of tax-free benefit options and cash or taxable benefits — to permit employees to begin making pre-tax contributions to pay for this expanded benefit. This also applies to self-employed individuals who qualify for the self-employed health insurance deduction on their federal income tax return. Learn more by reading the IRS notice.

Changes to Over-the-Counter Medications

Effective Jan. 1, 2011, the cost of an over-the-counter medicine or drug cannot be reimbursed from Flexible Spending Arrangements or health savings or reimbursement arrangements unless a prescription is obtained. The change does not affect insulin, even if purchased without a prescription, or other health care expenses such as medical devices, eye glasses, contact lenses, co-pays and deductibles. The new standard applies only to purchases made on or after Jan. 1, 2011, so claims for medicines or drugs purchased without a prescription in 2010 can still be reimbursed in 2011, if allowed by the employer's plan. A similar rule goes into effect on Jan. 1, 2011 for Health Savings Accounts (HSAs). Employers and employees should take these changes into account as they make health benefit decisions for 2011.

For more information, see news release IR-2010-95, Notice 2010-59, Revenue Ruling 2010-23 and our questions and answers.

Tax penalty increase for non-medical HSA

Money removed from an HSA and not used on qualified medical expenses will be taxed 20%. That's an increase of 10%. This change begins for disbursements made during tax years starting on or after January 1, 2011.

Nondiscrimination Testing Delayed

The Affordable Care Act establishes a number of new requirements for group health plans. Interim guidance on changes to the nondiscrimination requirements for group health plans can be found in Notice 2011-1, which provides that employers will not be subject to penalties until after additional guidance is issued. Other information on requirements is available on the websites of the Departments of Health and Human Services and Labor and in additional guidance.

Employer-Provided Health Coverage — Reporting Requirement Optional in 2011

Starting in tax year 2011, the Affordable Care Act requires employers to report the value of the health insurance coverage they provide employees on each employee's annual Form W-2. However, to provide employers the time they need to make changes to their payroll systems or procedures in preparation for compliance with this requirement, the IRS will defer the reporting requirement for 2011, making that reporting by employers optional in 2011.

This reporting is for informational purposes only, to show employees the value of their health care benefits so they can be more informed consumers. The amount reported does not affect tax liability, as the value of the employer contribution to health coverage continues to be excludible from an employee's income, and it is not taxable.

The revised Form W-2 for 2011 is now available in draft for viewing. This is the W-2 that most employees will receive in early 2012. The draft form includes the codes that employers may use to report the cost of coverage under an employer-sponsored group health plan.

The Pre-Existing Condition Insurance Plan— New Coverage Option for the Uninsured

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 now be eligible for a new government program-- the Pre-Existing Condition Insurance Plan.

This transitional program is available for children and adults in all 50 states and the District of Columbia 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.

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.

HealthCare Reform Lawsuits & Decisions

On January 19, 2011, the Republican-controlled House of Representatives passed a bill to repeal health care reform legislation. On February 2, 2011, the U.S. Senate defeated an amendment that would have repealed the Patient Protection and Affordable Care Act (PPACA) in its entirety. The vote was along party lines, with all 47 Republicans voting to repeal and 51 Democratic Senators voting not to repeal.

On Jan. 31, 2011, in response to the lawsuit filed in March 2010 by Florida and joined by 25 other states, Florida U.S. District Court Judge Roger Vinson, declared the "individual mandate" of the Patient Protection and Affordable Care Act (PPACA) unconstitutional, ruling the government cannot require Americans to purchase health insurance. Vinson concluded that, "Because the individual mandate is unconstitutional and not severable, the entire act must be declared void."

The Department of Justice will appeal the decision in this case. The Supreme Court is expected to rule on the constitutionality of the individual mandate, probably in 2012.

In December 2010, a Virginia federal district court decided against the individual mandate, but didn't declare the entire law unconstitutional. Two earlier decisions in Virginia and Michigan found the mandate constitutional. Other cases are pending while several other lawsuits have been dismissed.

It's likely to be some time before there's a final decision. Unless and until the Supreme Court decides otherwise, the law remains in effect.

Healthcare Reform Website

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

HealthCare.gov

REMINDER ~ Required PPACA Notices

Here are a list of Notices that you must provide to all of your employees (and COBRA or state continuation enrollees), as required by the PPACA.

You can obtain and modify the notices on the Department of Labor Website (click the Notice name below). For your convenience, we have also compiled them as a **Sample Notice** on our website.

Model Language for Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the first plan year beginning on or after September 23, 2010.] For more information contact the [insert plan administrator or issuer] at [insert contact information].

Model Language Notice Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under [Insert name of group health plan or health insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator or issuer] at [insert contact information].

Model Language Notice Patient Protection Disclosure

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

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.]

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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 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.

As of September 23, 2010

Beginning with plan years or policy years beginning on or after September 23, 2010...

Examples:

- Group's plan year start date is July 1, 2010 then the changes must be implemented July 1, 2011.
- Group's plan year start date is September 1, 2010, then the changes must be implemented September 1, 2011.
- Group's plan year start date is October 1, 2010, then the changes must be implemented October 1, 2010.
- Group's plan year start date is December 1, 2010 then the changes will be implemented December 1, 2010.