SIHO INSURANCE SERVICES

Health Care Reform Update

October 11, 2012

www.siho.org

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)

Comparative Effectiveness Research Funding

The Affordable Care Act (ACA) includes a fee for comparative effective research for self-insured groups. Plans ending before October 1, 2013 are required to pay one dollar multiplied by the average number of covered lives on the plan for the plan year. All self-insured plan years ending on or after October 1, 2013 through October 1, 2014, the fee increases to two dollars multiplied by the average number of covered lives on the plan during that plan year.

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

Summary of Benefits and Coverage (SBC)

The Summary of Benefits and Coverage regulation, designed to ensure consumers get clear, consistent information about their health coverage, became effective on September 23, 2012. All insurance companies and group health plans are required to distribute the same standard SBC form to help consumers better understand the coverage they have available to them, according to healthcare.gov.

"These new tools empower consumers to make informed decisions about their health coverage options and to choose the plan that is best for them, their families, and their business," said Kathleen Sebelius, Health and Human Services Secretary.

The SBC will include information about the covered health benefits, out-of-pocket costs, and the network of providers. The glossary defines terms commonly used in the health insurance market, such as "deductible" and "co-pay," using clear language.

Additional information is available by clicking on the link below.

Summary of Benefits and Coverage

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.

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