We are pleased to enclose the latest Benefits Newsletter addressing current employment benefits, life and health insurance topics.

HealthCare Reform Newsletter

LEGISLATIVE UPDATE FOR 2012 & BEYOND **January 2012**

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2012 is a year of few changes within ACA. However, some of the changes that took effect in 2011 will start with plan renewals in 2012. There are also some reforms that take place in 2013 that we have to keep an eye on, as it could impact us in 2012. This article will help you make sense of some of the moving parts in 2012.

Summary of Benefits and Coverage

Within the Patient Protection and Affordable Care Act, or Affordable Care Act (ACA) is a regulation for plan sponsors of both grandfathered and non-grandfathered plans to provide a summary of benefits and coverage documents to all of their eligible employees. The idea is the SBC will be simple and easy to understand for all employees.

The requirement was to begin for all plan renewals after March 23, 2012. However, at this time, the date has been placed on hold until further guidance is issued.

The proposed template can be found on the Department of Labor website: http://www.dol.gov/ebsa/pdf/SBCtemplate.pdf

The summary is required to be no more than 4 double sided pages (for a total of 8). In addition to the summary, there is a uniform glossary of coverage that will have standard definitions such as "What is a Deductible?" or "What is a Co-pay?" Groups will be required to distribute to their members upon renewal and within 60 days of a material change to a plan. What remains to be seen is if there will be a requirement to send to members showing each tier and each plan design offered by the group.

Small Business Tax Credit

If you are an employer with less than 25 lives, your average salary is $50,000 or less and you pay for more than 50% of the single premium coverage - you could qualify for the small business tax credit. You can claim the credit by filling out form 8931. To see if you qualify, use the following calculator: **Tax Credit Calculator**

2012 - W-2 Reporting

Starting in 2012 some employers will be required to report the aggregate cost of insurance on employees W-2's.

The idea behind the reporting of W-2's is to provide consumer information to the employee, primarily the true cost of their healthcare. However, not all employers will be required to report the aggregate cost of healthcare on the W-2's. Only employers that issue 250 W-2's or more have the reporting requirement. For all other employers the reporting, at this time, is optional.

The reporting will go in box 12 using code DD and will include the aggregate cost for both the employee and the employer. For example, if a single premium is $500 per month with the employer paying $400 a month and employee paying $100 per month, the amount reported would be $500 per month by the number of months the employee is on the plan.

In general dental and vision will not be included in the aggregate costs as long as they are stand-alone contracts and not tied to the medical premium. Some other coverage's not included are as follows: Long-term care, HSA & HRA's and Indemnity policies. As long as the Indemnity policy is only provided by the employer, independent of any other insurance and the employee pays the premium with post-tax dollars. FSA's are also not required to report on the W-2's unless the plan is run through a Section 125 plan and the amount for the plan year exceeds the salary reduction elected by the employee. (Q.19).
Interim guidance has been issued by the IRS in Notice 2012-9 : IRS Publication

Comparative Effectiveness Research Fee

When ACA was written, many legislators felt the variances of costs between different treatment protocols were driving the cost of healthcare. They sought to establish a research center that will study the clinical effectiveness relating to patient-centered outcomes, including research to evaluate risks and benefits of medical treatments, services, procedures, and drugs that treat, manage, diagnose or prevent illness or injury.

To fund the research, plans are charged $1 per member per year, starting with plans that renew after September 23, 2012. The fee will go up to $2 per member per year. The plan sponsor will be responsible for paying this fee. Look for further guidance on this fee in the near future.

2013 Flexible Spending Limitations

On January 1, 2013 Healthcare FSA plans will be limited to a maximum of $2,500 per calendar year. The dollar amount will be indexed annually based on CPI (such as the HSA). Plan sponsors will have to make sure their plan documents are updated accordingly.

Another issue will be for plan sponsors who currently offer amounts on a non-calendar year basis over the $2,500 limit. The plan sponsor will have to amend their plan to remain compliant with the law. Thus far, the IRS has not addressed the issue and until further guidance is issued we can only assume that no more than $2,500 can be set aside into a healthcare FSA annually.

There are a variety of strategies a plan sponsor can employ to ensure compliance. One would be to begin the $2,500 limit with plan year 2012. Another would be to adopt a "short plan year" for 2012. The last would be a "front-loading" technique whereby the plan sponsor requires any amount over the maximum to be spent in 2012. Your trusted advisor at Wine Sergi & Company can help you come up with the right plan for you and your employees.

Preventive Services

(Expanded coverage for Women)

Beginning for non-grandfathered plans with renewal dates on or after August 1, 2012, preventive care services for women will be expanded to include services not-previously covered. Some of the services that are to be included are contraceptivites, and contraceptive counseling, domestic abuse and STI-counseling. Further information can be found on the HHS website: **Women's Preventative Services**

House committee kills long-term care provision of health reform law

January 18, 2012 - 4:36pm

WASHINGTON-The House Ways and Means Committee on Wednesday voted to kill a health care reform law provision that would set up a voluntary long-term care program.

In October, Health and Human Services Secretary Kathleen Sebelius said the administration suspended implementation of the program, saying that because of its voluntary nature, the LTC program would have been unworkable.

Ms. Sebelius, though, lacked the authority to formally kill the program, prompting lawmakers to act. The measure, H.R. 1173, approved by the Ways and Means Committee on a 23-13 vote, would repeal the program.

"Today we have taken steps to repeal yet another poorly designed and unworkable piece" of the health care reform law, Ways and Means Committee Chairman Dave Camp, R-Mich., said in statement.

Adverse selection possible

Under the program, participants would have paid a monthly premium for five years, after which they would have become eligible for a cash benefit of at least $50 a day that could be used to offset the cost of long-term care services. The program was supposed to have started this year.

The law directed the HHS secretary to establish automatic enrollment procedures that employers could have used and that employees would have had to opt out of if they didn't want to participate. Because the program was voluntary, critics say it would have resulted in adverse selection, a point Ms. Sebelius has conceded.

"This could have led to a vicious cycle where premiums would have to be set higher and higher to cover the likely costs of the benefits, leading fewer and fewer healthier people to sign up for the program," she said.

The measure now goes to the House floor.

Source: businessinsurance.com

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