Federal Health Care Reform

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Proprietary material

The Patient Protection and Affordable Care Act (H.R. 3590), PPACA, signed March 23, 2010 is 2,407 pages.

Amended by the 153 page Health Care and Education Affordability Reconciliation Act of 2010 (H.R. 4872), Reconciliation or "Fix It" Bill, signed March 30, 2010.

Discussion Agenda:

- **Supreme court decision on constitutionality**
- **Nursing Mothers Mandate**
- **Prohibition against Rescission**
- **Medical Loss Ratio Standards and Rebating for calendar year 2011**
- **"Free" Preventive 9-23-2010 and "Free" Women's Contraceptive coverage - 8-1-2012**
- **SBC (Uniform Summary of Benefits Coverage and Uniform Glossary) 9-23-2012**
- **W-2 reporting tax year 2012**
- **Changes to FSA and deductibles**
- **Essential Benefits to qualify as a Qualified Benefits Plan (2014 Exchanges)**
- **Exchanges; Premium Credit (Subsidies) 2014**
- **Employer Play or Pay affecting employers with 50+ FTEs 2014**

Supreme Court ruling June 28, 2012

The ruling was that the individual mandate has been upheld as constitutional under the Congressional power of taxation.

Business as usual…Other than regarding Medicaid expansion

Medicaid eligibility is increased to 133% of the FPL (the Federal Poverty Level). If states reject the expansion they do NOT lose current Federal funding. The federal government will pay 100% of the cost of the new expansion population until 2016. Starting in 2017, states would begin to pay a phased in amount of the cost of covering the expansion population. By 2019, states would be paying all.

Court ruled that the Feds cannot hold back funds if the state decides NOT to expand.

Consider that these individuals will continue to seek care.

Concerns remain over the true drivers of costs i.e. the actual cost of care and the huge and costly compliance burden on American employers e.g. notices to employees and connecting with the correct professionals to assist employees properly.

Pharma costs not addressed at all.

Tort reform not addressed at all.

Some cost consideration for cost with Women's Contraceptives.

Nursing Mothers Mandate 3-23-2010

Employers must provide reasonable breaks and a private space (not a restroom) for mothers to express milk for their infants for up to one year after childbirth. The space must be free from intrusion by coworkers and the public. The requirement does not apply to small employers (fewer than 50 employees) if it would create undue hardship.

Non Discrimination 9-23-2010

All size group plans must comply with IRS 105(h)(2) which currently only applies to self-funded plans. The provision does NOT apply to grandfathered plans. The PPACA version of 105(h) does not apply to HIPAA excepted benefits, including "limited scope" (discount or rider type) dental or vision benefits offered separately. Generally, plans may not discriminate in favor of highly compensated employees or individuals as to benefits or eligibility to participate. Highly compensated individual has the meaning given by section 105(h)(5).

All benefits for dependents of HCE must be available on the same basis for dependents of non HCE.
Highly Compensated Individuals are:

-one of the five highest paid officers,

-a shareholder owning more than 10% of company stock;

-among the highest paid 25% of all employees.

****Enforcement of the provision prohibiting Discrimination in favor of Highly Compensated Employees provision has been delayed until final regulations are released.**

PROHIBITION AGAINST RESCISSION 9-23-2010

Applies to individual, group, fully insured, self-funded, grandfathered and non-grandfathered plans, rescission is not permitted unless there is evidence of fraud or intentional misrepresentation.

If the employee has paid premium, a retroactive termination may not occur until after the premium has been exhausted.

Example: employer takes $50 as the employee contribution on June 25 to cover July.

If the employee terminates July 17, coverage may not end before July 31. COBRA/ continuation date is August 1.

Preventive Care Services

Under the regulations, plans must cover without co-pay, coinsurance or deductible – certain preventive services. www.healthcare.gov

This applies to individual and group plans but NOT to grandfathered plans.

Women's Preventive and Contraceptive Coverage

Effective August 1, 2012 for new and upon renewal for existing, this includes

-FDA approved **contraceptive methods**

-Sterilization procedures

-Gestational Diabetes screening

-Human Papillomavirus testing for women age 30 and over every 3 years

-HIV screening and HIV and STI (sexually transmitted infection) counseling

-Contraceptive counseling

-Breastfeeding supplies and counseling

-Domestic violence screening

for all women with reproductive capacity when provided by **in network providers**.

Plans may continue to charge cost sharing for branded drugs if a generic version is available and just as effective and safe.

PPACA MLR & REBATES AUGUST 1, 2012

- Fully insured individual, small & large group starting calendar year 2011
- Provision **does not apply to Self-funded**
- 80% for claims & quality improvement for individual and small (1-100)
- 85% for 101+ plus
  - NY, MA, NM may use higher MLR
  - NY, NJ, PA and DE small group retains up to 50
  - Non pay Notices July ($3M price tag)
  - Actual rebates August 2012

MLR Rebates

- Carrier calculation is based on calendar year.
- Policyholder employers must rebate current covered employees proportionate to what the employee contributed towards premium. If premium was paid pre tax or the individual deducted the premium on taxes, any cash rebate is **subject to Federal tax and employment taxes.**
- The final rule directs issuers to provide through lower premiums or in other ways that are not taxable e.g enhanced benefits. Policyholders must ensure that the rebate is used for the benefit of **current** employees.
- To avoid being forced to establish a trust to hold the rebate, the employer should distribute the rebate within three months of receipt
- HHS Q&A regarding tax implications.

2011 PPACA MLR Rebates for New Jersey

▪ Cigna HealthCare	$407k	51+
▪ Nippon	$4.14M	51+
▪ Oxford Health Plans	$3M	51+

MLR calculation

- $50 x 12 = $600 annual employee contribution
- $10,000 x 12 = $120,000 annual premium
- $600 divided by $120,000 = .005 x the rebate amount of $1,000 = $5 for this employee

- Another example where an employee contributed $50 as a single for two months and then $75 per month as HW for nine months and then $150 for one month as family:

- ($50 x 2) + ($75 x 9) + ($150 x 1) = $925 annual employee contribution
- $10,000 x 12 = $120,000 annual premium
- $925 divided by $120,000 = .0077 x the rebate amount of $1,000 = $7.71 for this employee

Preventive Services with Zero Cost Sharing

- **Applies to all non grandfathered plans**
- **When services are provided in network**
- **! Provider must code as preventive**
- **8-1-2012 Women's contraceptive was added which includes all FDA approved contraception**
  - **-domestic violence counseling**
  - **-breast feeding counseling**
  - **-sterilization procedures**

  www.healthcare.gov **has entire list**

PPCA 2012 Summary of Benefits (SBC)

- SBC (Uniform Summary of Benefits (SBC) and Coverage and Uniform Glossary)
- New issue, renewal or open enrollment beginning 9-23-2012
- 4 page double sided = 8 pages
- Culturally linguistically appropriate applies to non grandfathered plans when more than 10% of the county is non-English speaking
- NJ: Cumberland, Hudson, Passaic, Union Counties -Spanish
- http://www.cciio.cms.gov/resources/factsheets/clas-data.html
- Carrier providing for fully insured and self funded
- TPAs providing for HRAs
- Sample forms and info dol/ebsa
  - (Dept of Labor/Employee Benefit Security Administration)

Summary of Benefits - Timing

-Upon application

-By first day of coverage (if there are any changes)

-HIPAA Special enrollees. The SBC must be provided to special enrollees no later than the date on which a summary plan description is required to be provided (90 days from enrollment)

-Upon renewal. If a plan or issuer requires participants and beneficiaries to actively elect to maintain coverage during an open season, or provides them with the opportunity to change coverage options in an open season, the plan or issuer must provide the SBC at the same time it distributes open season materials. If there is no requirement to renew (sometimes referred to as an "evergreen" election), and no opportunity to change coverage options, renewal is considered to be automatic and the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.

-Upon request. The SBC must be provided upon request for an SBC or summary information about the health coverage as soon as practicable but in no event later than seven business days following receipt of the request.

Additionally, members enrolled in a plan must be notified of a material modification to the plan that would cause a change to the SBC **at least 60 days prior to the effective date of the change.** This applies only to changes made during the plan or policy year, and not to changes at renewal.

SBC Electronic Delivery

- **Q1: A previous FAQ outlined the circumstances in which an SBC may be provided electronically. The FAQ discussed a safe harbor for providing the SBC to participants or beneficiaries covered under the plan who are able to effectively access documents provided in electronic form at the worksite. Are there any additional safe harbors for electronic delivery of SBCs?**
- Yes. The Departments have adopted the following additional safe harbor-. SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs also may be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request. (In addition, for individual market issuers that offer online enrollment or renewal, the SBC may be provided electronically, at all issuances, to consumers who enroll or renew online, consistent with the regulations.)
- http://www.dol.gov/ebsa/faqs/faq-aca9.html

SBC Resources

- FAQs http://www.dol.gov/ebsa/faqs/faq-aca9.html

  Corrected Sample- http://www.dol.gov/ebsa/pdf/CorrectedSampleCompletedSBC.pdf
- Uniform Glossary- http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf

Penalty/Fine:

- **Employers and health plans who willfully fail to provide the information can be fined up to $1,000 for each such failure. Each failure to provide information to an enrollee constitutes a separate offense.**

W-2 Reporting

- **This applies to fully insured and self-insured plans.**
- **Employers are required to include the aggregate cost of employer sponsored health benefits for informational purposes only. The cost of benefits will NOT be included in the taxable income. If the employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all coverage (see exclusions next slides).**

W-2 Reporting

- **Cost for fully insured and self-insured plans must be reported and include:**
  -Medical plans
  -Prescription drug plans
  -Dental and vision, unless they are "stand-alone" plans
  -Executive medical
  -On-site clinics unless only de minimis (De minimis means any service so small as to make accounting unreasonable or administratively impracticable, e.g. an on-site nurse who provided emergency services is de minimis).
- **Following ONLY reportable if the employer charges a premium.**
  -Medicare supplemental policies
  -Employee assistance programs and wellness (ONLY reportable if the employer charges a premium).

W-2 Reporting

Transition relief, meaning they are exempt, applies to:

- **Employers who send less than 250 Forms W-2**

Benefits Exempt from W-2 Reporting:

- **Stand alone dental / vision**
- **Long term care, accident or disability income benefits**
- **Specific disease or illness policies**
- **MSA or HSA contributions**
- **Salary reduction contributions to Health FSA**
- **HSA regardless of who funds the account,**
  HRAs,
- **FSAs if they are employee funded. Employer funded must be reported if paid after tax.**
- **Dental and Vision plans that are not integrated into another group health plan and**
  Self-insured plans of employers not subject to COBRA continuation coverage or similar requirements.

FSA , HSA and deductible changes

- Tax year 2011, OTC cannot be reimbursed without a script
- For distributions made after 12-31-2010, the tax for using HSA funds for non-qualified medical expenses is increased to 20% from 10%.
- Tax year 2013 max health FSA per person will be $2,500
- 2014 max deductible is $2k single/ $4k family
  - Verbally agencies have said that it can be higher if an employer is funding the rest via FSA or HRA.
  - This applies to inside and outside the exchange.

90 max waiting period - 2014

- **Waiting periods in excess of 90 days are prohibited for all plans, including grandfathered plans.**
- **Meaning...the employer may NOT have a 1st of the month after 90 day waiting period.**
- **See IRS Notice 2012-59 for guidance on some latitude that will be provided to employers who base eligibility on number of hours worked or when employees work variable hours.**
- **Details on the next slide.**

90 day max waiting period

- As long as the policy is not designed to avoid compliance, HHS, the DOL and IRS state that using the following methods will be acceptable:
- If the plan conditions eligibility on a specified number of hours per period (or working full time), and it cannot be determined what the new employee is expected to regularly work, the plan may include a measurement period of up to 12 months if coverage is effective no later than 13 months from the employee's start date. Plus if the start date is not the first day of the calendar month, the time remaining until the first day of the next calendar month.

  This works very well when the number of hours varies.
- If the plan conditions eligibility on a specified number of hours, for example, the plan provides part time employees with coverage after a cumulative 1,200 hours of service, it would be permissible for coverage to begin the 91st day after the 1,200 hours is satisfied.

Exchanges

- **Law requires the creation of an American Health Benefit Exchange (AHBE) (for individuals) and Small Business Health Options Program (SHOP) Exchange to facilitate the sale of QHP (Qualified Health Plans) to be operational Jan 1, 2014.**
- **Exchanges will be a purchasing portal for subsidized and unsubsidized QHPs as well as an enrollment point for Medicaid, CHIP and other state public health assistance programs.**

- **States can set the size of the small group market at either up to 50 or to 100 employees until 2016. In 2016, employers with up to 100 employees can participate in a SHOP. In 2017, states have the option to let businesses with more than 100 employees buy through the SHOP.**
- **People with adequate and affordable group coverage cannot leave group plan for the individual exchange**

*****Congress & staff MUST be in exchanges 2014**

Exchange readiness

- **States must complete and submit an Exchange Blueprint by Nov 16, 2012. States must document legal and operational requirements and readiness.**
- **HHS must approve or conditionally approve state based exchanges no later than Jan 1, 2013, for operation Jan 1, 2014.**
- **The IT challenge is the greatest at this point. ALL interested carriers, IRS links for income verification and detailed benefit summarize must be available for persons who qualify for state programs e.g. Medicaid and for individual and small group plans.**

Qualified Health Plan in 2014

- **Standards include mandated benefits, cost sharing requirements, out of pocket limits and a minimum actuarial value of 60%. Allows catastrophic only policies for those 30 and younger. Employer sponsored plans offered outside the exchange do not have to provide essential benefits coverage.**
- **The term "essential health benefits package" means, with respect to any health plan, coverage that:**
  (A) provides for "essential health benefits" (next slide);
  (B) limits cost-sharing for such coverage; and
  (C) provides either bronze, 60%, silver, 70%, gold 80%, or platinum 90% level of coverage.
- **Example: if the average use for mental health benefits is $2,000 per year, 60% of that would be considered bronze.**
- **Essential Benefits to be determined by each state.**
- **Essential Benefits do not apply to Self-Funded (Minimum Value Plans being developed).**

Premium Credits (Subsidies)

- The law creates sliding scale premium assistance tax credits for non Medicaid eligible individuals with incomes up to 400% of FPL (the Federal Poverty Level) to buy coverage through the exchange.
- Persons who have access to employer coverage but whose coverage is not considered of minimum essential value or coverage that is unaffordable may purchase through the exchange and receive a tax credit.
- Employers with 50 or more FTEs may be subject to a penalty ONLY if a full time employee obtains a premium credit.
- Note that 400% of the FPL for a single individual is $43,320 and for a family of four (4) is $88,200.
- Medicaid expands to 133% of the FPL so the subsidies would be for those between 134% and up to 400%.
- 133% of the FPL is $14,400 for a single individual and $29,400 for a family of four (4).

- ONLY available to individuals and ONLY when coverage is purchased through the PPACA Exchange starting 2014

EMPLOYER PLAY OR PAY
NOT OFFERING MINIMALLY ESSENTIAL

- **No mandate to provide coverage but there may be financial assessments on the employer a/k/a Shared Responsibility.**
- **Applies to employers with 50 or more FTEs.**
- **If at least one employee is eligible for a subsidy through the exchange:**
- **An employer with an average of at least 50 FTE on business days in the preceding calendar year that does not offer minimum essential coverage to all FTEs will pay $168/month or $2k/year or each FTE minus the first 30.**
- **Example: 60 FTEs - 30= 30 FTEs x $2k = $60k assessment.**
- **FT in this context is 30 hours per week.**

***commonly owned company rules apply**

PLAY OR PAY UNAFFORDABLE

For the employer that offers minimum essential coverage that is **unaffordable,** i.e. 1) the plan share of benefit is less than 60% or 2) premium exceeds 9.5% of household income defined as the modified adjusted gross of employee and family members.

- The employer will pay an assessment of $250/month of $3k/ year for each employee obtaining a subsidy through the exchange.
- There is no reduction of the first 30 as the assessment only applies to the individuals actually getting a subsidy.

* commonly owned company rules apply

EMPLOYER UNAFFORDABLE CALCULATION

- **Due to the difficulty of employers knowing household income, IRS Notice 2011-73 proposes and Notice 2012-17 permits a SAFE HARBOR.**
- **The employee portion (not household) of the self-only premium for the employer's lowest cost coverage that provides minimum value (the employee contribution) must not exceed 9.5 percent of the employee's W-2 wages.**
- **Example:**
  -Income is $50k
  -Single annual premium is $600x12=$7,200
  -9.5% of $50k = $4,750 (max to avoid penalty)
  -Employer must pay $7200-$4750 or pay penalty
- **-Income $150k**
  -Single annual premium low plan =$7,200
  -9.5% of $150k = $14,250
  -No penalty

EMPLOYER UNAFFORDABLE CALCULATION

- **On May 18, 2012, the IRS decided to delay making a final determination on how the exchange "affordability" qualification will be calculated. The proposed rule suggested that the lowest tier employee-only premium rate be used by the exchange as a means of determining whether or not an individual's employer-sponsored coverage is "affordable" for them. However, due to consumer-advocate pressure, the agency is considering using the employer-coverage's family rate as the standard.**
- **STAY TUNED**

Exchanges

- **Blueprint must be provided to HHS by November 16, 2012**
- **Readiness by January 2013**
- **First open enrollment October 1, 2013 – February 28, 2014**

- **Factoids**
  - **Premium same in and outside the exchange**
  - **Premium Credit/subsidies only available in the exchange to those <400% of FPL**
  - **Play or Pay criteria**

Self Funded

- **The following do NOT apply to Self-Funded:**

  Essential Benefits

  (Large groups and self-funded plans will be subject to a different, to-be-determined minimum value standard, to be developed by IRS/DOL/HHS for employer mandate compliance purposes)

- **Premium taxes on insurers which will be passed on to consumers**
- **Internet portal**
- **Medical loss ratios and rebating**
- **Premium rate review**

Medicare Part D Employer Requirements

- **Carrier advises creditable v non-creditable**
- **Employer must advise anyone eligible for Medicare due to age or disability (do not forget the COBRA/continuation folks) via creditable v non-creditable form letters.**
  - **This must be done before open enrollment i.e. October 15. OE ends December 7.**
  - **Anytime the plan changes from or to creditable**
- **Employer must advise CMS online**

THANK YOU !

QUESTIONS ?