

# Health Care Reform Update

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# Today's Focus

- Keeping up with the health care reform compliance marathon for employer-sponsored health care plans
  - Recent guidance
  - Upcoming deadlines
  - Where to get help
- Your most pressing issues and questions

# Health Care Reform Review

- PPACA and Reconciliation Act enacted in March 2010
  - Guidance from Treasury, Labor, HHS, others
- Direct impact on HR professionals and health plans
  - Reforms for individual and group health coverage (“Market Reforms”)
  - Employer mandate and reporting requirements

# Market Reforms: Background

- Effective dates: 2010  2018
- Applicability depends on
  - Size of group
  - Grandfathered/non-grandfathered
  - Insured/self-insured
  - Union/non-union
  - Type of plan (e.g., Excepted Benefits, retiree-only)

# Review of Market Reforms Already Effective

- Plan years beginning on/after Sept. 23, 2010
  - Grandfathering rules
  - No lifetime dollar limits on Essential Health Benefits (EHB)
  - No annual dollar limits on EHB less than \$750,000
  - Dependent coverage to age 26
  - No pre-existing condition exclusion (PCE) for children under age 19

# Review of Market Reforms Already Effective

- Plan years beginning on/after Sept. 23, 2010
  - Rescissions generally prohibited
  - Some new internal appeals/external review requirements (Non-GF plans only)
  - Full coverage of preventive services (Non-GF plans only)
  - New rules for coverage of emergency services, designation of primary care providers (Non-GF plans only)

# Review of Market Reforms Already Effective

- January 1, 2011
  - HSAs, FSAs, HRAs
    - Prescriptions required for over the counter medicines
    - Increase in additional tax on distributions from HSAs not used for qualified medical expenses

# Review of Market Reforms Already Effective

- January 1, 2011
  - Medical Loss Ratio Standards
    - Applies to insurers in group and individual markets
    - Insurers required to report accounting of amounts paid for claims and health care quality, premium revenue
    - Rebates required if less than 85% (large group) or 80% (small group) of premium revenue spent on claims/quality

# Review of Market Reforms Already Effective

- January 1, 2011
  - Medical Loss Ratio Standards
    - First reports due June 1, 2012, rebates in August 2012
    - Employers receiving rebates may be required to pass them on to enrollees, along with notices

# Review of Market Reforms Already Effective

- September 1, 2011
  - States to review and approve insurance rate increases in individual and small group markets
    - Small group in WV: 2-50 employees
    - Initially, reviews to be triggered by increases of 10% or more

# Upcoming Market Reforms

- Plan years beginning on/after September 23, 2011
  - Restricted annual limits: Minimum annual dollar limit on EHB is \$1.25 million
  - Increases in 2012 to \$2 million, then eliminated altogether

# Upcoming Market Reforms

- Varied effective dates in 2011/2012
  - Coverage of Preventive Services (non-GF only) already in effect, but requirements will change yearly
    - Recommendations/guidelines become effective for plan years beginning one year after issuance
  - <http://www.healthcare.gov/center/regulations/prevention.html>

# Upcoming Market Reforms

- Coverage of Preventive Services effective date examples
  - Screening and counseling for obesity recommendation issued January 31, 2010; effective for plan years beginning on or after January 31, 2011
  - Recommendation to include birth control as preventive services issued August 1, 2011; effective for plan years beginning on or after August 1, 2012

# Recent Guidance: Appeals

- Applies to non-grandfathered plans, insured, self-insured, individual and group
  - If insured, check with insurer
  - If self-insured, check with TPA

# Recent Guidance: Appeals

- Internal Appeals
  - Effective plan years beginning on or after September 23, 2010:
    - Compliance with DOL Claims Procedure Regulation
    - Definition of Adverse Benefit Determination
    - Full and fair review
    - Conflicts of interest rules
    - Continued coverage during appeal

# Recent Guidance: Appeals

- Internal Appeals
  - Effective plan years beginning on or after July 1, 2011:
    - Additional content for notices
  - Effective plan years beginning on or after January 1, 2012:
    - Deadlines for urgent care claims (still 24 hours)
    - Deemed exhaustion of administrative remedies
    - Include statement re: availability of diagnosis/treatment codes in notices
    - Compliance with cultural/linguistic standards

# Recent Guidance: Appeals

- External Review
  - What is external review?
    - Available after internal appeals procedures exhausted
    - Review conducted by an Independent Review Organization (IRO)

# Recent Guidance: Appeals

- External Review: Interim safe harbor design
  - Available for reviews initiated on or after September 20, 2011 of adverse benefit determinations involving medical judgment or rescissions

# Recent Guidance: Appeals

- External Review: Interim safe harbor design
  - Request must be made within 4 months of adverse determination
  - Preliminary review within 5 business days
  - Notice upon completing preliminary review
  - Referral to IRO

# Recent Guidance: Appeals

- External Review: Interim safe harbor design
  - Expedited review requires preliminary review, referral to IRO immediately

# Recent Guidance: Appeals

- External Review: Interim safe harbor design
  - Contract with at least 2 IROs by January 1, 2012, and 3 by July 1, 2012
  - Specific contractual requirements
  - Assignment of appeals must be in rotation or completely random

# Recent Guidance: Appeals

- Providing Notices in Culturally and Linguistically Appropriate Manner
  - Effective for plan years beginning on or after January 1, 2012
  - Applies to notices sent to counties in which 10% or more of the population is literate only in the same non-English language

# Recent Guidance: Appeals

- Providing Notices in Culturally and Linguistically Appropriate Manner
  - If a plan sends notices to specified counties, must:
    - Provide oral language services (e.g., hotline)
    - Provide notice in non-English language upon request
    - Include statement on notices of availability of assistance/translated notice

# Recent Guidance: W-2 Reporting

- Effective date
  - January 1, 2011, but not mandatory for 2011 year per IRS Notice issued in 2010
  - Additional extension – now applies to forms issued January 1, 2013 and forward, with respect to 2012 tax years and forward

# Recent Guidance: W-2 Reporting

- Effective date
  - Transition relief for some extends effective date to forms issued January 1, 2014 and after
  - Employers may voluntarily begin reporting now

# Recent Guidance: W-2 Reporting

- Applies to: Coverage under a group health plan made available to employee by employer which is excludable from income
  - But check for exceptions/transition relief

# Recent Guidance: W-2 Reporting

- Transition Relief: Until further guidance or 2014, not required for
  - Employers that file fewer than 250 Forms W-2 for 2011
  - Self-insured plan not subject to federal continuation coverage requirements
  - Plans maintained primarily for members of military or family

# Recent Guidance: W-2 Reporting

- Transition Relief: Until further guidance or 2014, not required for
  - Multiemployer plans
  - HRAs
  - Excepted Benefits
  - Employers furnishing W-2s before end of calendar year

# Recent Guidance: W-2 Reporting

- Interim Guidance addresses:
  - How to calculate reportable amounts when employee terminates during calendar year
  - How to report for individual who is an employee of multiple employers within a calendar year
  - What to do when employee transfers to successor employer

# Recent Guidance: W-2 Reporting

- Interim Guidance addresses:
  - How to calculate cost
    - Use COBRA premium method
    - Premium charged method (if insured)
    - Modified COBRA premium method (if employer subsidizes cost of COBRA or determines cost using prior year)

# Recent Guidance: Summary of Benefits and Coverage

- Plans must provide a Summary of Benefits and Coverage (SBC) and Prior Notice of Material Modification
  - Status: Effective on or after March 23, 2012, unless final guidance says otherwise; proposed guidance issued in August 2011
  - Applies to: Group health plans and health insurance issuers

# Recent Guidance: Summary of Benefits and Coverage

- What is an SBC?
  - A 4-page document designed to accurately describe the benefits and coverage under the applicable plan
  - Can be coordinated with SPD?

# Recent Guidance: Summary of Benefits and Coverage

- When must an SBC be provided?
  - Insurance issuer to plan
  - Plan/issuer to participant/beneficiary
  - Plan/issuer to plan/participant/beneficiary

# Recent Guidance: Summary of Benefits and Coverage

## Health Insurance Issuer to Plan

1. Upon application or request for information about coverage, ASAP but no later than 7 days after request
  - If information changes before coverage offered, or before first day of coverage begins, updated SBC must be provided before date of offer or first day of coverage

# Recent Guidance: Summary of Benefits and Coverage

## Health Insurance Issuer to Plan

(continued)

2. If and when policy, certificate, contract is renewed or reissued

- With written application materials or if renewal/reissuance automatic, no later than 30 days before first day of new policy year

# Recent Guidance: Summary of Benefits and Coverage

Plan/issuer to participant or beneficiary for each benefit package offered/eligible for

1. With written application materials, if any, or by first date participant/beneficiary is eligible to enroll
  - If information changes before first day of coverage, must provide updated SBC by first day of coverage

# Recent Guidance: Summary of Benefits and Coverage

Plan/issuer to participant or beneficiary for each benefit package offered/eligible for (continued)

2. Within 7 days of request for enrollment in any special enrollment period

# Recent Guidance: Summary of Benefits and Coverage

Plan/issuer to participant or beneficiary for each benefit package offered/eligible for (continued)

## 3. If and when coverage is renewed

- With written application materials or if renewal is automatic, no later than 30 days prior to first day of coverage in plan year

# Recent Guidance: Summary of Benefits and Coverage

Plan/issuer to plan/participant/beneficiary

1. Upon request within 7 days

# Recent Guidance: Summary of Benefits and Coverage

- Special rules
  - Issuer can satisfy requirements for plan
  - If participants and beneficiaries reside at same address, providing a single SBC to that address satisfies obligation for all residing there; otherwise, must send to last known addresses
  - When providing at renewal, need only automatically provide SBC for package in which participant or beneficiary is enrolled

# Recent Guidance: Summary of Benefits and Coverage

- Content

- Uniform definitions of standard insurance/medical terms
- Description of coverage, including cost-sharing, for various categories of benefits
- Exceptions, reductions, limitations on coverage
- Cost-sharing provisions
- Renewability and continuation of coverage provisions
- Coverage facts label including examples

# Recent Guidance: Summary of Benefits and Coverage

- Content (continued)
  - Statement re: minimum essential coverage and other requirements
  - Statement that SBC is summary only and reference to plan document, policy
  - Contact number and website for questions
  - Web address for list of network providers
  - Web address for information about prescription drug coverage/formulary
  - Web address for uniform glossary
  - Premiums or cost of coverage

## Insurance Company 1: PPO Plan 1

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2011 – 12/31/2011

Coverage for: Individual + Spouse | Plan Type: PPO



**This is not a policy.** You can get the policy at [www.insurancecompany.com/PLAN1500](http://www.insurancecompany.com/PLAN1500) or by calling 1-800-XXX-XXXX.

A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why this Matters:
What is the premium?	<b>\$481</b> monthly	The <b>premium</b> is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible?	<b>\$2,500</b> person / <b>\$7,500</b> family Doesn't apply to preventive care	You must pay all the costs up to the <b>deductible</b> amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there other deductibles for specific services?	Yes, <b>\$300</b> for pharmacy expenses	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes, <b>\$2,500</b> person / <b>\$7,500</b> family	The <b>out-of-pocket limit</b> is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Co-payments, premium, balance-billed charges, prescription drugs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the insurer pays?	No.	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See <a href="http://www.insurancecompany.com">www.insurancecompany.com</a> for a list of participating doctors and hospitals.	If you use an <b>in-network</b> doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term <b>in-network</b> , <b>preferred</b> , or <b>participating</b> for providers in their network.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section.

Questions: Call 1-800-XXX-XXXX or visit us at [www.insurancecompany.com](http://www.insurancecompany.com).

If you aren't clear about any of the terms used in this form, see the Glossary at [www.insuranceterms.gov](http://www.insuranceterms.gov).

OMB Control Numbers 1545-XXXX,  
1210-XXXX, and 0938-XXXX  
(expires XXX/XX/XXXX)

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## Insurance Company 1: PPO Plan 1

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2011 – 12/31/2011

Coverage for: Individual + Spouse | Plan Type: PPO



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is \$1,000 and you've met your deductible, your co-insurance payment of 20% would be \$200. If you haven't met any of the deductible and it's at least \$1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 co-pay/visit	40% co-insurance	none
	Specialist visit	\$50 co-pay/visit	40% co-insurance	none
	Other practitioner office visit	20% co-insurance for chiropractor and acupuncture	40% co-insurance for chiropractor and acupuncture	none
	Preventive care/screening/immunization	\$0	40% co-insurance	
If you have a test	Diagnostic test (x-ray, blood work)	0% co-insurance	40% co-insurance	none
	Imaging (CT/PET scans, MRIs)	0% co-insurance	40% co-insurance	none
If you need drugs to treat your illness or condition  More information about drug coverage is at <a href="http://www.insurancecompany.com/prescriptions">www.insurancecompany.com/prescriptions</a> .	Generic drugs	\$10 co-pay (retail); \$10 co-pay (mail order)	40% co-insurance	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	20% co-insurance (retail and mail order)	40% co-insurance	none
	Non-preferred brand drugs	40% co-insurance (retail and mail order)	60% co-insurance	none
	Specialty drugs (e.g., chemotherapy)	0% co-insurance		none

**Questions:** Call 1-800-XXX-XXXX or visit us at [www.insurancecompany.com](http://www.insurancecompany.com).

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## Insurance Company 1: PPO Plan 1

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2011 – 12/31/2011

Coverage for: Individual + Spouse | Plan Type: PPO

### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Routine hearing tests
- Weight loss programs

#### Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Hearing aids

### Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

### Your Grievance and Appeals Rights:

- A **grievance** is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. Call 1-800-XXX-XXXX or visit [www.XXXXXXXXXXX.com](http://www.XXXXXXXXXXX.com).
- An **appeal** is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-XXX-XXXX or visit [www.XXXXXXXXXXX.gov](http://www.XXXXXXXXXXX.gov).

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

**Questions:** Call 1-800-XXX-XXXX or visit us at [www.insurancecompany.com](http://www.insurancecompany.com).

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**Insurance Company 1: PPO Plan 1**  
**Coverage Examples**

Policy Period: 1/1/2011 – 12/31/2011  
 Coverage for: Individual + Spouse | Plan Type: PPO

**About these Coverage Examples:**

These examples show how this plan might cover medical care in three situations. Use these examples to see, in general, how much insurance protection you might get from different plans.

 **This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

**Having a baby**  
 (normal delivery)

- Amount owed to providers: \$10,000
- Plan pays \$0
- You pay \$10,000 (maternity is not covered, so you pay 100%)

**Sample care costs:**

First office visit	\$100
Radiology	\$300
Laboratory tests	\$200
Routine obstetric care	\$2,000
Hospital charges (mother)	\$4,100
Hospital charges (baby)	\$1,900
Anesthesia	\$1,000
Circumcision	\$200
Vaccines, other preventive	\$200
<b>Total</b>	<b>\$10,000</b>

**You pay:**

Deductibles	\$0
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$10,000
<b>Total</b>	<b>\$10,000</b>

**Treating breast cancer**  
 (lumpectomy, chemotherapy, radiation)

- Amount owed to providers: \$98,000
- Plan pays \$94,800
- You pay \$3,200

**Sample care costs:**

Office visits & procedures	\$4,000
Radiology	\$4,000
Laboratory tests	\$2,400
Hospital charges	\$3,300
Inpatient medical care	\$200
Outpatient surgery	\$3,400
Chemotherapy	\$64,000
Radiation therapy	\$13,000
Prostheses (wig)	\$500
Pharmacy	\$2,000
Mental health	\$1,200
<b>Total</b>	<b>\$98,000</b>

**You pay:**

Deductibles	\$2,500
Co-pays	\$200
Co-insurance	\$0
Limits or exclusions	\$500
<b>Total</b>	<b>\$3,200</b>

**Managing diabetes**  
 (routine maintenance of existing condition)

- Amount owed to providers: \$7,800
- Plan pays \$6,800
- You pay \$1,000

**Sample care costs:**

Office visits & procedures	\$960
Laboratory tests	\$300
Medical equipment & supplies	\$40
Pharmacy	\$6,500
<b>Total</b>	<b>\$7,800</b>

**You pay:**

Deductibles	\$300
Co-pays	\$260
Co-insurance	\$400
Limits or exclusions	\$40
<b>Total</b>	<b>\$1,000</b>

**Questions:** Call 1-800-XXX-XXXX or visit us at [www.insurancecompany.com](http://www.insurancecompany.com).  
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## Questions and answers about Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same policy period.
- There are no other medical expenses for any member covered under this plan. Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- \* **No.** Treatments shown are just examples. The care you would receive for these conditions could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- \* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-800-XXX-XXXX or visit us at [www.insurancecompany.com](http://www.insurancecompany.com).  
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# Recent Guidance: Summary of Benefits and Coverage

- Format:
  - 12-point font
  - Four pages (double-sided)
  - Stand-alone document
  - Culturally and linguistically appropriate manner
- Form: Paper or electronic options
  - If electronic, follow ERISA rules or individual market electronic disclosure rules in regs
- Model forms/templates issued

# Recent Guidance: Prior Notice of Modification of SBC

- Must provide prior notice of material modification in any terms of plan or coverage not reflected in most recent SBC
- Prior notice = no later than 60 days before effective date of change
- \*\*Does not apply to changes in connection with renewal or reissuance of coverage\*\*

# Recent Guidance: Uniform Glossary

- Must provide Uniform Glossary within 7 days of request
- Can be satisfied by providing Internet address, but must make paper copy available upon request

# Recent Guidance: Uniform Glossary

- Must provide Uniform Glossary within 7 days of request
- Can be satisfied by providing Internet address, but must make paper copy available upon request

## Glossary of Health Insurance and Medical Terms

- This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate. You can get a copy of the policy at [[www.insurancecompany.com](http://www.insurancecompany.com)] or you may call [1-800-xxx-xxxx.]
- **Bold** text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

### Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

### Appeal

A request for your health insurer or **plan** to review a decision or a **grievance** again.

### Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may *not* balance bill you.

### Co-insurance

Your share of the costs of a covered health care

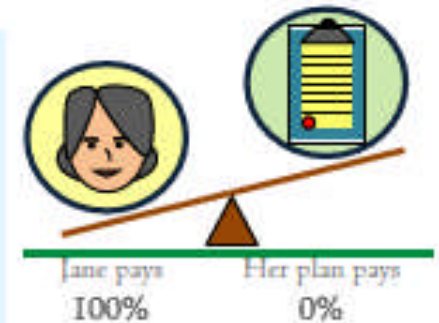


### Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

### Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

### Durable Medical Equipment (DME)

# Recent Guidance: SBC, Prior Notice, Uniform Glossary Penalties

- Penalty/enforcing authority depends on agency with jurisdiction: State, HHS, DOL, Treasury
  - Willful failure: Fine can be no more than \$1,000 for each such failure, but each enrollee is a separate offense
  - Failure can result in fine/excise tax/penalty of \$100 per day per individual

# Future Market Reforms

- Application of nondiscrimination rules to fully-insured plans (Non-GF plans only)
  - Status: In Notice 2011-1, IRS delayed enforcement until guidance issued

# Future Market Reforms

- Automatic Enrollment for Large Employers
  - Status: No guidance yet, public forum held in April

# Future Market Reforms

- Cap on Health FSA Salary Reductions in Cafeteria Plan
  - Status: Effective for taxable years beginning after December 31, 2012
  - Maximum limit is \$2,500 per calendar year
    - Guidance needed, but does not appear to apply to matching/seed employer contributions

# Future Market Reforms

- Plan years beginning on or after January 1, 2014
  - Guaranteed renewal/guaranteed issue
  - Clinical Trials coverage
  - Cost-sharing limits
  - Nondiscrimination based on health status-related factors

# Future Market Reforms

- Plan years beginning on or after January 1, 2014
  - Waiting periods limited to 90 days
  - Insurance issuer rating limitations
  - Requirement to provide Essential Health Benefits package

# Employer Mandate

- Employer Mandate, AKA “Pay or Play”
  - Effective January 1, 2014
  - Closely related to Exchanges and Individual Mandate

# Employer Mandate

- Individual Mandate: All individuals must have “Minimum Essential Coverage”
  - Exceptions: Prisoners; Undocumented aliens; Certain health care sharing ministry members; and Individuals qualifying for a religious exemption
  - Exemptions: Affordability; Hardship; Income; Tribal membership; Short lapses in coverage

# Employer Mandate

- Individual Mandate
  - Minimum Essential Coverage:
    - Government-sponsored – TRICARE, Medicare, etc.
    - Eligible employer-sponsored coverage
    - Individual coverage
    - Others recognized by HHS

# Employer Mandate

- Individual Mandate
  - Enforcement: Department of Treasury, IRS
  - Penalties: Lesser of the penalty amount or the national average of the cost of “bronze” level premium
    - Penalty amount is lesser of set dollar amount or percentage of income

# Employer Mandate

- Health Insurance Exchanges
  - State-run portals for purchasing required minimum essential coverage
  - Must be established by January 1, 2014
  - Initially open to individual and small group markets
    - 100 or fewer employers (or 50 or fewer if State limits further)

# Employer Mandate

- Health Insurance Exchanges
  - 4 levels of coverage offered through Exchange: Bronze, Silver, Gold and Platinum
  - Employers can enroll and offer Exchange coverage through a cafeteria plan
  - Premium Assistance and Cost-Sharing Subsidies available for Exchange-purchased coverage

# Employer Mandate

- Applicable Large Employers must provide Minimum Essential Coverage to all full-time employees
  - Applicable Large Employers: Employ, on average, at least 50 full-time employees
    - Full-time: 30 or more hours per week
    - Exceptions for seasonal/construction workers

# Employer Mandate

- Calculating the number of full-time employees for purposes of applicability of employer mandate only
  - Full-time employees (30 hours+ per week) + full-time equivalent employees
  - Full-time equivalent employees = hours of service for all part-time employees ÷ 120

# Employer Mandate

- Penalty depends on whether employer provides coverage or not
  - In both cases, penalty only applies if one or more employees enrolls in coverage through Exchange and receives premium assistance or cost-sharing subsidy

# Employer Mandate

- Employers not providing any health care coverage

Penalty =

Number of full-time employees over 30  
X 1/12 of \$2,000\*

# Employer Mandate

- Employers not providing health care coverage
  - Example: In January 2014, Employer A has 80 full-time employees, 30 full-time equivalent employees, and offers no Minimum Essential Coverage. 50 employees enroll in coverage through the Exchange, but only one qualifies for a cost-sharing reduction/premium assistance
  - Penalty for that month is  $50 (80-30) \times 1/12$  of \$2,000 = \$8,333.33

# Employer Mandate

- Employers providing health care coverage

Penalty =

Number of full-time employees enrolled in  
Exchange and receiving premium  
assistance/cost-sharing reduction X 1/12 of  
\$3,000

Capped at 1/12 of \$2,000 X full-time employees  
over 30

# Employer Mandate

- Employers providing health care coverage
  - Example: In January 2014, Employer B has 80 full-time employees, 30 full-time equivalent employees, and does offer Minimum Essential Coverage. 5 employees enroll in coverage through the Exchange, but only one qualifies for assistance
  - Penalty for that month is  $1 \times 1/12$  of \$3,000 = \$250

# Employer Mandate

- Penalty does not apply if employees purchase coverage through Exchange where small employer elected to participate directly in Exchange
- Penalty does not apply if employee was provided a Free Choice Voucher

# Free Choice Vouchers

- Effective: Effective date unclear but can only be used in Exchanges, which are not established until 2014
- Applies to employers offering Minimum Essential Coverage

# Free Choice Vouchers

- Employers offering Minimum Essential Coverage must give Free Choice Voucher to all qualified employees
- Voucher amount: Monthly portion of cost of employer-sponsored plan which would have been paid by employer if the employee was covered under the plan
  - If multiple plans offered, use the plan for which the employer pays the largest portion of the cost of the plan

# Free Choice Vouchers

- Qualified employees
  - Required employee contribution for coverage exceeds 8% of household income
  - Required employee contribution for coverage does not exceed 9.8% of household income
  - Employee's household income is not greater than 400% of Federal Poverty Level
  - Employee is not participating in health plan offered by employer

# Free Choice Vouchers

- Voucher can be used by employee to help pay for coverage obtained through Exchange
  - Employees using voucher won't trigger Employer Mandate penalties
- Tax credit for employer: Gross income of employee does not include amount of voucher, employers can deduct as compensation for personal services actually rendered

# Free Choice Vouchers

- Notice requirements: Employers must provide notice that, if employee purchases coverage through Exchange and employer does not offer Free Choice Voucher, employee may lose the employer contribution towards the cost of coverage

# Health Care Coverage Reporting

- Effective: 1/1/14
- Applies to any person (including employers) providing Minimum Essential Coverage
- Penalties in tax code for failure to file information return

# Health Care Coverage Reporting

- Information to be reported includes:
  - Name, address, tax ID of those covered
  - Dates of coverage
  - Whether coverage is through Exchange
  - Amount of any Federal assistance for cost of coverage
  - If provided by employer, employer ID and portion paid by employer

# Health Care Coverage Reporting

- Effective: 1/1/14
- Applies to employers offering Minimum Essential Coverage to employees which pays any portion of the costs of the plan, if the required contribution of any employee exceeds 8% of the wages paid to the employee

# Health Care Coverage Reporting

- Penalties in tax code for failure to file information return
- Information to be reported includes:
  - Name, address, employer ID
  - Certification that employer offers Minimum Essential Coverage
  - Number of full-time employees
  - Name, address, tax ID of employees and months they were covered
  - Length of waiting period
  - Cost paid by employer
  - Months during which coverage was available
  - Monthly premium for lowest cost option in each enrollment category
  - The option for which the employer pays the largest portion of the coverage and the portion paid

# Health Care Coverage Reporting

- Notification requirement: Notice must include
  - Name, address, phone number of employer required to file the return
  - Information required to be reported on the return

# Health Care Coverage Reporting

- This requirement may be combined with the Health Care Coverage Reporting requirement (see previous slides)

# Fees to Fund Comparative Effectiveness Research

- Applies to: Self-insured and fully-insured plans
- Effective: Plan years ending after 9/30/12 and before 9/30/19

# Fees to Fund Comparative Effectiveness Research

- Applies to: Self-insured (sponsor) and fully-insured (issuer) plans
- Effective: Plan years ending after 9/30/12 and before 9/30/19
- Fees = \$2 X average number of covered lives
  - Except: Plan years ending in fiscal year 2013, fee is only \$1 X average number of covered lives

# Resources

- Department of Labor Website
  - <http://www.dol.gov/ebsa/healthreform/>
- Federal Government Health Care Reform Website
  - <http://www.healthcare.gov/center/regulations/index.html>

# Questions?

These materials are presented with the understanding that the information provided is not legal advice. Due to the rapidly changing nature of the law, information contained in this presentation may become outdated. Anyone using information contained in this presentation should always research original sources of authority and update this information to ensure accuracy when dealing with a specific matter. No person should act or rely upon the information contained in this presentation without seeking the advice of an attorney.

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