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CSC Insurance

Health Care Reform

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Selective Highlights and Explanations of Sections of the Patient Protection and Affordable Care Act and the Health Care Reconciliation Act of 2010

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Patient Protection and Affordable Care Act ("PPACA") (P.L. 111-148)

- Commonly called "Affordable Care Act"
- Signed into law by President Obama on March 23, 2010
- June 28, 2012, the United States Supreme Court upheld the constitutionality of most of the PPACA.
- On May 16, 2013 the Republican – controlled U.S. Hose of Representatives voted to repeal or defund the PPACA for the 37th time, before full implementation on January 1, 2014.

Patient Protection and Affordable Care Act ("PPACA") (P.L. 111-148)

- Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)
- Signed into law by President Obama on March 30, 2010

No Lifetime or Annual Coverage Limits

- Shall not impose lifetime or annual limits on the dollar value of benefits for any participant or beneficiary.
  - "Essential health benefits"
    - Ambulatory patient services
    - Emergency Services
    - Hospitalization Maternity and newborn care
    - Mental health and substance use disorder services, including behavioral health treatment
    - Prescription drugs
    - Rehabilitative and habilitative services and devices
    - Laboratory Services
    - Preventive and wellness services and chronic disease management
    - Pediatric services, including oral and vision care
  - Pre-2014 Annual Limits – for plan years beginning before January 1, 2014, group health plans and health insurers offering group or individual health coverage may impose a restricted annual limit on the dollar value of benefit per participant or per beneficiary only for essential health benefits.

Note: Approximately 55% of individuals with employee – provided health insurance were subject to lifetime limits of $1 million or $2 million.

No Lifetime or Annual Coverage Limits

- May impose lifetime or annual cap on specific benefits that are not essential health benefits if permitted under state law.

Preventive Health Services Coverage

- Plans are required to cover without any cost – sharing, preventative services and immunizations that are recommended the U.S. Preventative Services Task Force and Center for Disease Control ("CDC"); as well as preventative services for women, as recommended by Health Resources and Services Administration.

Extension for Dependent Coverage

- The PPACA requires that group health plans and health issuers cover dependent children "until the child turns 26 years of age," regardless of marital status of the adult child and this provision does not affect the income tax exclusion for employer – provided health benefits under the Internal Revenue Code.

Note: Young adult age group tends to have a greater proportion of uninsured than do any other groups.

New Uniform Standards for Health Plan Summary of Benefit Coverage

- Standard Definitions Periodic Review and Update
  - Language and Appearance – A four (4) page length limit on the new summary of benefits and coverage. 12-point fonts.
  - Penalties – Fine up to $1,000 can be imposed for each failure. Considered a separate offense for each enrollee.
  - Employee Retirement Income Security Act "ERISA" does not contain rules governing the length of SPD's. ERISA plans administrators commonly use the plan document to double as SPD.

Insurers Cost Reductions Through Constraints on Loss Ratios

- Annual Report to DHHS for Each Group and Individual Coverage for Each Medical Plan Year
  - Report must describe the ratio of incurred claims plus a loss adjustment expense to earned premiums, typically called a "medical loss rate." On January 1, 2014, the minimum loss ratios will be averaged based on premiums expended for claims and total premium revenue in each of the previous three (3) years of the plan.

Insurers Cost Reductions Through Constraints on Loss Ratios

(continued)

- Required minimum loss ratios:
- 101 or more employees is 85 percent or a higher percentage if a state requires it versus 80 percent or a higher percentage if a state requires it for 100 or fewer employees.
- It does not meet the minimum loss ratios, must provide an annual rebate to each enrollee under such coverage on a pro rata basis.

Claims Appeals Process

- A group health plan and a health insurer must implement an effective process for appeals of coverage determination and claims.
- Establish an internal claims appeal process
  - A notice to participants, in a "culturally and linguistically appropriate manner," of available internal and external appeals processes; and
  - A provision allowing an enrollee to review his or her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage during the appeals process.

Claims Appeals Process

- External Review: Group health plans and insurers have two options regarding implementation of external reviews (Act Sec. 1001(5) of the Affordable Care Act, as amended by Act Sec. 10101(g), adding PHSA Sec. 2719 (b)):
  1. Plans and insurers must comply with State external review requirements that are binding and at a minimum include the consumer protections in the Uniform External Review Model Act from the National Association of Insurance Commissioners; or
  2. If state requirements do not meet the above minimums or if the plan is self-funded and not subject to state insurance regulations, then the plan must implement and external review process that is similar to that in the Uniform External Review Model Act and that meets standards established by the Department of Health and Human Services.

Patient Protections

- Selection of any Participating Care Provider by Enrollee Required
  - Pediatric care access – if in plan's network (Does not waive any exclusions of coverage.)
  - OB/GYN specialist – without a PCP referral
  - Coverage of emergency services
    - Without any required prior authorization
    - Regardless of whether or not provider participates in the plan's network; and
    - Non-participating provider services must be covered without limitations and in the same manner, with the same cost-sharing requirements, as coverage for emergency services from a participating provider

Insurance Premium Rates Limitation

(For plan years beginning on or after January 1, 2014)

- Discriminating Premium Rate Prohibited
  - Only the following factors:
  - Age – The highest premium rate for adults may not be more than three (3) times the lowest premium rate;
  - Rating Area;
  - Individual or family enrollment; and
  - Tobacco Use – The highest premium rate may not be more than 1.5 times the premium rate for a non-smoker in the same age bracket, rating area and types of coverage.

Additional Reforms

Guaranteed Availability and Renewal

(For plan years beginning on or after January 1, 2014)

- "Accept every employer and individual in the State that applies for coverage", which strictly limits the circumstances under which coverage may be denied or not renewed
- Subject to:
  - Special rules for network plans;
  - Financial capacity limits;
  - General exceptions; and/or
  - Uniform termination of coverage.

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Preexisting Condition Exclusion

(For plan years beginning on or after January 1, 2014)

- May not impose any preexisting condition exclusions with respect to such plan or coverage.

Prohibiting Discrimination Based On Health Status

(For plan years beginning on or after January 1, 2014)

- A group health plan and health insurance issuer offering group or individual health insurance coverage may not establish rules of eligibility (including continued eligibility) of any individual to enroll under terms of the plan or coverage based on any of the following factors in relation to the individual or a dependent of the individual:
  - Health status.
  - Medical condition.
  - Claims experience.
  - Receipt of health care.
  - Medical history.
  - Genetic information.
  - Evidence of insurability.
  - Disability.
  - Any other health status-related factor determined appropriate by the Secretary of Health and Human Services.

Note: The restriction on discriminatory premiums does not restrict the amount that an employer or individual may be charged for coverage under a group health plan or individual health coverage, as the case may be, or prevent a group health plan, and a health insurance issuer offering group or individual health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to a wellness program

Comprehensive Health Insurance Coverage

(For plan years beginning on or after January 1, 2014)

- Health insurers offering coverage in the individual or small group health insurance markets must ensure that the coverage they offer includes the essential health benefits package required under the Patient Protection and Affordable Case Act Sec. 1302(a), and that the annual cost-share under the plan does not exceed limits under Affordable Care Act Sec. 1302 (c)(1) and (2).

Prohibition on Excessive Waiting Periods

(For plan years beginning on or after January 1, 2014)

- Group health plans may not impose any waiting period exceeding ninety (90) days before individuals may enroll in the plan.

Coverage For Individuals Participating in Approved Clinical Trials

(For plan years beginning on or after January 1, 2014)

- Group health plans and individual health insurance policies must cover items and services typically covered under the plan when the items and services are provided to an enrollee in an approved clinical trial.

Inclusion of Cost of Employer-Sponsored Health Coverage on W-2

- Employers are required to disclose the aggregate cost of employer-sponsored health insurance coverage provided to their employees on the employee's Form W-2. Contributions to any Archer medical savings account or health savings account of the employee or the employee's spouse or salary reduction contributions to a flexible spending arrangement under a cafeteria plan will not be included. This employer disclosure requirement begins with the Form W-2 for the 2011 tax year.

Limitations of Distributions from Health Accounts for Over-The-Counter Medicines

- The cost incurred for a medicine or drug will be treated as a qualified medical expense for purposes of reimbursement through a health flexible spending arrangement (health FSA) or health reimbursement arrangement (HRA), as well as a distribution from a health savings account (HSA) or Archer medical savings account (MSA), only if the medicine is a prescribed drug or is insulin. Thus, the cost of over-the-counter medicines may not be reimbursed with excludible income, unless the medicine is prescribed by a physician.

Additional Tax on Health Savings Account ("HAS") and Archer Medical Savings Account ("MSA") Distributions

- The additional tax on distributions from health savings accounts (HSAs) and Archer medical savings accounts (MSAs) not used for qualified medical expenses is increased to 20 percent of the amount of the distribution included in gross income

Health Flexible Spending Accounts Offered in Cafeteria Plans

- Health flexible spending arrangements (health FSAs) offered as a part of a cafeteria plan must limit contributions through salary reductions to an annual amount of $2,500.

Note: The new limitation will protect employees from large forfeitures and protect employers from employees who game the system by signing up for large amounts, submitting large claims early in the year and then terminating employment, leaving the employer stuck with the bill.

Additional Requirements for Charitable Hospitals

- Community health needs assessment;
- Financial assistance policy;
- Limitations on charges; and
- Billing and collections requirements.
- Excise tax for failure to meet hospital exemption requirements

Health Care Coverage Reporting

Beginning in 2013

- Every person who provides minimum essential coverage to an individual during a calendar year is required to file a return reporting such coverage, at such time , the Secretary of Treasury may prescribe. I.R.C. §6055(a).

Automatic Enrollment for Employees of Large Employers

- New full-time employees will automatically be enrolled in one of the plans (subject to any waiting period authorized by law) and current employees will continue to be enrolled. The automatic enrollment program must include adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in. This federal law does not supersede any state law which established, implements, or continues in effect any standard or requirement relating to employers in connection with payroll unless the state law would prevent an employer from instituting the automatic enrollment program.

Automatic Enrollment for Employees of Large Employers (continued)

- Notice. Employers are required to provide an employee, at the time or hiring (or, with respect to current employees, not later than March 1, 2013), written notice –
  - Informing the employee of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance;
  - If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60%, that the employee may be eligible for a premium tax credit under Code Sec. 36B and a cost sharing reduction under the Affordable Care Act Sec. 1402 if the employee purchases a qualified health plan through the Exchange; and

Automatic Enrollment for Employees of Large Employers (continued)

- If the employee purchases a qualified health plan through the Exchange and the employer does not offer a free choice voucher, that the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for federal income tax purposes (Sec. 18B of the FLSA, as added by Act Sec. 1512 of the Affordable Care Act, as amended by Act Sec. 10108(i)(2) of the Affordable Care Act).

Note: Because of the new requirement that applies to employers that pay less than 60% of the premium to provide expanded notices to employees, 60% may become the new norm.

Shared Responsibility for Employers Regarding Health Coverage

- Large employers who fail to offer their full-time employees the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan for any month and have at least one full-time employee enrolled for that month in a qualified health plan for which a premium tax credit or cost-sharing reduction is allowed or paid for the employees are subject to an assessable payment. An assessable payment is also imposed on large employers who offer coverage, but have one or more full-time employees enrolled in a qualified health plan for which a premium tax credit or cost-sharing reduction is allowed or paid for these employees.

Shared Responsibility for Employers Regarding Health Coverage (continued)

- Shared responsibility assessable payment imposed on certain large employers. An assessable payment is imposed on an applicable large employer that:
  - fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan for any month, and
  - has a least one full-time employee who has been certified to the employer under Act Sec. 1411 of the Patient Protection and Affordable Care Act (the Affordable Care Act) (P.L. 111-148) as having enrolled for that month in a qualified health plan (a state exchange offered plan) with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid for the employee (Code Sec. 4980H(a), as added by Act Sec. 1513(a) of the Affordable Care Act). For a discussion of the Act 1411 certification procedures, see paragraph 315.

Shared Responsibility for Employers Regarding Health Coverage (continued)

- The assessable payment is equal to the product of the applicable payment amount, which is 1/12 of $2,000 for any month (i.e., $166.67 per month), and the number of fulltime employees for the month (Code Sec. 4980H(c)(1), as added by Act Sec. 1513(a) of the Affordable Care Act, and amended and redesignated by Act. Sec. 1003(b)(2) and (d) of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)). After 2014, the $2,000 amount will be adjusted for inflation. However, in computing the assessable payment, the number of employ's fulltime employees for any month is reduced by 30 (Code Sec. 4980H(c)(2)(D)(i)(I), as added and amended by Act Secs. 1513(a) and 10106(f)(2) of the reduced by 30 (Code Sec. 4980H(c)(2)(D)(i)(I), as added and amended by Act Secs. 1513(a) and 10106(f)(2) of the Affordable Care Act, and amended and redesignated by Act Sec. 1003(a) and (d) of the health Care Reconciliation Act of 2010)

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Shared Responsibility for Employers Regarding Health Coverage (continued)

- Example: In 2014, ABC, Inc. fails to offer minimum essential coverage and has 90 full-time employees, 10 of whom receive a premium tax credit for the year for enrolling in a state exchange offered plan. For 60 of its full-time employees (90 full-time employees, less 30), ABC, Inc. owes $2,000 per employee, for a total assessable payment of $120,000 ($2,000 x 60 full-time employees), which is assessed on a monthly basis.

Shared Responsibility for Employers Regarding Health Coverage (continued)

- Large employers offering health coverage. An assessable payment is also imposed on an applicable large employer that:
  - offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under a Code Sec. 5000A(f)(2) eligible employer-sponsored plan for any month, but
  - has one or more full-time employees who have been certified to the employer under Act Sec. 1411 of the Patient Protection Act as having enrolled for the month in a qualified health plan (a state exchange offered plan) with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid for these employees (Code Sec. 4980(H)(b)(1), as added by Act. Sec. 1413(a) of these employees these employees (Code Sec. 4980(H)(b)(1), as added by Act. Sec. 1413(a) of the Affordable Care Act, and amended and redesignated by Act Sec. 1003(b)(1) and (d) of the Health C are Reconciliation Act of 2010).

Shared Responsibility for Employers Regarding Health Coverage (continued)

- The assessable payment in this case is equal to the product of the number of the full-time employees receiving a premium tax credit or cost-sharing subsidy for the purchase of health insurance through a state exchange for the month and an amount equal to 1/12 of $3,000 for any month (i.e. $250 per month). After 2014, $3,000 amount will be adjusted for inflation.

Shared Responsibility for Employers Regarding Health Coverage (continued)

- Example: In 2014, XYZ, Inc. offers health coverage and has 100 full-time employees, 10 of whom receive a tax credit for the year for enrolling in a state exchange offered plan. For each employee receiving a tax credit, XYZ, Inc. owes $3,000, for a total assessable payment of $30,000 ($3,000 x 10 employees). The maximum amount of the assessable payment for XYZ, Inc. is capped at the amount of the assessable payment that it would have been assessed for a failure to provide coverage, or $140,000 ($2,000 x 70 full-time employees (100 full-time employees, less 30)). Since the calculated assessable payment ($30,000) is less than the overall limitation ($140,000), XYZ, Inc. owes the $30,000 assessable payment, which is assessed on a monthly basis.

Employer Health Insurance Coverage Reporting

- Beginning in 2014, applicable employers will be required to report to the Secretary of the Treasury whether they offer full time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer sponsored plan and provide details regarding the coverage offered. Applicable employers must also report the number of full-time employees for each month during the year, and their names, addresses and taxpayer identification numbers. A person required to file a return under the new provision is also required to furnish a written statement to the individual with respect to whom information is reported, detailing the contents of the informational return.

Employer Health Insurance Coverage Reporting (Continued)

- Any applicable large employer for this purpose, is with respect to a calendar year, any employer who employed an average of at least 50 full-time employees or business days during the preceding calendar year.
- This required return must be in the form as the Treasury Secretary may prescribe, and must contain the name, date, employer identification number of the employer, and a certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (Code Sec. 6056(b), as added by the Affordable Care Act).

Employer Health Insurance Coverage Reporting (Continued)

- For this purpose, an eligible employer-sponsored plan is defined in Code Sec. 5000A(f)(2), as added by the Affordable Care Act, and includes a group health plan or group health insurance coverage offered by an employer that is a governmental plan, or any other plan or coverage offered in the small or large group market within a state.
- If an employer certifies that it offered its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, the return must also report:

Employer Health Insurance Coverage Reporting (Continued)

- in the case of an applicable large employer, the length of any waiting period with respect to such coverage;
- the months during the calendar year for which coverage was available;
- the monthly premium for the lowest cost option in each of the enrollment categories under the plan;
- the employer's share of the total allowed costs of benefits provided under the plan; and
- in the case of an offering employer, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under that option (Code Sec. 6056(b)(2)(C), as added by the Affordable Care Act.)

Employer Health Insurance Coverage Reporting (Continued)

- Comment: The waiting period for this purpose is defined in Sec. 2701(b)(4) of the Public Health Service Act and means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

- The required return must also state the number of full-time employees for each month during the calendar year, the name, address and taxpayer identification number or each full-time employee during the calendar year, and the months, if any, during which such employee and any dependents were covered under a health benefits plan (Code Sec. 6056(b)(2), as added by the Affordable Care Act.)

Employer Health Insurance Coverage Reporting (Continued)

- A person required to file a return under the new provision is also required to furnish a written statement to each full-time employee whose name is required to be reported on the return, showing the name, address and phone number of the person required to make the return, and the information required to be shown on the return with respect to such individual (Code Sec. 6056(c)(1), as added by the Affordable Care Act). The required statement must be furnished on or before January 31 of the year following the calendar year for which the information return was required to made (Code Sec. 6056(c)(2), as added by the Affordable Care Act.)

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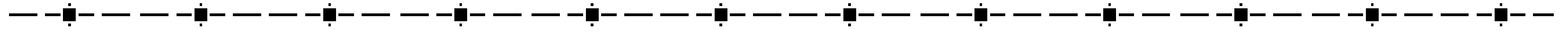
DISCUSSION AND QUESTIONS



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