COMPLYING WITH PPACA

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Introduction

- Legislation
  - Patient Protection and Affordable Care Act
  - Health Care and Education Affordability Reconciliation Act of 2010
- Main Objectives and Consequences
  - Increase transparency and efficiency of the health care system
  - Require health care coverage for individuals
  - Provide premium subsidies for lower income individuals
  - Impose new taxes, responsibilities, and penalties on employers and others

Employee Retirement Income Security Act of 1974 (ERISA)

- Establishes minimum standards for retirement and health and welfare benefit plans sponsored in private sector
- Sets standards of conduct for plan fiduciaries
- Requires covered plans to meet certain reporting and disclosure requirements
- Protects plan funds and plan participants
- Includes new health laws such as COBRA, HIPAA, and PPACA

Required Elements of ERISA Plan Document

- Named fiduciaries
- Allocation of responsibilities
- Funding policy
- Benefit payments
- Claims procedures
- Amendment procedures
- Privacy of PHI

"Wrap Plan" Document

- Insurance contracts alone do not satisfy ERISA documentation requirements
- Wrap plan:
  - Satisfies ERISA documentation requirements
  - Incorporates all programs into single health and welfare plan
  - Simplifies plan administration
  - Only one Form 5500 need be filed for all health and welfare coverage

Summary Plan Description (SPD)

- Plan administrators must furnish SPDs to participants free of charge
- SPD explains to participants what the plan provides and how it operates
- Defective SPD can result in penalties for plan administrators

"Wrap" SPDs

- Materials provided by insurers/TPAs lack required language for SPDs
- Wrap SPDs add required language to make complete SPD
- Wrap SPDs simplify plan administration:
  - minimize costs – avoid drafting new SPDs
  - reduce errors – use existing materials

ERISA Reporting Requirements for Benefit Plans: The Form 5500

- ERISA requires most plan administrators to annually file Forms 5500 with DOL
- Plans subject to ERISA's Form 5500 filing requirements that fail to timely file are liable for serious penalties

The DOL's Delinquent Filer Voluntary Compliance (DFVC) Program

- Normal civil penalties:
  - Late filers: $50 /day, with no limit
  - Non-filers: $300/day, up to $30,000/year

- DFVC's reduced civil penalties:
  - Small Plan: $10/day late, not to exceed $750/year; maximum of $1,500 per plan
  - Large Plan: $10/day late, not to exceed $2,000/year; maximum of $4,000 per plan

DFVC Program: Eligibility and Requirements

- Eligibility for DFVC Program:
  - IRS late-filer notice does not disqualify
  - DOL notice about late Form 5500 disqualifies
- DFVC Program Requirements:
  - Must file Forms 5500 using EFAST2
  - Certain forms and schedules must be used

PPACA From the Beginning--Stage 1

- It's now been 3 years since PPACA was signed into law
- You should have already:
  - Determined if your plan has Grandfathered status
  - Extended coverage to adult children to age 26
  - Removed lifetime limits from your plans
  - Held special enrollment periods when required

Required Amendments to Health Plans and Insurance Contracts

- Eliminate Health FSA and HRA reimbursements for over-the-counter drugs
- Cover adult children until age 26
- Eliminate lifetime/annual limits on Essential Health Benefits
- Revise claims procedures

Changes to FSAs and HRAs

- Health FSAs and HRAs can no longer reimburse for purchases of over-the-counter medications (except insulin)
- The age 26 rule applies to these plans

Required Notices

- Grandfathered Health Plan Notice
- Special Enrollment for Adult Children
- Lifetime Limits Notice
- Patient Protection Notice

Grandfathered Status

- You may presently have Grandfathered status, but does it make sense going forward?
- Can it realistically be maintained? Cost to provide coverage will likely go up as vendors raise costs, so employer will need to balance appropriate cost sharing with Grandfathered status benefits.
- Reminder of how Grandfathered status is lost
  - Increase in cost sharing
  - Decrease in employer contribution
  - New annual limits on benefits

Provisions Applicable to All Plans

- Coverage for adult children
- Restrictions on annual and lifetime benefit limits
- Elimination of pre-existing condition exclusions
- Limitation of rescissions

Provisions Applicable to Non-Grandfathered Plans

- Provide free preventive care services
- Selection of primary care providers
- No prior authorization for emergency services
- Insured group health plans will be subject to nondiscrimination rules
- Out-of-pocket limits
- Essential health benefits
- Internal and External Appeals Process

Internal and External Reviews

- Internal
  - Comply with DOL's current claims requirements plus six new requirements, including:
    - Resolving urgent care claims within 72 hours
    - Hiring independent decision makers to conduct reviews
    - Providing "culturally and linguistically appropriate" notices to participants and beneficiaries
- External
  - Comply with either:
    - state external review process for insured plans, or
    - procedures in a DOL Technical Release

Compliance--Stage 2

- What did you need to do during the past year?
  - Coordinating HRAs
  - Form W-2 reporting
  - Distribute Summary of Benefits and Coverage
  - Advance notice of material changes

HRAs and Restriction on Lifetime and Annual Limits

- HRAs: group health plans that reimburse medical expenses up to a specified dollar amount
- HRAs “integrated” with group health plans that satisfy lifetime and annual limits will not violate PPACA
- Transitional relief available to employers that currently sponsor non-integrated HRAs

Form W-2 Reporting Requirement

- What it is…
- Employers exempt from Form W-2 reporting until IRS issues further guidance:
  - Employers filing less than 250 Forms W-2 for the previous calendar year;
  - Employers sponsoring self-funded plans that are not subject to COBRA (e.g., self funded charity plans); and
  - Federally recognized Indian tribal government and tribally chartered corporations wholly owned by a federally recognized Indian tribal government

Summary of Benefits and Coverage

- No longer than four pages
- Culturally and linguistically appropriate
- Font cannot be smaller than 12 point
- Can be distributed electronically
- Must be provided by first day of the first open enrollment period beginning on or after Sept. 23, 2012

Responsibility for Providing Summary of Benefits and Coverage

- Group health plans and insurers must provide SBCs to participants/beneficiaries
- For insured plans, insurers must provide SBCs but plan administrators responsible for distributing SBCs
- For self-funded plans, plan administrator must create and distribute SBCs

Notice of Material Modifications

- 60-day advanced notice for any “material modification” in:
  - Terms of plan
  - Coverage involved
- Not required for contract renewals

What's coming next?--Stage 3

- Essential Health Benefits
- 90-day Waiting Period Limitation
- Annual Out-of-Pocket Maximums and Deductible Limits
- Automatic Enrollment
- Health Care Exchanges
- Individual and Employer Mandate

Essential Health Benefits (EHBs)

- Beginning in 2014, all Non-Grandfathered health insurance coverage offered in individual and small group markets must offer EHBs
- PPACA defines EHBs as the following 10 broad categories:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance abuse disorder services
  - 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

Essential Health Benefits (Continued)

- Defined on a state-by-state basis
- Use state benchmark
- Self-funded and large employer plans not subject to EHB rules

90-day Waiting Period Limitation

- Group health plans cannot impose waiting period in excess of 90 days
- Effective for plan years beginning on or after January 1, 2014
- Limit applies to Grandfathered and Non-Grandfathered group health plans

Annual Limits on Out-of-Pocket Maximums and Deductibles

- In 2014, PPACA limits annual out-of-pocket maximums and deductibles for certain employer sponsored plans
- For 2014:
  - Out-of-pocket maximum is same as for HSA-high deductible plans
  - Annual deductible limit are $2,000/single and $4,000/family

Auto Enrollments

- General rule
- When does it apply?
- How will it be applied?

Health Care Exchanges

- State operated arrangements that offer small employers and individuals the opportunity to purchase health coverage from private and non-profit insurers
- Exchanges begin operation in 2014
- Five categories of coverage offered through Exchanges: Bronze, Silver, Gold, Platinum, and Catastrophic

Health Care Exchange Notice

- Employers must provide notice to employees explaining:
  - Existence of Exchanges
  - Eligibility to receive premium tax credit through Exchange
  - Employee may lose employer contribution by purchasing coverage through Exchange

Individual Mandate: Minimum Essential Coverage

- Minimum Essential Coverage is defined as coverage under:
  - Employer-sponsored plans
  - Plans in the individual market
  - Certain government-sponsored plans
  - Other plans selected by HHS

Exemptions from Individual Mandate

- Members of religious organizations
- Members of federally recognized Indian tribes
- Individuals who were uninsured for short periods
- Individuals who:
  - qualify for hardship exemption;
  - cannot afford coverage because cost exceeds 8% of annual household income; or
  - are below tax filing threshold
- Incarcerated individuals
- Individuals not lawfully present in the U.S.

Individual Mandate: Penalty for Noncompliance

- For 2014: greater of $95 per adult and $47.50 per child and 1% of income over tax filing threshold
- Penalty is prorated on a monthly basis
- Penalties payable when income tax returns filed

Employer Mandate: Does it Apply?

- Employers with 50 or more Full-time Equivalent Employees (FTEs) are subject to Employer Mandate
- Employees of all members of a controlled group counted to determine whether Employer Mandate applies
- Employees working outside U.S. not counted

Employer Mandate: Penalty for Not Offering any Coverage

- Employers that do not offer coverage are subject to penalty if one full-time employee purchases coverage through Exchange with premium tax credit
- Annual penalty: $2,000/full-time employee (minus first 30)

Premium Tax Credits

- Premium tax credit available to people with incomes up to 400% of the Federal Poverty Level
- Usually based on household income

Employer Mandate: Penalty for Not Offering "Affordable Coverage"

- Coverage must have "minimum value" of 60% and employee contribution cannot exceed 9.5% of income, and
- one full-time employee receives premium tax credit
- Annual penalty: $3,000/full-time employee who receives premium tax credit

Safe Harbors for Determining Income

- W-2 Safe Harbor
- Rate of Pay Safe Harbor
- Federal Poverty Line Safe Harbor

Conclusion-Action Steps for Employers

- Determine if you should keep Grandfathered status
- Assess plan with regards to new requirements, including claims review procedures
- Prepare for:
  - Required open enrollments and automatic enrollments
  - New required communication materials and notices
  - Revisions of summary plan descriptions and new summaries of material modifications
  - Keep Alert: Government agencies will issue additional regulations and revise those that have already been issued

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