HealthSmart

Healthcare Reform Guide

READINESS ALERT

Mandates for 2013-2014

This update is part of our continuing series on healthcare reform.

1. AUTOMATIC ENROLLMENT

- Healthcare reform requires certain large employers to automatically enroll new full-time employees in one of the employer's health plans and continue the enrollment of current employees.
- The requirement applies to employers that are subject to the Fair Labor Standards Act, have more than 200 full-time employees and maintain one or more health plans. Employers must provide "adequate notice" to employees, and employees must be given the opportunity to opt out of coverage.
- PPACA did not specify an effective date for this requirement, so employers are not required to comply until final regulations are issued. Regulations are not expected to be circulated in time to implement this provision by 2014.

2. PROHIBITION ON EXCESSIVE WAITING PERIODS

A group health plan is prohibited from applying a waiting period that exceeds 90 days. This applies to grandfathered plans, but not to certain "excepted benefits." It is effective beginning January 1, 2014.

A waiting period is defined as the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.

3. NON-DISCRIMINATION BASED ON HEALTH STATUS

- Group health plans and insurers are prohibited from discriminating against an individual with regard to eligibility or coverage based on a health status-related factor (medical history, claims experience, genetic information, etc.). This means that, among other things, plans may not charge individuals different premiums or impose different costs based on the presence or absence of a health status-related factor. This is effective for plan years beginning on or after January 1, 2014.
- These provisions were not meant to prevent a plan from establishing premium discounts or reduced co-payments or deductibles in return for adherence to programs of health promotion or disease prevention (i.e., wellness programs).

Benefit of Wellness Plans

Healthcare reform increased the reward amount under a health-contingent wellness program from 20% to 30% of the cost of coverage, and up to 50% for programs designed to prevent or reduce tobacco use.

4. NOTICE OF EXCHANGE

- Any employer subject to the Fair Labor Standards Act must provide written notice about the health coverage options that are available through the State Exchanges and the consequences if an employee decides to purchase through the Exchange instead of purchasing employer-sponsored coverage.
- Notice must be provided to current employees by October 1, 2013 (to coincide with the initial open enrollment period for the Exchanges).
- Notice must be provided to new employees hired after October 1, 2013 within 14 days of their start date.
- Each employee must receive the Notice of Exchange, regardless of plan enrollment status or of part-time or full-time status. Employers are not required to provide a separate notice to dependents or other individuals who are eligible for coverage but who are not employees.

Additional Written Requirements for Your Plan

1. Inform employees on how to contact the State Exchanges for assistance.
2. Employees must be notified that they may be eligible for a premium tax credit or a cost-sharing reduction through the Exchange if the plan's share of the total cost of benefits under the plan is less than 60%.
3. Provide notice that if employees purchase coverage through the Exchange, they may lose any employer contribution toward the cost of employer coverage, and that all or a portion of employer contributions may be tax-exempt.

The Department of Labor has provided two model notices — one for employers who do not offer health coverage and another for employers who do offer employees health coverage. The notice may be modified, as long as it meets the content requirements under the regulations.

5. ANNUAL LIMITS PROHIBITED ON ESSENTIAL HEALTH BENEFITS (EHBs)

Plans are prohibited from imposing annual dollar limits on Essential Health Benefits. Previously, the limits were restricted, but now they are prohibited altogether. This applies to plan years beginning on or after January 1, 2014 and to both grandfathered and non-grandfathered plans.

Essential Health Benefits include the following general categories (specifics to be determined by HHS).

Ambulatory patient services	Emergency services	Hospitalization	Maternity and newborn care	Mental health and substance use 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

- Until HHS issues guidance, there is no way to precisely determine which benefits will be considered "essential" within the categories. Until regulations are issued, the agencies will take into account "good faith" efforts to comply with a reasonable interpretation of EHBs.
- In February 2013, HHS finalized regulations establishing standards for defining EHBs. Health plans in the small and individual group markets are required to ensure that coverage includes the EHB package. The basic building block for an EHB package is a benchmark plan designated by each state.
- There is no requirement that employer-sponsored self-insured health plans offer all EHB categories or conform to any of the EHB benchmarks. However, these plans are prohibited from imposing annual and lifetime dollar limits on the EHBs they do offer.

6. COVERAGE FOR CLINICAL TRIALS

- Group health plans providing coverage to a "qualified individual" can't deny the individual participation in an "approved clinical trial," deny (or limit or impose additional conditions on) coverage of "routine patient costs" for items and services in connection with the trial or discriminate against the individual based on participation in the trial.
- A "Qualified Individual" is a participant or beneficiary who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening diseases or conditions and either:

  The referring healthcare professional is a participating provider and has concluded that the participant's participation in the trial would be appropriate; or

  The participant provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In FAQ guidance, the agencies indicated they do not intend to issue regulations on this requirement before the effective date. Until further guidance is issued, plans are expected to follow a good faith, reasonable interpretation of the law.

- "Routine patient costs" include items and services typically provided under the plan for a participant not enrolled in a clinical trial. However, such items and services do not include (a) the investigational item, device, or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.
- "Approved Clinical Trial" is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening diseases or conditions and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the FDA; or is exempt from investigational new drug application requirements.
- "Life Threatening Condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.
- Applies to plan years beginning on or after January 1, 2014. Grandfathered plans are not required to comply.

7. NON-DISCRIMINATION AGAINST HEALTHCARE PROVIDERS

Healthcare reform prohibits group health plans and insurers from discriminating with respect to plan participation or coverage against any healthcare provider acting within the scope of that provider's license or certification under applicable state law. This becomes effective for plan years beginning on or after January 1, 2014. FAQ guidance indicates that the agencies do not intend to issue regulations before the provision's effective date and that until further guidance is issued, plans and insurers are expected to follow a good faith reasonable interpretation of the law. This does not require group health plans or insurers to contract with any provider willing to abide by the terms and conditions for participation established by the plan or insurer. It does not prevent group health plans from establishing varying rates of reimbursement based on quality or performance measures and doesn't apply to grandfathered plans.

8. PRE-EXISTING CONDITION PROHIBITION (APPLIES TO EVERYONE)

At-a-Glance

A pre-existing condition exclusion means a limitation of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial).

Healthcare reform prohibits group health plans and insurers from imposing any pre-existing condition exclusions. This is effective for plan years beginning on or after January 1, 2014.

The prohibition includes both denial of enrollment and denial of specific benefits based on a preexisting condition. In addition, a pre-existing condition exclusion also includes any limitation or exclusion based on information relating to an individual's health status, such as a condition identified as a result of a pre-enrollment questionnaire or physical exam given to the individual.

9. PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE FEES (PCORI)

- Healthcare reform created the Patient-Centered Outcomes Research Institute, a non-profit corporation to support clinical effectiveness research. This research will be funded partially by PCORI fees paid by certain health insurers and self-funded employee health plans.
- The fee applies to plan years ending on or after October 1, 2012, and applies to plan years ending after September 30, 2019.
- The PCORI fee must be reported and paid once a year using IRS Form 720.

Fee Calculations

To calculate the amount of the fee, self-funded plans have a choice to use any of the following three methods:

- **Actual Count Method** – The average number of covered lives can be calculated under the plan for the plan year by calculating the sum of the lives covered for each day of the plan year and dividing that sum by the number of days in the plan year.
- **Snapshot Method** – The average number of covered lives is calculated by adding the total of lives covered on one date in each quarter, or an equal number of dates for each quarter, and dividing the total by the number of dates on which a count was made.
- **Form 5500 Method** – The average number of covered lives is calculated based on a formula that includes the number of participants actually reported on the Form 5500 for the plan year. Under this method, the total number of lives is determined by adding the participant counts at the beginning and end of the year.

The fee is $2.00 times the average number of covered lives under the plan. In later years, the fee will increase.

10. REINSURANCE PAYMENTS

- Contributing Entities are required to make contributions toward reinsurance payments in order to establish a temporary reinsurance program for non-grandfathered plans in the individual market. This includes insurers and self-funded plans and is effective from January 1, 2014 through December 31, 2016.
- For the 2014 benefit year, contributing entities must submit their enrollment counts to HHS by November 15, 2014. HHS will invoice each contributing entity based on its enrollment count within 30 days, or by December 15, 2014. The contributing entity then has 30 days to remit the contribution.
- The contribution amount for 2014 is $63.00 per enrollee per year.
- The method to determine the number of covered lives are the same as those used to determine the PCORI fee (Actual Count, Snapshot, and Form 5500 Method).

Did You Know?

Your plan is "grandfathered" if you kept the changes that were in effect on March 23, 2010 and have made only those changes permitted by the grandfather rules. If your plan is grandfathered, there are provisions of the ACA that will not apply to you. Typically, a plan can lose its grandfathered status if it eliminates certain benefits, increases co-insurance, or decreases contributions toward the cost of coverage by more than 5% below the contribution rate on March 23, 2010.

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11. COST-SHARING LIMITATIONS

- This applies to plan years beginning on or after January 1, 2014 (exception for grandfathered plans). There is a one-year safe harbor to the Out of Pocket (OOP) max rule in recognition of the fact that plans may utilize multiple service providers to help administer benefits (such as a TPA for medical and a separate PBM for prescription drug coverage).
- Healthcare reform requires cost-sharing to be limited. This includes deductibles, coinsurance and copays to Essential Health Benefits covered under the plan. It does not include premiums, balance billing amounts for non-network providers or non-covered services.
- The cost-sharing limitations contain an overall limit on the OOP maximum and a deductible limit.
- For the deductible limits, the agencies have clarified that this will only apply to the small group market. The OOP maximums apply to all group health plans.

One-Year Safe Harbor

Regarding the one-year safe harbor, where the plan uses more than one service provider to administer benefits that are subject to the annual OOP max limitation, the requirement will be satisfied if both of the following conditions are met:

- The plan complies with the OOP maximum limit with respect to its major medical coverage (excluding, for example, prescription drug coverage).
- To the extent there is an OOP maximum on other coverage (for example, if a separate OOP applies with respect to Rx coverage), such OOP maximum does not exceed the allowed dollar amounts for the OOP maximums.

The cost-sharing for self-only and coverage other than self-only coverage cannot exceed the maximum OOP expense limits for self-only and family coverage for HSA-compatible HDHPs for taxable years beginning in 2014. For 2014, the HDHP maximum OOP expense limit (that is, the sum of the plan's annual deductible and other annual OOP expenses (other than premiums) that the insured is required to pay, such as copayments and coinsurance for a HDHP) cannot exceed $6,350 for self-only coverage and $12,700 for family coverage. In addition, the deductible cannot exceed $2,000 for a plan covering a single individual or $4,000 for any other plan.