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Compliance at-a-glance

- Essential Health Benefits, Minimum Value, and Cost-Sharing…Oh My! Health Care Reform Further Defined

- Contraception Mandate, Meet Non-profit Religious Organizations. Offerings by Carriers with no Cost-Sharing
- Small Businesses SHOP until they drop; How to use the Exchange
- Carriers Get a Little Reprieve on Medical Loss Ratio Rebates
- Non-profit Carriers Get Exemption from Health Insurance Provider Fees
- Premium Tax Credits and Cost-Sharing Rules Finalized… Somewhat
- Multiple Employer Welfare Arrangements Crackdown!
- Multi-State Plan Programs Cover More Ground

FINAL REGULATIONS RELEASED ON HEALTH CARE REFORM'S ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE, AND MINIMUM VALUE

On February 20, 2013, Final Regulations were released on the health care reform Essential Health Benefits, Actuarial Value and Minimum Value. Highlights are as follows:

INDIVIDUAL AND SMALL GROUP PLANS

Essential Health Benefits[1] (EHBs) must be included in all non-grandfathered Individual and Small Group plans beginning January 1, 2014. These EHBs must provide:

- Plans with Actuarial Values (AV) of 60%, 70%, 80%, and 90%

[1] Ambulatory Patient Services, Emergency Services, Hospitalization, Maternity and Newborn Care, Mental Health and Substance Use Disorder Services, Prescription Drugs, Rehabilitative and Habilitative Services and Devices, Laboratory Services, Preventative and Wellness Services and Chronic Disease Management, Pediatric Services (Oral and Vision)

Important Dates

Plan Years on/after 9/23/2012 - Summary of Benefits and Coverage (SBC) must be provided to plan participants and prospective participants upon marketing, 30 days prior to renewal and within 7 days of special enrollment election (for calendar year plans the effective date was January 1, 2013)

Plan Years Ending on/after 10/1/2012 - Comparative Effectiveness Fee: Fully-insured carriers and self-funded plan sponsors will be subject to a fee in the amount of $1 per covered life. The Fee is due July 31 of each year using Form 720 "Quarterly Federal Excise Tax Return"

Plan Years on/after 1/1/2013 - Flexible Spending Accounts limited to $2,500 for employee contributions

60 days after the beginning of the plan year - Employer Creditable Coverage Reporting to CMS due (e.g., if your plan effective date is 1/1, you must report by 3/1)

3/1/2013 - Notice of Exchange delayed pending further regulations (Expected effective date of Summer/Fall 2013)

10/1/2013 – Health care reform Exchange open enrollment begins

10/15/2013 - **Medicare Part D creditable and/or non-creditable coverage notices** to plan participants due (if not previously provided earlier in the year as part of the Benefits Information Guide or at open enrollment)

11/15/2013 - Barney & Barney's Legislative Compliance 2014 Outlook Seminar in San Diego, CA

11/15/2013 – Health care reform reinsurance fee reporting due for carriers and self-funded plans (including HRA plan sponsors where not integrated with a self-funded plan)

1/1/2014 – Health care reform employer mandate effective for calendar plan years. For non-calendar plan years, the effective date is the first day of the plan year only if on December 27, 2012, the plan offered coverage to 1/3rd of employees or covered 1/4th of employees

- Cost-sharing limits equal to amounts allowed for High-Deductible Health Plans (HDHPs):
  - ✓ $6,250 self-only
  - ✓ $12,500 family
  - ✓ Including deductibles, coinsurance, and copayments for in-network providers
- No annual or lifetime dollar limits (grandfathered and non-grandfathered)

Small Group Health Plan Deductible Limits

- $2,000 for self-only coverage
- $4,000 for other than self-only coverage
- Subject to future indexing

MINIMUM VALUE

In 2014, employer plans must offer Minimum Value (MV) coverage to an employee, or potentially be subject to a tax penalty.

- Alternative methods for calculating MV to come, including design-based safe-harbor checklists
- Plans with non-standard plan features may use actuarial certifications
- Employer Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA) contributions made (where integrated with a major medical plan) will be used in the MV calculation (not dollar-for-dollar)

The Minimum Value (MV) Calculator can be found here: http://cciio.cms.gov/resources/regulations/index.html#pm

OUT-OF-POCKET MAXIMUMS

In 2014, non-grandfathered, large group, individual and small group plans will be subject to Out-Of-Pocket (OOP) maximums for cost-sharing.

- Cost-sharing limits equal to amounts allowed for High-Deductible Health Plans (HDHPs):
  - ✓ $6,250 self-only
  - ✓ $12,500 family
  - ✓ Including deductibles, coinsurance, and copayments for in-network providers
- Indexed for future years

Payments that do not count towards the maximum cost-sharing limit are:

- Premiums
- Non-covered services
- Balance billing amounts
- Cost-sharing for out of network providers

TRANSITION RELIEF FOR PLANS WITH MORE THAN ONE SERVICE PROVIDER AND WITH DIFFERENT OOP LIMITS

- The limit on out-of-pocket maximums is satisfied if both of the following conditions are met:
  - ✓ The major medical plan complies with the out-of-pocket maximum; and
  - ✓ Satisfies the limit on out-of-pocket maximums for coverage other than major medical

Example: third party administrators for major medical coverage, separate pharmacy benefit manager, and a separate managed behavioral health organization

ACTION REQUIRED

- ☐ *Small group employers should ensure that all plans include all ten EHBs*
- ☐ *Ensure that OOP maximums and deduction limits are met*
- ☐ *Large group employers are encouraged to take a look at the MV calculator*

For more information regarding these final regulations, please go to: http://www.gpo.gov/fdsys/pkg/FR-2012-07-20/pdf/2012-17831.pdf*; and,* http://www.ofr.gov/OFRUpload/OFRData/2013-02420_PI.pdf

PROPOSED REGULATIONS ISSUED ON HEALTH CARE REFORM'S CONTRACEPTION MANDATE AND RELIGIOUS EMPLOYERS

Non-grandfathered health plans are prohibited from imposing cost-sharing for specified women's preventive services, including contraceptive services defined as any:

- Food and Drug Administration (FDA) approved contraceptive methods
- Sterilization procedures
- Patient education and counseling for all women with reproductive capacity

Religious employers are exempt if:

- Opposes providing coverage for contraceptive services on account of religious objections
- Organized and operates as a non-profit entity (assets may not accrue to private individuals or shareholders)
- Holds itself out as a religious organization
- Self-certifies above criteria and maintains such records for 10 years

Exemption includes student health plans of eligible religious organizations. If there are multiple employers

who offer coverage under one group health plan, then each entity will be assessed as to whether that entity is an eligible employer.

Delayed enforcement was granted for certain non-profit religious organizations for one year (for plan years beginning on or after August 1, 2012 through August 1, 2013) meeting the following requirements:

- The organization is a non-profit entity
- From February 10, 2012, the group health plan has consistently not covered contraceptive services
- Notice was provided to participants that contraceptive services would not be covered under the plan
- The organization self-certifies that it meets the above three requirements

This above enforcement exception is set to expire for plan years beginning after August 1, 2013, at which time religious employers meeting the **current** definition for religious employers will be the only religious organizations exempt from the Employer Contraception Mandate.

In addition, upon receipt of a religious employer's self-certification, a carrier or Third-Party Administrator (TPA) should provide:

- Options to employees for contraceptive services outside of the group plan
- Assurance that costs for contraceptive services are not passed onto the group policy; and
- Written notice of contraception availability to plan participants

Proposals to create a separation between an employer and the cost-sharing prohibition for contraceptive services:

For self-insured plans:

- TPA would voluntarily arrange (or automatically enroll) employees into coverage that prohibits cost-sharing for contraceptive coverage; or
- The TPA would arrange for an affiliated carrier or an independent carrier to handle the contraceptive coverage

For fully-insured plans:

- The carrier would automatically enroll plan participants and beneficiaries into individual plan policies covering contraceptive services with no cost-sharing, at no charge to plan participants and beneficiaries
  - ✓ This contraceptive coverage plan would be a new contraceptive services-only HIPAA-excepted benefits category

ACTION REQUIRED

- ☐ *Qualified religious employers with objections to providing contraceptive services should obtain a religious employer exemption through self-certification*
- ☐ *For-profit religious organizations will be required to comply with the contraception mandate beginning plan years on/after August 1, 2013*

Information regarding these proposed regulations is available at:
http://www.ofr.gov/OFRUpload/OFRData/2013-02420_PI.pdf

REGULATIONS RELEASED ON THE SMALL BUSINESS HEALTH OPTIONS PROGRAM

Employers that use the Exchange's Small Business Health Options Program (SHOP) when offering employee health coverage, need only offer one Qualified Health Plan (QHP) option within the "medal band" rather than multiple QHP options. This one option QHP is allowed until 2015.

- Applies to the Federally Facilitated SHOPs (FF-SHOPs) where it is only required to offer a single QHP choice for the 2014 plan year
  - ✓ FF-SHOPs do not allow for different contribution percentages for different categories of employees
- For plan years 2014 and 2015 only:
  - ✓ State Exchanges may define their own parameters for counting employees or determining full-time employees
  - ✓ State-Based Exchange (SBE) SHOPs will allow states to permit employees to "buy up" to richer plans

Other highlights from these latest regulations include:

- Carriers participating in the SHOP Exchange are not required to participate in the Individual Exchange
- Carriers in the Individual Exchange will only be required to participate in the SHOP Exchange if they have at least a 20 percent market share in the small group market
- QHPs in the Federally-Facilitated Exchange (FFE) or FF-SHOP must offer brokers the same compensation as those paid for similar plans outside of the Exchange

- Minimum participation rates may also be set by SHOPs
  - ✓ FF-SHOPs will have a minimum participation requirement of 70 percent, which may be varied for purposes of SBEs
  - ✓ Employees who participate in another group plan will not be counted toward the participation rate

NO ACTION REQUIRED

Applicable small employers should be aware of the ability to obtain coverage for employees through the SHOP or FF-SHOP. However, certain limitations may apply as to employee choice on these plans. More information regarding the SHOP and FF-SHOP final rules can be found at:
http://www.ofr.gov/OFRUpload/OFRData/2013-04902_PI.pdf

More information on the interim final amendments on SHOPs and FF-SHOPs can be found at:
http://www.ofr.gov/OFRUpload/OFRData/2013-04904_PI.pdf

FINAL REGULATIONS ON HEALTH CARE REFORM'S MEDICAL LOSS RATIO

- Carriers required to spend 80% (small group) to 85% (large group) of premium dollars on medical care and health care quality improvement
- Reinsurance fees are to be subtracted from earned premiums as a regulatory fee
- Date for payment of the Medical Loss Ratio (MLR) rebates to insured individuals and beneficiaries moved to September 30th annually (from the previous date of August 1st)

NO ACTION REQUIRED

Employers should now be aware that MLR rebates will be issued later in the year. More information can be found on the MLR final rule at::
http://www.ofr.gov/OFRUpload/OFRData/2013-04902_PI.pdf

PROPOSED REGULATIONS FOR HEALTH INSURANCE PROVIDERS FEE

The following covered entities will be subject to additional fees pursuant to health care reform:

- Health insurance issuers (carriers)
- Health Maintenance Organizations (HMO)
- An insurance company that would be subject to a tax, but for the entity is exempt from tax under section 501(a) of the Internal Revenue Code (IRC)
- An insurer that provides health insurance under Medicare or Medicaid
- A non-fully-insured Multiple Employer Welfare Arrangement (MEWA)

Entities that are not subject to the health insurer fee are the following:

- Self-insured employers
- Governmental entities
- Certain non-profit corporations
- Voluntary Employee's Beneficiary Associations (VEBAs)
- Educational institutions in relation to Student Health Insurance (because carrier is the covered entity)

Health insurance policies that are subject to the fee include:

- Any medical service policy or certificate
- Hospital or medical service plan contract
- Health maintenance organization contract offered by a health insurer
- Limited dental and vision benefits
- Retiree-only health plans (fully-insured)

Health insurance policies that are not subject to the fee include:

- HIPAA-excepted benefits, *except for limited dental and vision benefits*
- Educational institution arrangements, other than through an insured arrangement, that charge student administrative health fees for access to student health clinics

AMOUNT OF THE HEALTH INSURANCE PROVIDER FEE

- Fee is based on covered entity's share of the net premiums written for health insurance in the United States for the year prior (reduced by ceding commissions and MLR rebates)
- First $25 million of net premiums is exempt
- 50 percent of the net premiums written for amounts between $25 million and $50 million will be subject to the fee
- 100 percent of the premiums written above $50 million will be subject to the fee

NO ACTION REQUIRED

Employers should be aware that this fee will most likely increase premiums for fully-insured plans.

Further information on Heath Insurance Provider Fees can be found at:
http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf

FINAL REGULATIONS ISSUED ON HEALTH CARE REFORM'S REINSURANCE FEE PROGRAM

- Program built to help stabilize premiums within the market
- Fee will be collected by the Department of Health and Human Services (HHS)
- Responsible entities are fully-insured carriers and self-funded plan sponsors
- Fee is $63 per year, per plan member (including spouses and dependents), or $5.25 a month, per enrolled member
- Must disclose number of covered lives by November 15th of each year
  - ✓ HHS will then notify the entity of the payment amount, no later than December 15th, or 30 days after the submission of the covered lives report
  - ✓ Entity must then pay the amount to HHS within 30 days

ACTION REQUIRED

- ☐ *Employers with self-funded plans should prepare to report the number of plan participants to HHS by November 15th (forms yet to be issued)*
- ☐ *Employers with fully-insured plans should expect this cost to be passed down in their next renewal*

Further information regarding the Reinsurance Program, is available at:
http://www.ofr.gov/OFRUpload/OFRData/2013-04902_PI.pdf

FINAL REGULATIONS ON COST-SHARING AND PREMIUM TAX CREDITS IN THE EXCHANGE

Qualified individuals seeking health coverage in the Exchange may be entitled to an advanced premium tax credit or a reduction in their cost-sharing (i.e., co-pays, deductions, etc.) should they be of low income (i.e., 100-400% of the Federal Poverty Level (FPL). The FPL for 2013 is $11,490 for a single person). Highlights from the regulations are as follows:

- Eligibility will be based upon an enrollee's expected annual income
- A change in income during the year will be subject to reconciliation to ensure no over payment of tax credits
- Family members entitled to different levels of cost-sharing requirements can obtain separate insurance policies, or purchase family coverage at the lowest level of cost-sharing that a family member would be eligible
- Catastrophic plans are not entitled to premium tax subsidies or cost-sharing
- Stand-alone dental plans are not entitled to reduced cost-sharing subsidies
- Certain Tribal members with household incomes below 300 percent of the FPL may have zero cost-sharing
- Maximum OOP limits for households with incomes 250 - 400 percent of the FPL will have a standard OOP expense limit of $6,400
- Households with incomes 200 - 250 percent of the FPL will have OOP limits reduced by 1/5 of the standard OOP expense limit
- Households with incomes below 200 percent of the FPL will have OOP limits reduced by 2/3 of the standard OOP expense limit
- FFEs will charge a 3.5 percent, of monthly premium charges, as a user fee
- QHPs must submit to the Exchange three silver-plan variations that include the following:
  - ✓ With actuarial values of 94 percent for household incomes between 100 and 150 percent of the FPL
  - ✓ 87 percent for household incomes between 150 and 200 percent of the FPL
  - ✓ 73 percent for households with incomes between 200 and 250 percent of the FPL

NO ACTION REQUIRED

Employers should be aware of these final regulations in order to better inform their employees. Further information on this topic is available at:
http://www.ofr.gov/OFRUpload/OFRData/2013-04902_PI.pdf

Information can also be found on Federal and State Partnership Exchanges as it relates to QHPs is available at:
http://cciio.cms.gov/resources/files/issuer-letter-3-1-2013.pdf

FINAL REGULATIONS ON REPORTING REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

Final regulations relating to the reporting requirements for Multiple Employer Welfare Arrangements (MEWAs), Entities Claiming Exceptions (ECEs), and additional enforcement against fraudulent health plans, were recently released. Highlights are as follows:

- Non-plan MEWAs must register with the Department of Labor (DOL) before operating in a

State

- Plan MEWAs, as well as non-plan MEWAs, and ECEs subject to M-1 filing must also file a Form 5500, regardless of the plan size or funding arrangement
- The Department of Labor (DOL) may issue cease and desist orders against a MEWA that may be participating in fraudulent activity, without formal notice or hearing, to the MEWA
- Plan assets of the MEWA may also be seized in order to preserve plan assets

NO ACTION REQUIRED (UNLESS A MEWA)

☐ *Employers participating in a MEWA should ensure that these above regulations are being followed, including proper Form 5500 filing and M-1 filing*

For further review of these final regulations, go to:
http://www.gpo.gov/fdsys/pkg/FR-2013-03-01/pdf/2013-04863.pdf

FINAL REGULATIONS ON ESTABLISHMENT OF THE MULTI-STATE PLAN PROGRAM FOR EXCHANGES

Final regulations in relation to the Multi-State Plan Program (MSPP) were recently released. The multi-state program allows carriers to offer Multi-State Plans (MSPs) that may be marketed in multiple health insurance Exchanges. Highlights from these regulations are as follows:

- U.S. Office of Personnel Management (OPM) will be responsible for certifying an MSP
- Once certified, the MSP may participate in all health insurance Exchanges
- MSPs cannot be placed in a more competitive position, or less competitive position, than its non-MSP counterparts
- MSPs must offer plans in 60% of states in the first year of issuing policies, but are not required to offer coverage throughout the entire state, only "to the extent it is within their capability to do so"
- By the fourth year, the MSP must be offered to all States and the District of Columbia
- Two MSPs must be offered in each insurance Exchange, with one of those issuers being a non-profit entity
- MSPs must comply with state rating rules and regulation, although OPM retains the right to approve rates for final participation

NO ACTION REQUIRED

For further review of these final regulations, go to:

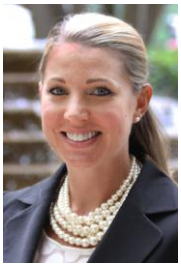
https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-04954.pdf

QUESTION OF THE MONTH

Q: For 2013, one of our employees elected $2,400 of health FSA coverage under our calendar-year cafeteria plan. She has already incurred medical expenses equal to this amount and wants to be reimbursed for the expenses now, even though she has only made health FSA salary reductions of $400 to date. (Our health FSA is funded solely through employee salary reductions and does not include a grace period.) Do we have to reimburse all of these expenses right away, or can we limit reimbursements to the amount our employee has already contributed and ask her to resubmit the remaining expenses as additional contributions are made?

A: Your employee must be reimbursed for all of her expenses now, assuming that the expenses are otherwise eligible for reimbursement (e.g., they are for medical care incurred during the current period of coverage, and appropriate substantiation has been provided). That's because IRS requirements for health FSAs include a "uniform coverage" rule under which the maximum amount of reimbursement must be available at all times during the plan year (or other period of coverage), reduced only for any prior reimbursements for the same period. Reimbursement is deemed "available" under the uniform coverage rule if claims are paid at least monthly, or when an employee's submitted claims reach a reasonable plan minimum (e.g., $50). Thus, reimbursements cannot be restricted to the amount of the employee's contributions.

The uniform coverage rule also prohibits accelerating an employee's salary reductions based on health FSA claims submitted or paid. (Note that the uniform coverage rule does not apply to DCAPs, so reimbursements under a DCAP can be limited to the amount that has been contributed, less expenses already reimbursed.)



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