BARNEY&BARNEY™
Legislative Compliance

Compliance Monthly | June 2013 | Issue 6

IN THIS ISSUE

Contacts

Lisa R. Nelson, Esq.
Director, Compliance & Regulatory Affairs
(858) 875-3017

Christopher K. Bao, Esq.
Compliance Mgr., Orange County
Compliance & Regulatory Affairs
(949) 540-6924

CA Insurance LIC: 0C03950
www.barneyandbarney.com

FINAL RULES ISSUED ON SMALL BUSINESS HEALTH OPTIONS PROGRAM

The Final Rules were released on June 4, 2013 mainly adopting the previously proposed rules on the Establishment of Exchanges and Qualified Health Plans. However, some differences do exist, and substantiation on previous positions from the proposed rules were made final. Highlights of these rules are below:

SUMMARY

Background

The Patient Protection Affordable Care Act establishes that there will be a Small Business Health Options Program (SHOP) in each State, to help small employers provide coverage to their employees. These SHOPs will have special enrollment periods, and be able to receive aggregated premium payments from employees enrolled in multiple Qualified Health Plans (QHPs) in the Exchange.

In addition, qualified employers participating in SHOPs may offer employees a choice among all QHPs at a level of coverage chosen by the employer (e.g., bronze, silver, gold, platinum), in addition to small employers being able to offer QHPs by other means. Federally-Facilitated SHOPs (FF-SHOPs) are to have similar choices offered to employees.

Special Enrollment Periods in SHOPs

Previously, in the proposed Exchange Establishment Rule, special enrollment periods for SHOP and FF-SHOP Exchanges were 60 days (rather than the standard 30 days from a triggering event, for group health plans).

The Final Rule has amended the special enrollment period for SHOPs to 30 days, for most triggering events. A 60 day special enrollment period to select a QHP is only allowed when an employee or dependent has the following two triggering events:

- Becomes eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP); or
- Loses eligibility for Medicaid or CHIP

Final Rules Issued on Small Business Health Options Program (Continued)

Transitional Relief for SHOPs

Guidance indicates that, SHOPs and FF-SHOPs are to allow employers the option of offering QHPs at a level of coverage chosen by the employer (e.g., bronze, silver, gold, platinum). However, because of the initial complications associated with setting up the Exchanges, the following transition relief has been offered to SHOPs and FF-SHOPs:

- SHOPs – For plan years beginning on or after January 1, 2014, and before January 1, 2015, SHOPs are not required to offer employees a choice of QHPs at a certain level of coverage, but may do so, and are not required to aggregate premiums for employees who enroll in multiple QHPs
- FF-SHOPs – For plan years beginning on or after January 1, 2014, and before January 1, 2015, FF-SHOPs will only be required to offer employers a single QHP option from the choices in the FF-SHOP to offer to their employees,

On January 1, 2015, SHOPs and FF-SHOPs will be required to allow employers to offer multiple QHPs under a specific level of coverage chosen by the employer.

Action

Small employers should be aware of the different options available in the SHOP and FF-SHOP.

For more information regarding this regulation, please go to:

http://www.ofr.gov/OFRUpload/OFRData/2013-13149_PI.pdf

FORM 5500 METHOD FOR REINSURANCE CONTRIBUTIONS

As of recent, The Centers for Medicare and Medicaid Services (CMS) issued a set of Frequently Asked Questions (FAQs), addressing various health care reform provisions needing clarification. FAQ Q4 in particular, addresses how to properly handle reinsurance contributions for employers wishing to use the 5500 count method.

Health insurers and self-insured health plan sponsors must contribute to a temporary reinsurance program for years 2014 through 2016. The contribution is based upon the number of covered lives in a benefit year. Several methods are offered for counting the number of covered lives.

One of these methods for counting covered lives is the Form 5500 method. Confusion previously existed as to whether the Form 5500 method for non-calendar year plans could be used for non-calendar year plans, because reinsurance contributions were based upon a "benefit year" (which is defined as a calendar year) rather than a plan year.

The clarification, and point of FAQ Q4, is to notify employers that self-funded health plans may use the Form 5500 counting method, even if its plan is not a calendar year plan (i.e., plan year beginning January 1)

Action

Employers with self-funded non-calendar year plans should be aware that the Form 5500 method is available to be used to calculate reinsurance contributions.

For more information regarding this FAQ, please go to:

https://www.regtap.info/uploads/library/PMQHP_FAQ11_052813_5cr_052913.pdf

QUESTION OF THE MONTH

Q: My business is a plan sponsor for a calendar-year, non-grandfathered major medical plan. When are we required to comply with changes made midyear to the recommendations or guidelines relating to the coverage of preventive health services?

A: Non-grandfathered, non-excepted group health plans are required to provide coverage for specified preventive services without cost-sharing, when those services are delivered by in-network providers, for plan years beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar-year plans).

A list of the preventive services that must be covered without cost-sharing – including services for adults, women, and children, can be found on the HHS's website. This list will be updated as recommendations and guidelines are changed over time by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration.

Initially, plans were required to cover preventive services that were listed in recommendations and guidelines issued on or before September 23, 2009. Compliance with future recommendations and guidelines is required for plan years beginning one year or later after the recommendation or guideline is issued, creating a year space between the date on which a recommendation or guideline is issued, and the date on which a plan must cover the services listed in that recommendation or guideline. For example, for the plan year that begins January 1, 2014, your plan must cover (without cost-sharing to the extent they are delivered by in-network providers) the preventive services listed in recommendations and guidelines that were issued on or before January 1, 2013.

Contributing Editors: EBIA Staff.

IMPORTANT DATES

PLAN YEARS ON / AFTER 08/01/2012

- **Health Care Reform's Women's Preventive Services Mandate** with no cost-sharing (for calendar year plans the effective date was 01/01/2013)

PLAN YEARS ON / AFTER 09/23/2012

- **Health Care Reform's Annual Dollar Limits** for "essential health benefits" restricted to no less than $2 million, absent a waiver (for calendar year plans the effective date was 01/01/2013)
- **Summary of Benefits and Coverage (SBC)** must be provided to plan participants and prospective participants when marketing, 30 days prior to renewal, upon demand within 7 days, and upon special enrollment election (for calendar year plans the effective date was 01/01/2013)

PLAN YEARS ENDING ON / AFTER 10/01/2012

- **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 07/31 of the year following the calendar year in which the applicable plan year ended using Form 720 "Quarterly Federal Excise Tax Return"

PLAN YEARS ON / AFTER 01/01/2013

- **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 a plan effective date is 01/01, reporting must be completed by 03/01)

OCTOBER 2013

- **10/01/2013 – Notice of Exchange**. Ongoing employees must receive notice before 10/01/2013; for each new employee, notice must be provided upon hire beginning 10/1/2013
- **10/01/2013 – Exchange Initial Open Enrollment** begins
- **10/15/2013 – Medicare Part D Creditable and/or Non-Creditable Coverage Notice** to plan participants due (if not previously provided earlier in the year as part of the Benefits Information Guide or at open enrollment)

NOVEMBER 2013

- **11/14/2013 – Barney & Barney's Legislative Compliance 2014 Outlook Seminar** in San Diego, CA
- **11/15/2013 – Reinsurance Fee** reporting due for carriers and self-funded plans (including HRA plan sponsors where HRA is not integrated with a self-funded plan)

JANUARY 2014

- **01/01/2014 – Employer Mandate** effective for calendar year plans. For non-calendar year plans, the effective date is the first day of the plan year only if on 12/272012, the plan offered coverage to 1/3rd of all employees (full-time and part-time) or covered 1/4th of employees (full-time and part-time)