P4P … Preparing for PPACA

Session #15:

Traps for the Unwary: Open PPACA Issues Heading into 2013-2014

September 20, 2012

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4980H – Determining Full-Time Status

- Two "just-released" notices – Notice 2012-58 and Notice 2012-59 (or DOL Technical Release 2012-02)
- Can be relied upon through 2014
- Builds on existing "guidance" to date
  - 30 hours per week/130 per month = FT
  - Permits use of Look-back/stability periods for determining FT status of variable rate employees
    - Note: New vocabulary: "look-back" now = "measurement period"
  - Seasonal employees? -- Employers may use reasonable good faith interpretation through at least 2014
  - Maximum 90-day waiting period can run consecutive to look-back (with some very important exceptions)

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4980H – Determining Full-Time Status

- But many issues/open questions remain:
  - Can you start the look-back/measurement period in 2014 or do I need to look back into 2013 for this purpose?
  - If I use a shorter look-back/measurement period for initial compliance with 4980H, will I be able to move to a longer period?
  - How do I treat rehires?
  - Hot do I count "hours"?
  - What happens if because of administrative errors, a *de minimis* percentage of variable rate employees who should be classified as FT for the stability period are not so classified or are classified as so, but after some inadvertent delay?

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4980H – Dependent Coverage

- Open issue remains how the following language will be addressed in formal rulemaking by the regulators in interpreting the statutory requirements of IRC sections 4980H(a) and (B) –

  "full-time employees (and their dependents)"

- Preamble to NPRM on IRC section 36B indicates that the regulators are of the view that –
  - Applicable large employers must make qualifying minimum essential coverage available to full-time employees <u>and their dependents</u>,
  - BUT that affordability will be based on self-only coverage
    - Issue of whether dependents could be left ineligible for a premium tax credit by reason of the employer providing affordable self-only coverage

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Minimum Value and HSAs/HRAs

- MV calculations for employer-sponsored plans could be complex
- Potential avenue for regulators to require employers to provide specific benefits under plan
- HSA/HRA contribution will likely be treated as first dollar coverage under accompanying health plan
  - IRS Notice 2012-31 (minimum value request for information)
  - Employer's HSA/HRA contribution will improve actuarial value but not as much as if an alternative "full credit" method were used
  - Rationale in allowing only partial credit is that full amount of HSA/HRA contribution may not be used each year

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Exchange Notice - Overview

- Employers must provide notice to all employees about Exchange coverage
- Due date 3/23/13 (but no guidance)
- Notice to explain availability of Exchange coverage, how to access, and that premium credit may be available

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Exchange Notice - Issues

- Due date: 3/23/13
- But no model or guidance yet
- Most plans are already printing enrollment materials/SPDs that include other legal notices, so may need separate mailing for this notice
- Notice required for all current employees and new hires, not just plan participants (so may not be able to just include in SPD)

Cost-Sharing Limits

- Cost-Sharing Limits (PHSA sec. 2707(b)) effective 2014
  - Deductible limit - $2,000 individual / $4,000 family
  - Out-of-Pocket Maximum - $6,250 individual / $12,500 family (as indexed)
- Statute applies to a “group health plan” (non-grandfathered) but other interpretations may be possible

Women's Preventive Care – Overview

- Plans must cover "recommended" preventive services at 100% without cost sharing
- Full range of preventive care services required to be covered for plan years on or after 9/23/10 (1/1/11 for calendar year plans). List at www.healthcare.gov/prevention
- New guidelines for women's health adopted for plan years on or after 8/1/12 (1/1/13 for calendar year plans). List at www.hrsa.gov/womensguidelines
- N/A to Grandfathered Plans
- Does not apply to out-of-network (may require individual to go in-network)

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Sample List of Women's Services Plan Years On or After 8/1/12

- Well-woman visits
- Screenings for gestational diabetes
- HPV testing
- Counseling for STDs
- Counseling & screening for HIV
- All-FDA approved contraceptive methods & counseling (exemption for certain religious employers)
- Breastfeeding support, supplies & counseling
- Screening & counseling for interpersonal & domestic violence

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Women's Preventive Care - Issues

- Plans may establish "reasonable medical management techniques" to determine frequency, method, treatment, or settings of care to the extent not specified in recommendation
  - Examples: Require prescription for contraceptives, cover generic over brand
- Only required to cover women's preventive care. Agencies have noted that condoms and vasectomies not required to be covered
- Specific services to be covered? For example, how many pre-natal visits? What type of breast pump?

Transitional Reinsurance Program Fee

- New per capita fee that legally or effectively will run to plan sponsors
  - Estimates are that the fee could range from $60 to $105 per covered life/enrollee or dependent
- Effective only for 2014-2016
- Requires all health insurance issuers, and third party administrators "on behalf of" self-insured "group health plans", to make contributions to support the transitional reinsurance program
  - Does not apply to HIPAA-excepted benefits and non-commercial business
  - Question about how it will apply to EAPs, wellness, disease management and onsite medical if "group health plan"

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Transitional Reinsurance Program Fee

- Contributions are collected quarterly beginning 1/14
  - Aggregate contributions to be collected for and/or by all states (although states may collect more) are: $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016
  - An additional amount equal to $2 billion in 2014, $2 billion in 2015 and $1 billion in 2016 will be collected for general Treasury fund
- Final regulations - a flat per capita amount is determined based on all "covered enrollees"
- Very many open questions

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Expatriate Coverage - Issues

- Expatriate coverage excepted out of some provisions, but not all.
- No “one size fits all” rule.
- Different applicability rules based on specific provision of PPACA.
- May vary significantly based on particular facts.
- *May differ based on whether participants are US expatriates, resident aliens in US, or non-US citizens abroad. Also may differ based on whether insured or self-funded and whether insurer is licensed in US.

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Expatriate Coverage
Some Guidelines

- Insurance market reform provisions (age 26 rule, annual limits, preventive care) apply to "group health plans" with no exception for expatriate coverage
- HHS has said that insurance market reforms apply to US territories
- If plan excepted under ERISA foreign plan provision, may be able to argue also excepted from insurance market reform
- ERISA foreign plan exception applies if coverage "maintained outside the United States primarily for benefit of persons substantially all of whom are nonresident aliens." ERISA 4(b)(4)

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Expatriate Coverage
Some Guidelines

- Some specific guidance on expats:
  - MLR rules have different treatment for expats
  - SBC rules allow one-year delay for SBCs for expats
  - PCOR fee not applicable to expats
- Some requirements may depend on particular employer/employee relationship
  - Example: W-2 reporting required if employer otherwise must provide W-2 for that employee

Expatriate Coverage Some Guidelines

- Individual mandate not applicable to:
  - Non-US citizens or nationals or to individuals not lawfully present in US (presumably because not US taxpayer)
  - Individuals eligible for foreign earned income exclusion (generally if bona fide resident of foreign country for at least 330 days of year)
  - Residents of US Possession (for at least 183 days of year and no tax home outside of possession)

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Stand-Alone HRAs

- Permitted for active employees?
  - No annual/lifetime limit on essential health benefits
- Typical HRA today vs. future
- Exempt from annual/lifetime limit rule:
  - Retiree-only HRAs
  - HRAs that are “integrated” with other group health plan coverage
- If permitted, how will HRAs satisfy employer’s obligation to meet mandate?

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