P4P ... Preparing for PPACA

Session #15:

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

September 20, 2012
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)
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?
  – How 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?
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 and their dependents,
  - 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
 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
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
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)
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
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 prenatal 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”
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
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.
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)
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)
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?