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PPACA Update: 2012 and Beyond

August 9, 2012

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Agenda

- PPACA and the Supreme Court
- 2012
  - W-2 Health Value Reporting
  - Comparative Effectiveness Research Tax on Plans
  - Quality of Care Reporting
  - Summary of Benefits & Coverage & Uniform Glossary
  - Women's Preventive Services
- 2013
  - Health FSAs
  - Notice of Exchanges

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PPACA and the Supreme Court

PPACA and the Supreme Court

- *United States v. Alvarez*
  - Anti-Injunction Act (labels matter)
  - Individual mandate:
    - Commerce Clause
    - Taxing authority (labels don't matter)
  - Medicaid expansion
  - Severability
- Continued litigation
  - Religious plans and contraception

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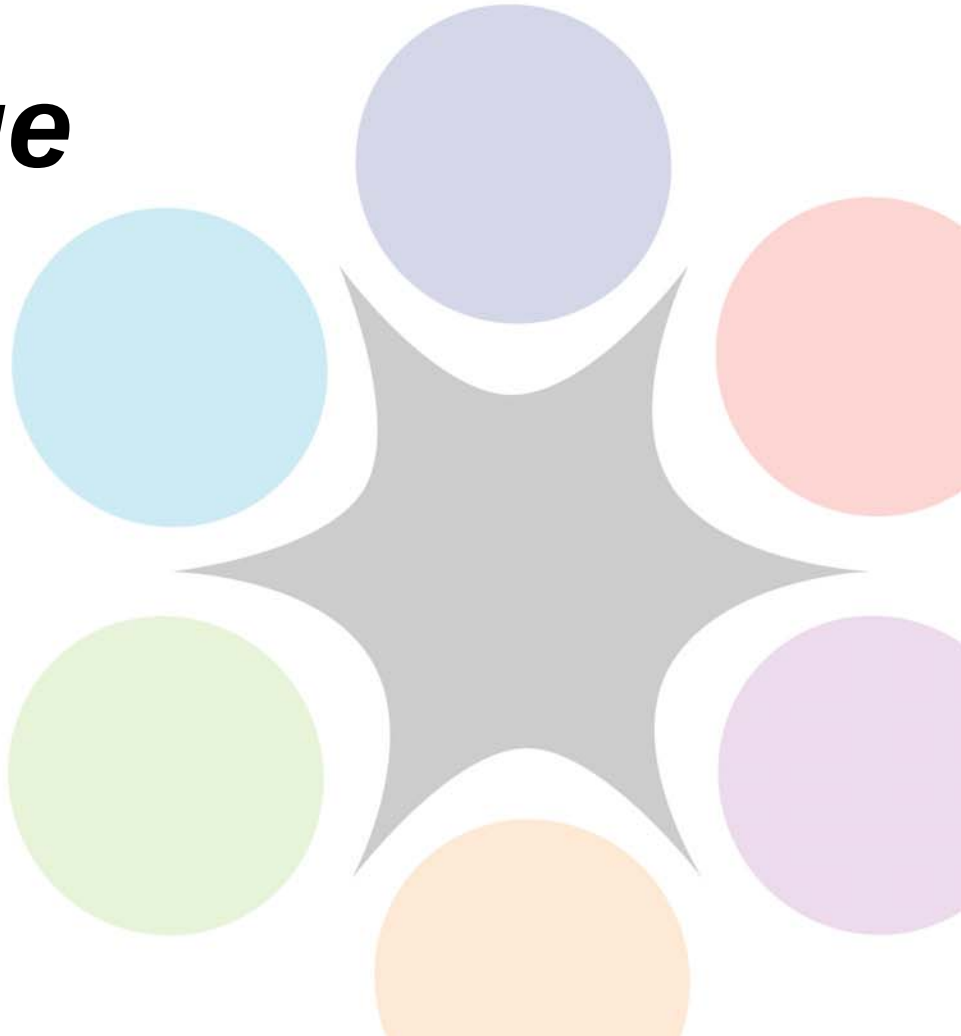
W-2 Health Value Reporting



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W-2 Health Value Reporting

- Employers must report the value of group health plan coverage on the Form W-2
  - Uses COBRA rate to calculate
  - Includes employer and employee contributions
  - Begins the 2012 tax year
  - Does not change the tax treatment of employer-provided health coverage. For informational purposes only

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W-2 Health Value Reporting

- Employers are required to report the value of all “applicable employer-sponsored coverage”
- Relevant employers:
  - All private-sector employers
  - Federal, state, and local governments
- However there are exemptions for:
  - Self-funded employers exempt from COBRA (religious plans)
  - Indian tribal government plans
  - Individuals not otherwise receiving a W-2 (retirees)

W-2 Health Value Reporting

- "Applicable employer-sponsored coverage" does not include:
  - Health FSA Contributions (but separate rules apply for optional employer flex credits)
  - Coverage under HSAs
  - Coverage under HRAs
  - HIPAA-excepted benefits
  - Onsite medical clinics, employee assistance & wellness programs (unless a separate COBRA rate is charged)

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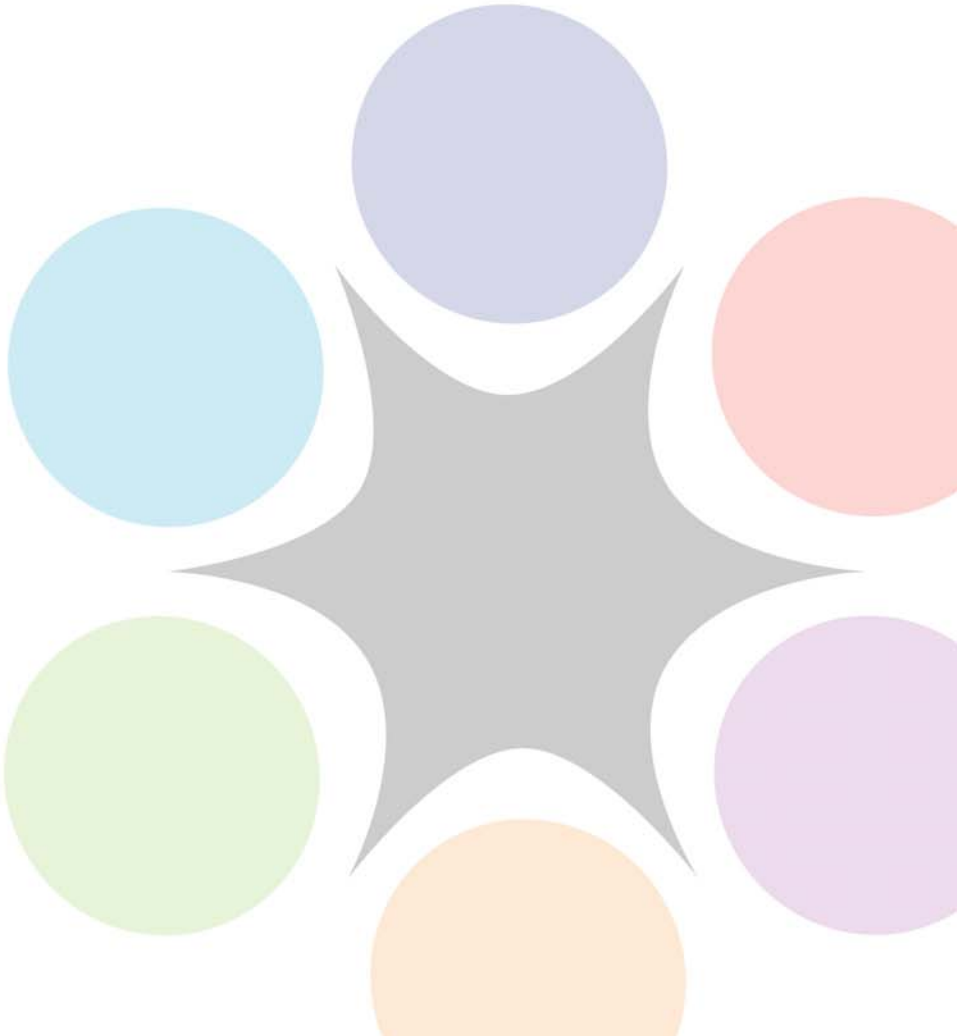
Comparative Effectiveness Research Tax on Plans



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What is CER?

- Comparative Effectiveness Research (“CER”)
  - Compares health treatments and strategies to provide evidence on the effectiveness, benefits and harms of different treatment options available to patients
  - Performed in an effort to:
    - Present research evidence to the public to assist clinicians and patients with making well-informed, health-related decisions on the best treatment options available
    - Cut the overall cost of healthcare by providing patients with essential information needed to make well-informed health decisions

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Funding

- Although CER has been conducted in America for many years, it failed to receive significant federal funding until now
  - In 2009 the American Recovery and Reinvestment Act (“ARRA”) earmarked $1.1 billion over a two-year period
  - In 2010 healthcare reform continued ARRA’s expansion of CER by further financing it through the establishment of the Patient Centered Outcomes Research Trust Fund

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CER Trust Fund

- Funding for the CER Trust Fund will begin in 2012
  - Funded through apportions from private health plans
  - Employers will pay an annual CER fee of:
    - $1 per plan participant for the fiscal year ending in 2013
    - $2 per plan participant for fiscal years ending in 2014-2019
- The fee is effective for:
  - Plan years ending on or after October 1, 2012
- Duration:
  - The Fund will only be available for research until Sep 2019
  - After that date, the fee sunsets and any remaining balance will be transferred to the general treasury

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CER Trust Fund

- The fee applies to:
  - Fully insured and self-funded group health plans
    - Including expat, retiree, mini-med, and HRA plans
- Certain exceptions allowed:
  - Excepted benefits, Medicare, potentially health FSAs, and HSAs
- Reporting and payment
  - IRS Form 720 is required to be submitted by July 31 of the next calendar year
- Fee calculation
  - Actual Count Method
  - Snapshot Method (ERISA plans only)
  - Form 5500 Method

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Controversy

- The recent expansion of CER through healthcare reform has been a source of controversy
  - Questions have been raised over whether:
    - The research will ultimately lead to a limitation on patient health care options
      - Studies have shown that while the general public sees the value in the research, there is a fear that it will ultimately be used to ration care or limit doctors' ability to tailor their care
    - Given the amount of funding allocated to the project, whether it will even actually lower health care costs at all

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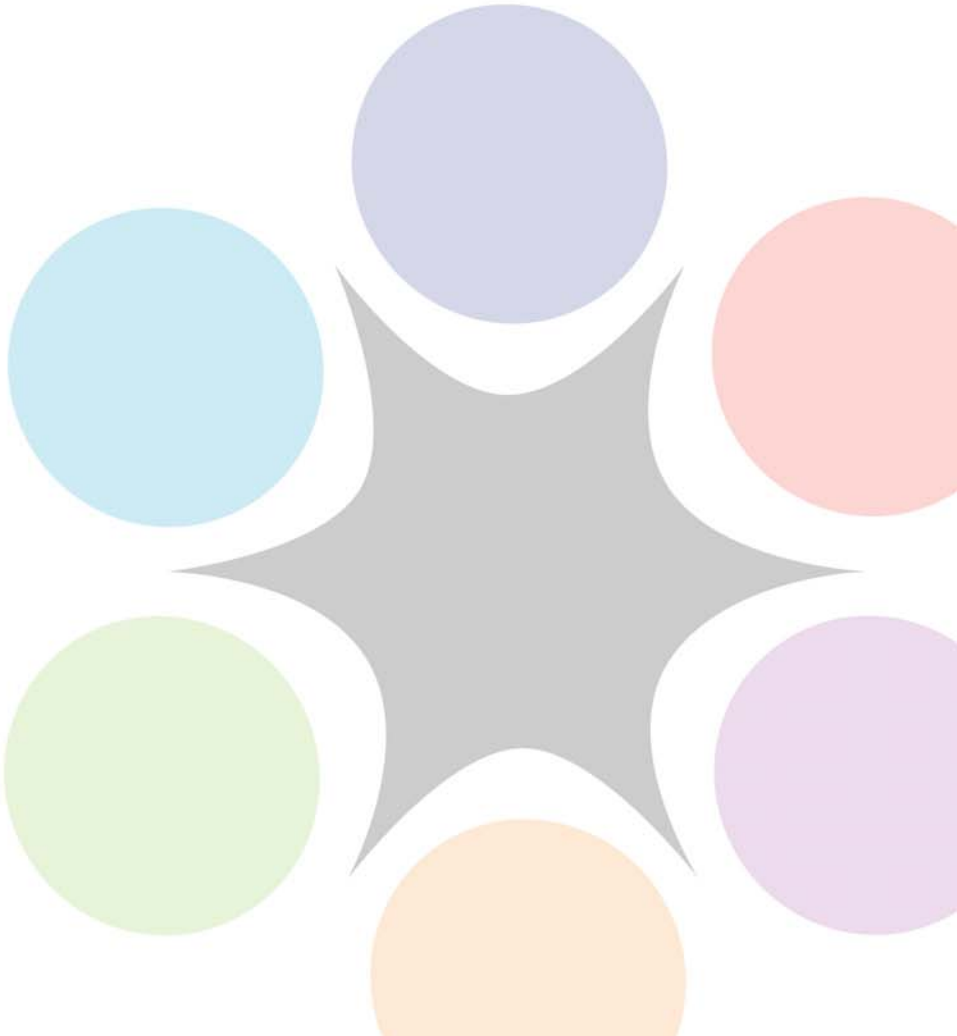
Quality of Care Reporting



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Quality of Care Reporting

- Group health plans must submit an annual report to the HHS addressing whether or not plan benefits satisfy several criteria related to the cost and quality of health care
- The requirements of this report are being developed through consulting with health care quality experts and stakeholders

Quality of Care Reporting

- HHS must develop the requirements by March 23, 2012
- HHS must also issue regulations that provide criteria for determining whether a "reimbursement structure" is subject to the reporting rule
- No specific due date yet → HHS will address this in upcoming regulations

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Quality of Care Reporting

- The Report will include whether the plan:
  - Improves health outcomes for treatment or services under the plan through activities such as quality reporting, CM, care coordination, DM, and medication and care compliance initiatives
  - Implements activities to prevent hospital re-admissions using a comprehensive discharge program and post-discharge reinforcement
  - Improves patient safety and reduces medical errors through best clinical practices, evidence-based medicine, and health information technology
  - Implements wellness and health promotion activities

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Quality of Care Reporting

- The Report:
  - Must be provided to enrollees during each open enrollment period
  - Will be available to the public on the Internet
- Grandfathered plans are not required to comply with these reporting requirements

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Summary of Benefits & Coverage & Uniform Glossary

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SBC & Uniform Glossary

- For all plans beginning or renewing on or after September 23, 2012,new documentation must be provided to beneficiaries of a plan to include:
  - A summary of benefits and coverage (“SBC”)
  - A uniform glossary of standard definitions for certain insurance and medical terms

SBC & Uniform Glossary

- Must be provided:
  - If the plan provides written materials for enrollment, no later than the first date the participant is eligible to enroll
  - For special enrollment, 90 days from enrollment
  - Upon request, 7 business days
  - If the plan automatically renews, 30 days from the start of the plan year
  - 60 days before a material modification

SBC & Uniform Glossary

- Issues to consider:
  - Culturally and linguistically appropriate?
  - When due?
  - Integrated with the SPD?
  - What benefits must be included?
- Compliance with this regulation is essential because of the heavy penalties that can result
  - $100 per day, per person
  - $1,000 violation if willfully committed

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Women's Preventive Services

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Women's Preventive Services

- Non-grandfathered group health plans are required to provide preventive services. This requirement:
  - Includes certain women's preventive services
  - Must be provided with no co-pay, co-insurance, or a deductible
  - Is effective starting the first plan year on or after August 1, 2012*

*Religious plans have a one-year delayed effective date

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Women's Preventive Services

Preventive Service	Guideline	Frequency
Well-woman visits ("WWV")	WWV annually for adult women to obtain age and developmentally appropriate preventive services	Annually, with exceptions depending on woman's health status, risks and needs
Screening for gestational diabetes	Screening for gestational diabetes	In pregnant women between 24-28 weeks of gestation and at the 1st prenatal visit for pregnant women identified to be at high risk for diabetes
Human papillomavirus ("HPV") testing	High-risk HPV DNA testing in women with normal cytology results	Screening beginning at age 30 every 3 years regardless of pap smear results
Counseling for sexual transmitted infections ("STIs")	STIs counseling for all sexual active women	Annually

Red text indicates a new preventive service requirement

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Women's Preventive Services

Counseling & Screening for human immune-deficiency virus ("HIV")	HIV counseling and screening for all sexually active women	Annually
Contraceptive methods and counseling	All FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for women capable of reproducing	As prescribed (includes over-the-counter items) (women only)
Breastfeeding support, supplies, and counseling	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting or purchasing breastfeeding equipment	In conjunction with each birth
Screening & counseling for interpersonal & domestic violence (In draft form recently released)	Screening & counseling for interpersonal & domestic violence	Annually

Red text indicates a new preventive service requirement

Women's Preventive Services

- Contraceptives
  - FDA-approved contractive methods include barrier methods, hormonal methods, emergency contraception, implanted devices, and permanent methods.
    - Cost Sharing allowed for branded drugs if a generic version is available and just as effective and safe.
    - Reasonable management techniques allowed: frequency, method of delivery, treatment, prescription requirement, and setting
- Breast pump machine administration
- Updating plan document/SPD and employee communications

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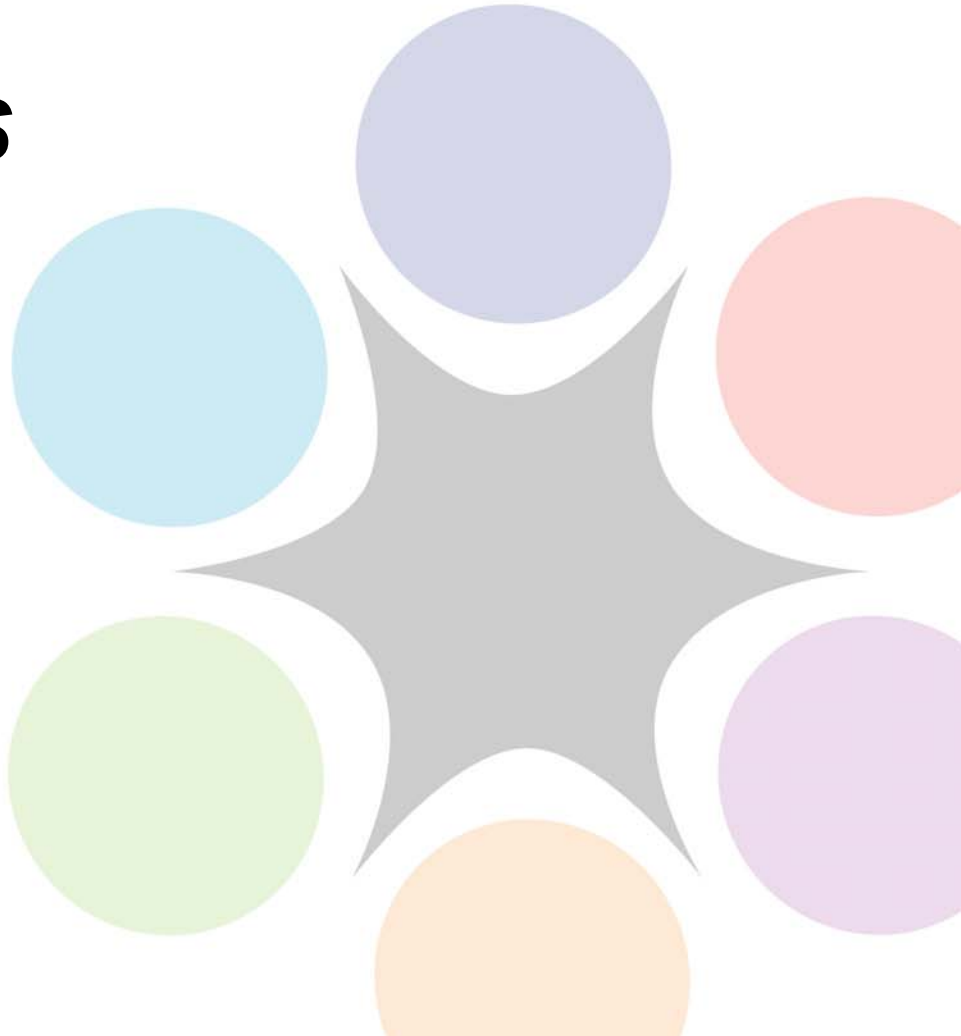
Health FSAs



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Health FSAs

- PPACA imposed a $2,500 limit* on health FSAs
  - Begins the first plan renewal on or after January 1, 2013
  - Applies to salary reductions (but not non-cash employer flex credits)
  - Applies on a per-employee basis (regardless of the number of dependents)
    - But spouses can have their own health FSAs and $2,500 limit, even if they work for the same employer

*Indexed annually for cost-of-living adjustments

Health FSAs

- Failure to comply means loss of tax exempt status
  - Allowance for failure if due to reasonable mistake
- Amend plan document/SPD and notify participants
  - Grace period: retroactive amendment/SMM possible by December 31, 2014

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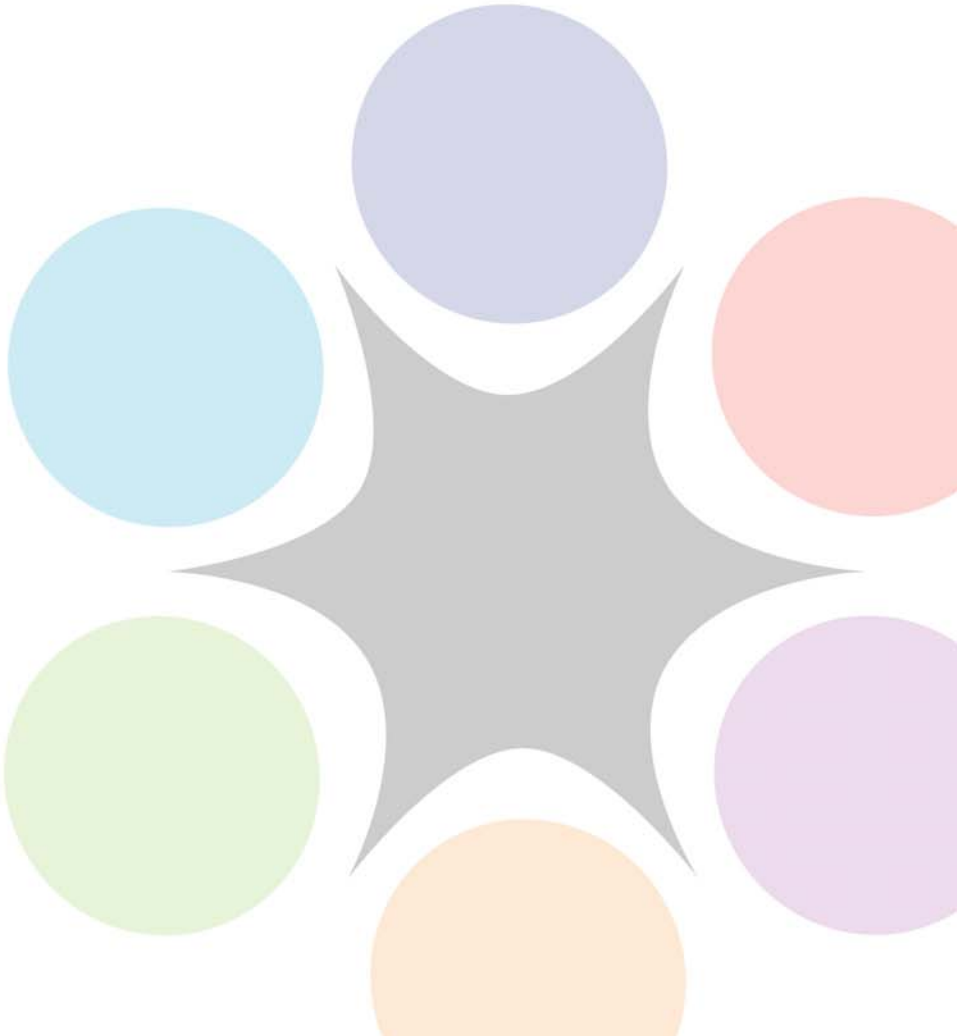
Notice of Exchanges



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Notice of Exchanges

- Under FLSA, employers must provide all new hires and current employees with a written notice about the health benefit Exchange and some of the consequences if an employee decides to purchase a qualified health plan through the Exchange in lieu of employer-sponsored coverage
- Model notices to be issued by HHS
- Notice due earlier of March 1, 2013 or time of hiring
- Applies to any "employer" to which FLSA applies

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Questions or Comments

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