2014 PPACA Overview

Patient Protection Affordable Care Act	Employer Size		Funding	
Patient Protection Affordable Care Act Administrative Costs March 23, 2010	**< 50 employees**	**>50 employees**	**Fully Funded Compliance Required**	**Self Funded Compliance Required**
Patient Centered Outcome Research Institute (PCORI): The "plan sponsor" (self-funded designated employer) fee is addressed under Section 4376 for applicable self-insured plan. The current regulations identify a fee structure for plan years 2012-2018. The annual filing will be identified on the revised IRS Form 720. Fees must be paid by July 31, 2013 of the calendar year immediately following the last day of the plan years **ending after September 30, 2012/Plan Years on or after October 1, 2012. (October Plan Years will pay initial PCORI fee schedule July 2014 all other plan months initial payment July 2012)** Fee is $1.00 per participant for 2012, **$2.00** per participant for 2013, and fee will be indexed for future payments. HRA and H.S.A. counts will be fee applicable if integrated with a health plan. Eligibility audits and documentation requirements should be implemented Public Sector trend is 8% -10% error rates. Private Sector is 6%-8% error rate. Fee is $1.00 per participant for 2012, $2.00 per participant for 2013, and indexed for the future. HRA and H.S.A. counts will be applicable if integrated with a health plan.	$1.00 PPPY Compliance Required	$1.00 PPPY Compliance Required	Compliance Required	Compliance Required
Transitional Reinsurance Fund: The program designed to help stabilize premiums in the individual health insurance market for those with pre-existing conditions, will be effective from 2014 through 2016. Fees of $63.00 PPPY (Employee, Dependent, COBRA, Retirees accessing plan) to support this transitional reinsurance program will be assessed against both insured and self-funded group health plans. HHS will collect the reinsurance fees on an annual basis. **By Nov 15 of each year, the contributing entity must submit the number of covered lives subject to the fee that calendar year. HHS will notify the contributing entity of the total fee to be paid within 15 days of submission or by December 15. Payment to HHS will be within 30 days of receiving notice of the amounts. Established in each state by January 1, 2014. The program will operate from November 2014 through 2016**. **November 2014 is projected to be timeframe for first payment**. The total amount of fees to be collected over the three-year period is $25 billion. Of this amount, $20 billion will fund the reinsurance program, while the other $5 billion will be paid to the U.S. Treasury. This program, designed to help stabilize premiums in the individual health insurance market for those with pre-existing conditions, will be effective from 2014 through 2016. Health insurance issuers and third party administrators will pay the assessment to fund state nonprofit reinsurance entities, which will establish high-risk pools for the individual market.	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Annual Insurance Provider Fee: Net Premium in 2014/by total industry net premiums from health, vision, dental, and retiree benefits. Take the ration of the net premium per industry premium and multiply the cost to achieve the annual insurance provider fee schedule for 2014=$8B – 2018=$14.3B. Awaiting public comments. Current discussion is in regards to definition of covered entity and will that include self-funded employers or will it only include commercial carriers. Awaiting June 21, 2013 meeting. In some portion of the language it states self-insured and governmental entities are excluded and in other portions of the language it defines self-insured and governmental entities as "covered entities". **Proposed regulation is in comment and definition phase of development.**	Awaiting June 21, 2013 regulatory response from comments.	Awaiting June 21, 2013 regulatory response from comments.	Awaiting June 21, 2013 regulatory response from comments.	Awaiting June 21, 2013 regulatory response from comments.
Summary of Benefits and Coverage (SBC) uniform information about the plan and coverage, as well as a uniform glossary of terms commonly used in health coverage, at the time of enrollment and each subsequent ear during annual enrollment and upon request. Both documents must comply with certain appearance and format requirements and must utilize terminology understandable by the average plan enrollee. Must be compliant on or after September 23, 2012. The summary must contain information regarding cost sharing, continuation of coverage, benefit limitations and details on where participants	Compliance Required	Compliance Required	Compliance Required	Compliance Required

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can obtain more information. This summary is required in addition to the ERISA summary plan description. Failure to comply will result in a $1,000 fine per employee.				
Medical Loss Ratio Payment: Employer subsidy vs. employee risk	Return Premium/Contribution excess if loss ratio is <80	Return Premium/Contribution excess if loss ratio is <85	Return Premium/Contribution excess if loss ratio is <85	N/A
HITECH Upgrades: 4010 to 5010 June 2012, Health Plan Identifier Application March 29, 2013, Electronic Fund Transfers: V-Payment/ACH Payment **by January 2014** compliance date, ICD 10 conversion from ICD 9 October 2014 compliance date. Group health plans must file a certification with the Secretary of HHS that their plan is in compliance with the "administrative simplification" rules for electronic fund transfer, health claim status and health care payment. The penalty for non-compliance is $1.00 per covered life per day of non-compliance, to a maximum of $20.00 per covered life per year. A double penalty applies in the case of a misrepresentation by the employer. Hybrid timeline for ICD 9 and ICD 10 October 2014. Automatic electronic > 200 enrollment 2014 possible delay.	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Calendar Year 2012 W-2 Form reporting required to be furnished to employees in January 2013 for employers that were required to file 250 W-2 Forms. Notice 2012-9 includes information on how to report, what coverage to include and how to determine the cost of coverage.	N/A IRS publishes guidance giving at least 6 months of advance notice of change to the transition.		X	X
Employer Cost Share Program/Pay or Play Penalty: **Beginning Plan Years January 2014 and thereafter (July 2, 2103 announcement that the IRS penalty will be delayed until January 2015 HB 2667 vote 246-161 individual mandate 251-174 vote)** the pay or play rule will be effective. If employers with at least 50 full-time equivalent employees fails to offer minimum essential major medical health coverage to its full-time employees and their dependents, and at least one full-time employee who works on average 30 hours or more a week/130 hours a month and/or 120 consecutive seasonal days a year obtains a subsidized coverage in a state health insurance Exchange/Insurance marketplaces the 4980H(a) penalty is $2,000 times the total number of full-time employees employed by the employer for employees in excess of the employee deductible of thirty (30). Hours of service include both hours paid based on performance of duties as well as paid time for vacation, holiday, illness, incapacity (including disability) layoff, jury duty, military duty or leave of absence. Special rules apply to unpaid leave subject to the FMLA of 1993 and the Uniformed Service Employment and Reemployment Rights Act of 1994 that the averaging method exclude if from calculation so that the employee is not disadvantaged by taking these leaves. Rules only apply to employees who are in continuing service, not to those who are terminated and then rehired. Employees rehired with less than a 26 week break in employment may apply "rule of parity" if rehired with a greater than 26 week break, will be treated as new hire. Employees not paid on an hourly based may be calculated on (1) counting actual hours of service; (2) using a days-worked equivalency, which credits the employee with 8 hours of service for each day or (3) using a weeks-worked equivalency of 40 hours of service per week. A large employer will be treated as having offered coverage to its full-time employees and their dependents for a calendar month if, coverage is offered to 95% of its full-time employees as long as dependent coverage was also offered. Failure to offer coverage to 95% of all full-time employees will result in the 4980H (a) penalty being imposed. Measurement Period: of 12 consecutive months not less than 6/3 months. Begin no later than July 1, 2013 and ends no earlier than 90 days before the first day of the plan year that begins on or after January 1, 2014. Payroll Departments need to review reporting for hours worked, measurement period, high turnover positions, unpaid work hours, employees being paid outside of payroll, unpaid work hours, variable hourly employees, temporary staff, terms and rehires.	Compliance Not Required	Compliance Required	> 50 full time equivalent employee's compliance required: **Small employer (generally under 50) maximum deductible $2,000 individual and $4,000 family and maximums for High Deductible Plans Out of Pocket Maximums cannot exceed $6,250 Out of Pocket and $7,500 family Out of Pocket.** **Awaiting final regulations**	>50 full time equivalent employees compliance required

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Affordability Test/Employer Shared Responsibility Penalty: If the coverage does not meet the "affordability test" or the "minimum value test" and at least one full time employee obtains subsidized coverage in a state health insurance Exchange/Marketplaces than the employer would pay a 4980H (b) penalty. $3,000 times each full-time employee who receives subsidized coverage in Exchange/Marketplaces. Penalty (b) impacts the employer who offers health coverage to its full-time employees and their dependents but the coverage does not meet the "affordability test" or the minimum value test and at least one full-time employee obtains subsidized coverage in a state health insurance exchange, then the employer would pay a 4980H (b) penalty. The amount would be $3,000 times each full time employee who receives subsidized coverage in Exchange with a maximum of the 4980H (a) penalty amount that would have been due if the employer did not receive coverage. » "Affordability Test" allows the employers to measure 9.5% of the employee's wages from the employer, as reported in Box 1 of the Form W-2 instead of household income in regards to the most cost effective minimum qualified health plan option actuarially equivalent to the Bronze Plan. » Employers should be aware that there are two "play or pay" tests – the **objective test** and the **subjective test**. The objective test asks whether the covered employer provides any level of health care coverage. If the answer is no, the employer penalty is $2,000 per employee (with a 30 person deductible). The subjective test asks if the employer provides health care coverage, is that coverage sufficiently affordable and robust. Coverage is sufficiently affordable if the cost is 9.5% or less of employee's W-2 form compensation for the most cost effective single coverage for an employee's benefit plan. » The Penalty will be the lesser of the objective and subjective test-the IRS wants to make sure the employers who are providing some level of coverage do not end up paying more in penalties than an employer who is not providing any coverage. » Employers will be penalized if an employee receives a premium tax credit provided by the Federal Government to Insurance Marketplaces/Exchanges on behalf of individuals whose income is between 100 and 400 percent of the poverty level. The existence of premium tax credit matters to employers because a penalty will apply if one employee receives a premium tax credit. Minimum Essential Major Medical Actuarial Value Calculator: 60% Bronze Plan/Individual Deductible not excess of $2,000 individual/$4,000 family for small employers. The 2013 maximum out of pocket for major medical plans currently excluding prescription plans is $6,250 for single coverage and $12,500 for family. The 2014 maximum out of pocket has not been released. Discussion for 2014: Individual $6,350, Family $12,700.				
Small Employer Premium Tax Credit: Full Time Employees + full time equivalents +total employees. If the total is less than 25/50 take the total wages of the full time and full time equivalents and divide by number of employees-average wage amount. If the result is less than $50,000 the employer may be able to qualify for the premium credit. TML IEBP has a new bill that dropped on 3.12.13 number 1076. Congressman Hall has introduced the bill with Thornberry as co-sponsor. Employer Premium Tax Credits that provide coverage for 25/50 or fewer employees with $50,000/$40,000 maximum average wage. Premium Tax Credit for employer maximum of 35%, Tax Exempt employer maximum 25%.	Recipients are Qualified Health Plans	N/A	25/50 fewer employees	Most self-funded groups are larger than 25/50 employees.
Health Flexible Spending: Accounts starting in 2013 implemented limits on contributions to $2,500 annually.	Compliance Required	Compliance Required	Compliance Required	Compliance Required

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Model COBRA Continuation Coverage Election Notice: The notice must contain information about individual's right to continue health care coverage in current plan as well as other health coverage alternatives that may be available through the Health Insurance Marketplace with tax credits. Additional note requirement that preexisting condition exclusion and/or limitations will be prohibited **beginning 2014** under the Patient Protection Affordable Care Act. IRS proposed regulations lower and middle – income employees who quit or are laid off, or employees' widowed or divorced spouses who are eligible for COBRA but do not enroll, will be entitled to premium subsidies to buy health insurance in public exchanges that begin operating in 2014. Currently proposed regulations state that the COBRA plan would have to fail the 9.5% affordability test and satisfy the 400% federal poverty level test to access COBRA single-coverage. Comments are being received on this proposed regulation and potential penalty.	Compliance Required	Compliance Required	Compliance Required	Compliance Not Required
Prohibition of Pre-Existing conditions for >19 years of age participants Plan Years Jan 2014 thereafter	Compliance Required	Compliance Required		
Essential Benefits: Ambulatory patient services, Emergency services, Hospitalization, Maternity and Newborn Care, Mental Health and Substance Use Disorder services (including Behavioral Health treatment), *Rehabilitative/Habilitative* Services and Devices, *Pediatric Services including Oral and Vision* Services (Pediatric defined child to attained 19 years of age), Laboratory Services, Preventive and Wellness, Chronic Care Management, Prescription drugs (Use of US Pharmacopeia's (USP) Model Guidelines as a common organizational tool for plans to report drug coverage. Plan must offer one drug for each USP category and class or the number of drugs in the EHB benchmark Plan), Prior Authorization can be used as long as it is not discriminatory Health Plans have two options: Cover at least the greater of: One drug in every category Same number of drugs in each category and class as the benchmark plan. Essential Benefits defined by the State Benchmark Plan. Plan may have limitations on coverage that differ from the limitations in the EHB – benchmark plan, but covered benefits and limitations on coverage must remain substantially equal to the benefits in the EHB-benchmark plan. Out of Pocket Maximums: Deductibles: Individual $2,000 Family $4,000 Out of Pock Individual $6,250, Family $12,500- Discussion for 2014 Individual $6,350, Family $12,700. Actuarial Value(AV) Calculators being designed to assist in measurement of minimum value.	Compliance Required	Compliance Required	Compliance Required	Compliance Not Required
90 day limitation on Waiting Periods: January 1, 2014 thereafter. A group may not apply any waiting period that exceeds 90 days. Note: Waiting period of more than 90 days are subject to a $600 per employee fine.	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Coverage for routine medical procedures within clinical trial services	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Fair Health Premium	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
>> Tiered Rates	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
>> Age Bands : 0-20; 21-63; > 64	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
>> Geographic	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
>> Tobacco 1:5	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
>> Age 1:3	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
>> Community Rating: Health insurance issuers providing individual or small group policies covering 100 or fewer individuals must abide by strict community rating rules with premium variations				
Prohibition of Discrimination: Age, Disability, Life Expectancy	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Limit on Out-of-Pocket Expenses: Group health plans must limit out-of-pocket costs to $5,950 for single coverage and $11,900 for family coverage, and deductibles can be no greater than $2,000 for single coverage or $4,000 for family coverage.	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations

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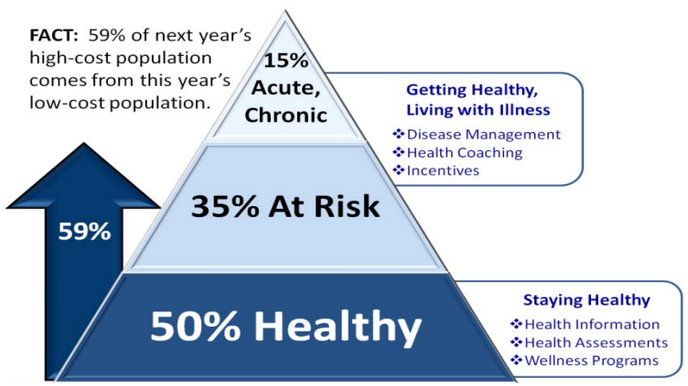
Wellness Compliance: Currently 20% variance in review for 30% variance. Confirmation of Completion: Biometric Screening/Health Power Assessment Well Woman Act: Expanded Coverage of Preventive Services for Women without cost sharing expenses: Contraceptive benefits, breastfeeding support, domestic violence screening Over the Counter Prescriptions: Doctor Ordered: Aspirin, Folic Acid, Fluoride Chemoprevention Supplements, Iron Deficiency Supplements, and Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at an increased risk for falls.	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
	Awaiting final Regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
Prescription covers at least the greater of one drug in every U.S. Pharmacy Category	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Web Portal	see fully or self funded compliance guidelines	see fully or self funded compliance guidelines	Compliance Required	Compliance Not Required
Automatic Enrollment Employer in excess of 200 employees 2014	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
NCQA/URAC Accreditation	Accreditation required for Qualified Health Plan Exchange/Marketplaces recognition	Accreditation required for Qualified Health Plan Exchange/Marketplaces recognition	Accreditation required for Qualified Health Plan Exchange/Marketplaces recognition	Accreditation required for Qualified Health Plan Exchange/Marketplaces recognition
Revision to Provider Payment Model	Provider Delivery System: Fee for Service vs. Shared Risk Pricing	Provider Delivery System: Fee for Service vs. Shared Risk Pricing	Provider Delivery System: Fee for Service vs. Shared Risk Pricing	Provider Delivery System: Fee for Service vs. Shared Risk Pricing
State High Risk Pools	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
Medicare Tax Increase for High Earners: Beginning in 2013, individuals making $200,000 and joint filers making $250,000 must pay an increase of 0.9% in the Medicare tax. A 3.8% tax on unearned income for high-income individuals will also take effect.	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
Student Health Insurance	Non Compliant with PPACA	Non Compliant with PPACA	Non Compliant with PPACA	Non Compliant with PPACA
Individual Mandate: Health Care Reform requires individuals to obtain "minimum essential coverage" Waivers will be allowed for specified individuals and circumstances. 2014 Tax penalty is $95 per individual to a maximum of $285 per family, or 1% of household income, 2015 Tax penalty is $325 per individual to a maximum of $975 per family, or 2% of household income, 2016 Tax penalty $695 per individual to a maximum of $2,085 per family, or 2 1/2% of household income.	N/A	N/A	N/A	N/A

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Young Invincible Plans	Catastrophic Coverage Only	Catastrophic Coverage Only	Catastrophic Coverage Only	Catastrophic Coverage Only
Electronic Medical Records: Group health plans must certify to the Society of HHS that they are using electronic systems for processing health claims, enrollment and premium/contributions payments and that their systems are in compliance by December 31, 2015.	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
Excise Tax on High Cost Employer-Provided Health Coverage: In 2018, plan administrators will pay a 40% tax for any health insurance plan that is above the threshold of $10,200 for singles and $27,500 for families. This excise tax would apply to the amount of the premium that is above these thresholds.	Awaiting final Regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
Exchange Notice Requirement: ***(Distribution delayed until October 2013)*** Employers to send employees a written notice not later than March 1, 2013 (sample notice not released yet) telling them about the new health insurance Exchanges. Notice should include information regarding employee purchases coverage through an Exchange then they may no longer be eligible for employer contribution toward health coverage on a pre-tax basis. The law also requires the notice to explain that if the employer plan's payment of plan costs is less than 60%, the employee may be eligible for a premium assistance tax credit if he or she purchases coverage in the Exchange. Awaiting Guidance. Starting in 2014, small business with up to 100 employees* (states may apply waiver to insure business with up to 50 employees in their SHOP exchange) and individuals without employer-sponsored coverage will be able to buy insurance on state-administered "exchanges." State-based Exchanges will be administered by a government agency or non-profit organization. A qualified health plan, to be offered through the new American Health Benefit Exchange/Insurance Marketplaces must provide essential health benefits which include cost sharing limits. No out-of-pocket requirements can exceed those in Health Savings Accounts, and deductibles in the small group market cannot exceed $2,000 for an individual and $4,000 for a family.	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Review and Revise your Notice of Privacy Practices and make necessary revisions by September 23, 2013, the compliance deadline for the new rules. If you maintain your Notice of Privacy Practices on your website, you must pose the revised notice to the website as of the effective date of the new notice. Distribution of a paper copy of the revised notice to each covered employee enrollee in the next annual health plan mailing, usually your open enrollment period	x	x	X	X
Review and Revise you Business Associate Agreement executed on or after January 25, 2013 the compliance date is September 23, 2013. For contracts already in existence prior to January 25, 2013, the earlier of: The date the contract or other arrangement is renewed or modified on or after September 23, 2013 or September 22, 2014				
Grandfather Status Loss: Current Grandfather Groups lose status if they increase in a benefit percentage cost-sharing requirement, regardless of the status: an increase in deductible if out of pocket amount excess medical inflation plus 15%, increase in copayment if the increase exceeds $5 (adjusted for medical inflation) or medical inflation plus 15%. Medical Inflation means the increase since March 2010 in the overall medical care component of the Consumer Price Index for all Urban Consumers (CPI-U) (unadjusted). A decrease in the employer's contribution rate by more than 5% measured by each tier of coverage. Elimination of all or substantially all benefits to diagnose or treat a particular condition. Adding a new overall annual dollar limit or decreasing the overall annual dollar limit in effect on March 2010. Any change must be measured relative to the plan in effect on March 23, 2010. Any of the following plan changes may also trigger the loss of grandfathered status. The addition of a new prescription drug tier with new cost-sharing, an increase in cost-sharing related to wellness incentives or	Grandfathered Employers Only	Grandfathered Employers Only	Grandfathered Employers Only	Grandfathered Employers Only

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penalties, an increase in retiree self-pay rates, transfer of employees into a less generous plan or plan option where the transfer is not due to bona fide employment-based reason, and certain changes made in response to the Mental Health Parity and Addiction Equity Act such as increasing cost sharing for medical/surgical benefits instead of lowering cost sharing for mental health and or substance use disorder benefits. Changes that do not trigger grandfather status loss: signing a new insurance contract, switching from insured to self-insured coverage, changing third party administrators, pharmacy benefit managers and changing the plan's network or switching PPO networks. Effective Plan Years after 2014 patient protection affordable care act compliance will be required for: attained age twenty-six benefits, no cost-share Phase I-III preventive benefits, network benefit deductible and out of pocket cost shares for emergent and immediate care, appeal procedure, direct access to primary care physicians, pediatricians, and OB-GYNs, compliance with non discrimination rules to prevent favoring highly compensated participants, measurement of provider performance based outcomes.				
Texas Emergency Room and Anesthesiologist Network Providers	Minimize Covered Individual Out of Pocket Expenses	Minimize Covered Individual Out of Pocket Expenses	Minimize Covered Individual Out of Pocket Expenses	Minimize Covered Individual Out of Pocket Expenses