

Health Care Reform and More: What Employers Need to Know

Presented by



Health Care Reform and More:

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Speakers

John Nelson, CEO of Warner
Pacific Insurance Services

Jill Brooking, Vice President of
Benefits Compliance with National
Financial Partners

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Benefits Compliance Update

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Presented by:

Jill Brooking
VP, Benefits Compliance
National Financial Partners, Austin, Texas

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Agenda

- » Health Care Reform
- » COBRA
- » HIPAA/HITECH
- » Section 111 Medicare Reporting
- » Form 5500 Electronic Filing
- » Wellness Programs
- » CHIP Notice

HEALTH CARE REFORM

Employer Grants and Tax Credits



THE **PATIENT PROTECTION**
AND **AFFORDABLE CARE ACT**

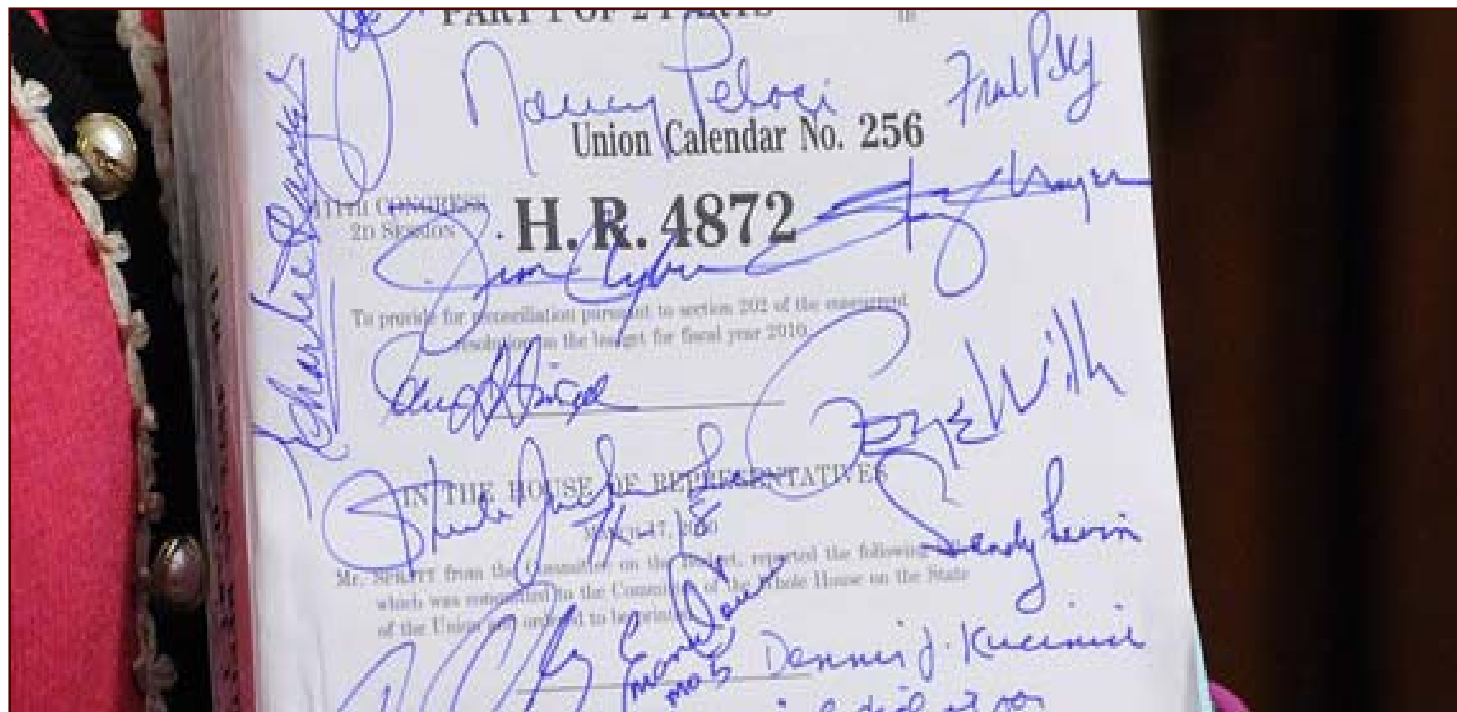
The Patient Protection and Affordable Care Act (“PPACA”)

President Obama signed HR 3590 into law on March 23, 2010



Health Care and Education Reconciliation Act

HR 4872 was signed into law on March 30, 2010,
which contains the “fixes” to HR 3590



Small Business Tax Credit

- » “Small employers” means an employer with less than 25 employees and less than \$50,000 average annual wages:
 - Take full-time workers (40+ hours/week) plus full-time equivalents (total annual hours of part-time EEs and divide by 2,080).
 - Take total annual wages and divide by number # of employees from above.

- » When calculating number of employees and average wage:
 - Do include leased employees;
 - Do not include partner in partnership, sole proprietor, more than 2% S-corp. owner, or more than 5% owner; and
 - Do not include seasonal workers (unless they work more than 120 days in a tax year).

Effective 2010

Small Business Tax Credit (continued)

- » The employer must contribute at least 50% of insurance premiums for employees at the single coverage rate.
- » Small employers may be eligible for a tax credit up to 35% of the employer contribution (25% for tax exempt) for years 2010 - 2013. Credit is greatest for employers with 10 or fewer EEs and less than \$25,000 avg. annual wage.
- » Available credit in 2014 equals maximum of 50% for purchase through exchange and available for 2 years (35% for tax exempt).
- » Businesses with no tax liability and non-profits are eligible for the credit (or refund).
- » File tax credit on annual income tax return starting in 2011.

Effective 2010

Wellness Programs and Incentives

Federal grant for small employers to implement wellness program

- Less than 100 employees who work 25 or more hours per week
- Do not have a wellness program in place on 03/23/10
- \$200 million appropriated. Program runs through 2015 or until funds are exhausted.

Components of wellness program:

- Health awareness initiatives (health education, preventive screenings, and HRAs);
- Efforts to maximize employee participation;
- Initiatives to change unhealthy behaviors and lifestyle choices (counseling, seminars, etc);
- Supportive environment efforts (policies to encourage healthy lifestyles, healthy eating, etc.).

October 2010

Temporary Retiree Reinsurance Program

- » Applies only to employers who sponsor a retiree health plan for retirees who are aged 55 or older and not eligible for Medicare.
- » Receive up to 80% of costs for health benefits between \$15,000 and \$90,000.
- » Plans must use these proceeds to lower health costs for enrollees.
- » Employer plans will submit an application to HHS to participate in the program (available June).
- » Plans will submit paid claims to HHS.
- » Both self-funded and insured plans can participate. Proceeds are excluded from gross income.

Available June 2010

HEALTH CARE REFORM

*Plan Design Changes and
Employer Reporting Requirements*



THE **PATIENT PROTECTION**
AND **AFFORDABLE CARE ACT**

Important Term – “Grandfathered” Plan

“Grandfathered” Plan means a plan or policy in existence on March 23, 2010.

- » Some provisions do not apply to grandfathered plans.
- » A plan may not be able to make plan design changes and keep grandfathered status (additional guidance expected).
- » May add or delete participants without losing grandfathered status.
- » Collectively bargained plans not subject to reforms until date on which last agreement relating to coverage terminates.



What is the Benefit of Being a Grandfathered Plan?

Provisions applicable to large group, small group and self-funded plans but not applicable to grandfathered plans:

- » Nondiscrimination: Employers may not discriminate in favor of highly compensated employees in terms of eligibility. Applies self-funded Section 105 rules to all group health plans.
- » Emergency services covered in-network regardless of provider status and without prior authorization.
- » Enrollees may designate any in-network doctor as their primary care physician.
- » New coverage appeal process including both internal and external appeal rights. HHS to provide guidance.
- » Must provide coverage for certain preventive services with no cost sharing for participants:
 - Preventive care that the US Preventive Services Task Force rates A or B
 - Immunizations recommended by the Advisory Comm. on Immunization practices
 - Preventive care and screenings for children and women supported by the Health Resources and Services Administration

For Plan Years starting on or after September 23, 2010

What Provisions Apply to All Plans?

Apply to small group, large group, self-funded and grandfathered plans:

- » **Lifetime limits:** No lifetime dollar limit on benefits.
- » **Annual limits:** Only on a restricted basis for non-essential benefits. Regulations will soon be released. Annual limits totally prohibited after January 1, 2014.
- » **Pre-existing conditions:** All group health plans must cover pre-existing conditions for children under age 19.

For Plan Years starting on or after September 23, 2010

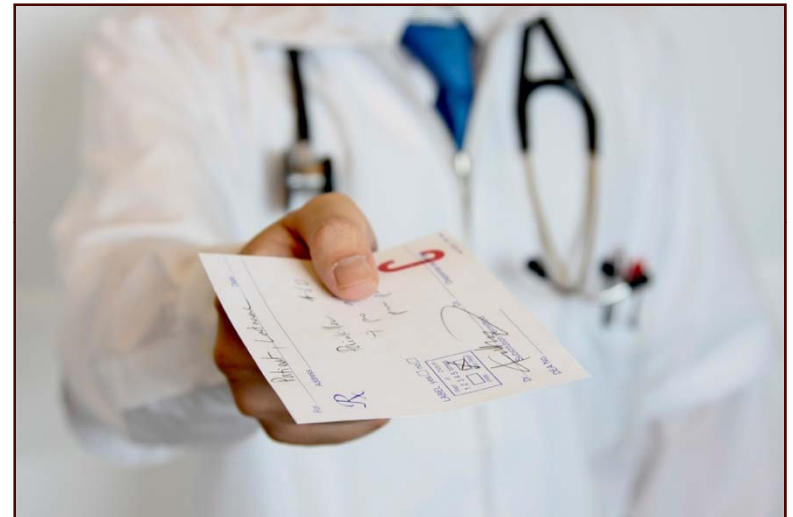
Adult Dependent Coverage

- » All group plans that offer dependent coverage will have to extend coverage to age 26.
- » Eligibility not based on marital status, residency, financial support, etc.
- » Coverage is not required for child or spouse of dependent.
- » Until 2014, grandfathered group plans would only have to cover dependents who do not have another source of employer-sponsored coverage.
- » Coverage is not taxable for children through tax year in which dependent reaches age 26.
- » Cost-sharing and benefits may not vary based on age of dependents under 26 years old.
- » Cafeteria Plans may allow mid-year election changes; special enrollee status under HIPAA.

For Plan Years starting on or after September 23, 2010

Other requirements- Effective 2011

- » Over the counter drugs will no longer be reimbursable under HSAs, health FSAs, and HRAs unless prescribed by a doctor.
- » HSA penalty increased from 10% to 20% for non-qualified expenses.
- » W-2 reporting- aggregate value of health coverage. Does not include any HSA contributions or employee FSA contributions
- » New public long-term care program. Employers to automatically enroll employees. Employee may opt out.
 - 5 year waiting period on benefits
 - 100% employee paid
 - Minimum benefit of \$50 per day



COBRA

COBRA, ARRA, DoDAA, TEA and Continuing Extension Act

COBRA originally amended by American Recovery and Reinvestment Act

- » Applies to federal COBRA and comparable state continuation “mini-COBRA”
- » Must be involuntarily terminated through December 31, 2009 to be eligible for subsidy
- » If loss of coverage is after December 31, 2009, the individual is not eligible for subsidy
- » Pays 65% of continuation cost up to 9 months

COBRA, ARRA, DoDAA, TEA and Continuing Extension Act

Further amended by Department of Defense Appropriations Act, the Temporary Extension Act, and the Continuing Extension Act

- » Extends subsidy period up to 15 months
- » Must be involuntarily terminated on or before May 31, 2010 regardless of when they are eligible for COBRA
- » If originally lost coverage due to reductions of hours between September 1, 2008 and May 31, 2010 AND had a later involuntary termination of employment between March 2, 2010 and May 31, 2010- individual is an AEI

COBRA Subsidy FAQ's

- » Does the subsidy apply to dental and vision?
- » Does the subsidy apply to state continuation?
- » If the employee terminates employment on May 31, 2010 and is not eligible for COBRA until June 1- are they eligible for the subsidy?
- » Will the subsidy be extended again?



HIPAA- Privacy and Security Overview

- » Responsibilities depend upon whether the plan sponsor creates, receives, or maintains protected health information (PHI)
- » PHI is defined as individually identifiable health information that:
 - relates to the past, present, or future physical, or mental health or condition of an individual
 - the provision of health care to an individual, or
 - the past, present, or future payment for the provision of health care to an individual.
- » Examples include applications for insurance that contain health questions, EOB's, claims information, reports containing individually identifiable health information

HIPAA- Privacy and Security, exception

There is an exception for a group health plan that meets the following definition:

- » A group health plan is not subject to the standards or implementation specifications, to the extent that:
 - The group health plan provides health benefits solely through an insurance contract with a health insurance issuer or an HMO; and
 - The group health plan does not create or receive protected health information, except for:
 - Summary health information as defined in §164.504(a) ; or
 - Information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the plan.

HIPAA Privacy and Security- What does an employer need to do?

Fully Insured (No PHI)

1. Conduct and document a risk assessment
2. Name a Privacy Official and Privacy Contact
3. Develop required policies (“Prohibition of Retaliation” and “Prohibition of Waiver of Rights”)
4. Authorization Form needed to obtain protected health information

HIPAA Privacy and Security- What does an employer need to do?

Self insured (creates, maintains, or receives PHI)

1. Conduct a risk assessment
2. Develop necessary policy and procedures
 - Appoint Privacy Official and Privacy Contact
 - Business Associate Agreements
3. Conduct employee training for those in contact with protected health information
4. Distribute Notice of Privacy Policy
 - Distribute notice of availability at least once every three years
5. Breach Notifications

HIPAA- Breach Notifications

- » Health Information Technology for Economic and Clinical Health Act (HITECH)
- » Effective 09/23/2009
- » Notification requirements not enforced for breaches that occur before 02/22/2010
- » Breach defined as:
 - unauthorized
 - access, use, or disclosure of protected health information (PHI)
 - which results in a significant risk of financial, reputational, or other harm to the individual

HIPAA- Unsecured Data

» Notification is only required when there is a breach of unsecured data



» Secured data

- Unusable, unreadable, or indecipherable
- Encrypted or destroyed
- Firewall or access controls- not sufficient

» Entities are still not required to encrypt data if unreasonable for the entity. But they will not be exempt from notice requirements.

HIPAA- Next Steps if a Breach Occurs

For every breach

- » Notify affected individuals
- » Enter onto log for annual submission to HHS

For breaches involving more than 500

- » Notify HHS immediately

For breaches involving more than 500 in one state

- » Notify prominent media outlets

HIPAA- Next Steps if a Breach Occurs

- » Timeframe for all mid-year notifications
 - “without unreasonable delay” but no later than 60 days following discovery of breach
 - Discovery is first day someone with the covered entity knows of breach (other than the person who committed)
 - There is an exception if a delay is requested by law enforcement b/c notice would impede investigation or harm national security

- » Annual notification
 - To the Department of Health and Human Services (HHS)
 - Include all breaches of information (affecting less than 500) since 09/23/09
 - Due within 60 days of end of calendar year (March 1)

HIPAA- Notice to Affected Individuals Following Breach

Required contents

- » What happened (include dates of breach and discovery)
- » Type of information that was breached (ex- SSN or diagnosis)
- » Any steps the individual should take to protect themselves.
- » What the covered entity is doing to investigate the breach, mitigate harm to the individuals, and protect against future breaches.
- » Contact information for additional information or questions, which shall include a toll free telephone number, an e-mail address, website address, or postal address.

Breach Notification- Action Items

- » Review and revise systems and procedures to make sure that breaches are being identified.
- » Revise policies and procedures to include notification requirements.
- » Revise business associate agreements to require business associates to notify the covered entity of any breaches.
- » Maintain log of breaches occurring on or after 09/23/09 (affecting less than 500) to report to HHS on an annual basis
- » Train staff members.

HIPAA- Civil Penalties

For violations of the HIPAA privacy and security requirements that occur on or after February 18, 2009, the following penalties may be imposed by HHS:

- » The covered entity/business associate did not reasonably know that a violation occurred- \$100 to \$50,000 per violation
- » The covered entity/business associate did not act with willful neglect- \$1,000 to \$50,000 per violation
- » The covered entity/business associate acted with willful neglect and corrected the violation within 30 days- \$10,000 to \$50,000 per violation
- » The covered entity/business associate acted with willful neglect and did not correct the violation within 30 days- at least \$50,000 per violation

In any circumstance- multiple violations within the same calendar year can be up to \$1,500,000

HIPAA- Criminal Penalties

The following criminal penalties may be enforced against an individual for a privacy or security violation:

- A fine up to \$50,000, imprisoned for 1 year, or both
- A fine up to \$100,000, imprisoned for 5 years, or both if violation is under false pretenses
- A fine up to \$250,000, imprisoned for 10 years, or both if there was an intent to sell, transfer, or use PHI for commercial advantage, personal gain, or malicious harm

SECTION 111 MEDICARE REPORTING

Section 111 Medicare Reporting

- » Effective January 1, 2009

- » To assist CMS in determining coordination of benefit responsibilities

- » Who is the Responsible Reporting Entity (RRE)
 - Insurer for fully-insured plan, TPA for self-funded plan, Plan administrator for self-funded plan that self-administers
 - RRE must file quarterly electronic report with CMS Coordinator of Benefits Contractor

Section 111 Medicare Reporting

- » Health FSAs, HSAs, stand-alone dental, vision, Rx plans need not be reported
- » HRA (Health Reimbursement Arrangement) reporting added in 4th Quarter 2010- exception for integrated plans and plans with less than \$1,000 annual benefit max
- » Small plans sponsored by employers with less 20 employees need only report those receiving a kidney transplant or kidney dialysis

Section 111 Medicare Reporting

- » SSNs need to be reported for participants:
 - Ages 55 through 64 based on active employment (will change to age 45 in January 2011)
 - Ages 65 and older based on active employment
 - Under age 55 based on active employment and who are known to be Medicare enrolled (will change to age 45 January 2011)
 - Any age kidney dialysis or kidney transplant

- » CMS has issued Revised Model Collection Form if employee refuses to share their SSN

FORM 5500 ELECTRONIC FILING

Who has to file a Form 5500?

- » Retirement plans of any size
- » Health plans:
 - That have more than 100 participants on the first day of the plan year AND
 - That are unfunded or insured
- » Cafeteria plans do not have to file, but component plans do

Form 5500 Electronic Filing

Mandatory Electronic Filing Required

- Effective January 1, 2010 for:
 - All Form 5500s for 2009 and 2010,
 - Any applicable schedules, and
 - Form 5500-SF (Short Form)- New Form for eligible small plan filers

Limited exception for delinquent and amended returns

- 2008 plan year filings
- Use paper system through October 15, 2010, or electronically through June 30, 2010

Form 5500 Electronic Filing

Approved software vendors:

- Fort William
- SunGuard- Relius
- Blazessi
- ASC Corporation
- AXA Equitable
- Thompson Reuters
- CCH (a Wolters Kluwer Company)
- Principal Financial Group

<https://www.efast.dol.gov/software/software.html>

Form 5500 Electronic Filing

Plan administrators who do not use approved software vendors will use the IFILE submission application

- IFILE can only transmit single filings
- IFILE does not assist the user to complete the forms (i.e. does not pre-populate)
- Does not contain filing assistance or integrated instructions
- No file sharing functionality

Form 5500 Electronic Filing

- » **Q33: I am a plan administrator that needs to electronically sign a Form 5500. Can I tell the service provider that manages the plan's Form 5500 filing process what my PIN is so the service provider can sign and submit it for me?**

- » No. As the plan administrator, you must examine the Form 5500 or 5500-SF that will be sent to EFAST2 before it is submitted. Your electronic signature attests that has been done and that, to the best of your knowledge and belief, it is true, correct, and complete. Since the EFAST2 PIN is the plan administrator/plan sponsor electronic signature for purposes of the Form 5500 and Form 5500-SF, PINs must be protected and not shared. However, as described below in response to question 33a, if a service provider manages the Form 5500 filing process for your plan, the service provider may get his or her own Signer credentials and electronically sign the filing attesting that he or she is authorized to submit the return/report and has attached a PDF copy of the plan's Form 5500/Form 5500-SF that has been manually signed and dated by the plan administrator under penalty of perjury.

Form 5500 Electronic Filing

To obtain filing credentials, **the individual(s) at the plan sponsor** must register on the DOL's website at www.efast.dol.gov.

1. Register
2. Read the Privacy Statement.
3. Complete the Register Profile Information page
4. Complete the Profile Information
 1. Name, address, phone number, email address and company name. The email address is the most important piece of information because EFAST2 will use that email address to send the signer a confirmation email
 2. Select the "Filing Signer" credential only in the user type section
5. Select a challenge question and provide the answer
6. Check your email for User ID and PIN Code
7. Do not share PIN with anyone
8. Confirm receipt of PIN and choose password

Form 5500 Electronic Filing

Delinquent Filer Voluntary Correction Program (DFVC)

- Late filers may be assessed \$50 a day, with no limit, extension is not taken into account
- Non-filers may be assessed \$300 per day, up to \$30,000 per year, until a complete annual report is filed
- Criminal penalty of \$100,000, ten years in prison, or both. (Willful)

DFVC reduces penalties for self-reporting to:

- \$10 per day
- Maximum limit of \$750 for a small plan
- Maximum limit of \$2,000 for a large plan

Multiple years' filings

- Small plan penalty is \$1,500
- Large plan penalty is \$4,000

Form 5500 Electronic Filing

EFAST2 website:

<https://www.efast.dol.gov/portal/app/welcome?execution=e1s1>

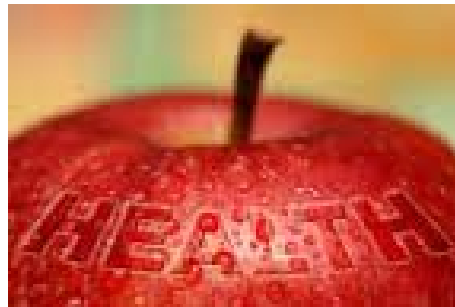
EFAST2 FAQ:

<http://www.dol.gov/ebsa/faqs/faq-efast2.html>

DFVC:

http://www.dol.gov/ebsa/FAQs/faq_DFVC.html

WELLNESS PROGRAMS



Two Types of Wellness Programs

- » **Type 1- Reward based on participation.** Available to all similarly situated

- » **Type 2- Reward based on satisfying health standard.** Must meet five requirements:
 - Amount of reward
 - Reasonable standard
 - Annual qualification
 - Reasonable alternative
 - Disclosure



GINA

- » If employees are rewarded for completing a health risk assessment through a wellness program- the assessment cannot ask for genetic information including questions on family medical history
- » HRA can ask family history questions if no reward is given



EMPLOYER CHIP NOTICE

CHIP Reauthorization Act

- » What is this notice?
 - Notifies eligible employees that they may be eligible for a state program that would pay some or all of their group health plan premiums
 - If they are approved for such program, they are eligible to enroll in the group health plan mid-year
 - Is a new HIPAA Special Enrollment Right
 - Effective April 1, 2009
 - Have 60 days from program approval to enroll in group health plan

CHIP Reauthorization Act

- » Model Employer CHIP Notice released February 4, 2010
www.dol.gov/ebsa/chipmodelnotice.doc
- » Employer must send notice by the start of the next plan year
 - For plan years beginning on or after February 4, 2010 through April 30, 2010- send by May 1, 2010
 - If plan year starts on May 1, send by May 1, 2010
 - Calendar year plans would send by January 1, 2011
- » Must send notice to employees who are eligible for group health plan and reside in a state that has a Medicaid or CHIP premium assistance program- states listed on Notice

QUESTIONS?