McGraw Wentworth

REFORM Update

Issue Forty-Five June 2012

June 11, 2012

Several government agencies recently released a variety of bulletins on the 2014 health care reform initiatives. Most of the guidance reviews proposed approaches to various requirements and requests stakeholder comments. This *Update* summarizes the following:

- **IRS Notice 2012-31:** Calculating Minimum Value for Employer Health Plans
- **IRS Notices 2012-32 and 33:** Reporting Requirements for Employer-Sponsored Health Plans
- **Verification of Access to Employer-Sponsored Coverage Bulletin:** Proposed Communication Between Exchanges and Employers
- **More FAQs on SBCs**

While none of these are final, they do offer a glimpse of key requirements in 2014.

IRS Notice 2012-31: Calculating Minimum Value for Employer Health Plans

In 2014, employers with 50 or more full-time employees will be subject to the "play or pay" requirements. They will have to either offer a plan that provides a minimum value at an affordable cost or pay a penalty.

"Minimum value" means on average the plan must pay 60 percent of covered medical expenses. This latest guidance proposes three approaches for calculating the 60 percent plan value.

The first approach is an actuarial value calculator, called the minimum value calculator. This calculator will be developed by the Departments of Health and Human Services and Treasury. An employer enters plan information about benefits, coverage for services and cost-sharing. The calculator then analyzes the data using a standardized claim database. The calculator will determine the minimum plan value.

The second approach uses design-based safe harbor checklists. The idea is that the checklists will evaluate specific elements of plan design. If a plan meets the safe harbors in the checklists, then it can be considered to be of 60 percent or greater value. These checklists provide a simple way for employers to evaluate health plan values without using a calculator or an actuary.

The third approach requires certification from a certified actuary. The guidance suggests using this approach only when the calculator or safe harbor checklists are not feasible. For example, it can be used when a plan has such a non-standard approach to benefits that the other two methods will not work. The actuary would be required to use prescribed continuance tables, recognized actuarial standards and other conditions that may be prescribed in future administrative guidance.

The minimum value calculator would be different from the actuarial value calculator used to determine metal tiers in the Exchange. Plans offered in the Exchange must cover essential health benefits to some degree. This guidance clarifies that self-funded plans and the insured health plans of large employers are not required to cover essential health benefits. Large employers, for this purpose, have, on average, no more than 100 employees. However, states can lower the threshold to no more than 50 employees.

Employers can use the actuarial value calculator to determine the minimum value of qualified health plans offered to fully-insured small group plans through the Exchange. The minimum value calculator will not evaluate coverage related to essential health benefits. For more information on essential health benefits, please review our Reform Update at http://www.mcgrawwentworth.com/Reform_Update/2012/Reform_Update_37.pdf.

The actuarial measurement to determine minimum value will review coverage based on a different set of services, and not on essential health benefits. The Department of Health and Human Services (DHHS) has determined that four categories of services are the greatest drivers of health plan cost:

1. Physician and mid-level practitioner care
2. Hospital and emergency room services
3. Pharmacy benefits
4. Laboratory and imaging services

DHHS recognizes that nearly all employer plans cover these services. These services will be measured to determine minimum value.

Some employers offer consumer-driven health plans combined with health savings vehicles. If an employer funds a portion of the employee's health savings account (HSA), the current year's funding of the HSA will be included in the plan valuation. If an employer offers a health reimbursement arrangement (HRA), the current year's funding of the HRA is also included in the plan valuation.

The agencies requested comments on the proposed approaches. Once they review the comments, the agencies will likely issue additional guidance.

IRS Notice 2012-32 and 33: Reporting Requirements for Employer-Sponsored Health Plans

Health care reform added another reporting requirement for employers subject to the "play or pay" requirements applicable in 2014. Specifically, it will apply to employers with at least 50 full-time and full-time equivalent employees. Starting in 2015, those employers must file an informational return with the IRS for plan years beginning after December 31, 2013. The data provided will be used to administer premium assistance subsidies in the Exchange.

Employers must include the following information in the return:

- Name and Employer Identification Number (EIN).
- The date the return is filed.

- Certification that full-time employees and their dependents can enroll in an employer-sponsored health plan meeting the minimum value and affordability requirements. Employers offering this "minimum essential coverage," must also provide:
  - The duration of any new hire waiting period
  - The months during the calendar year that coverage was available
  - The monthly premium for the lowest-cost option in each enrollment category under the plan
  - The employer's share of the total allowed cost of benefits provided under the plan
- The number of full-time employees enrolled for each month of the calendar year.
- The name, address and taxpayer identification number (TIN) of each full-time employee, and the number of months the plan covered the employee.
- Any additional information the Department of the Treasury requires.

IRS Notice 32 covers similar reporting requirements as they apply to health insurance issuers, government agencies, and others that offer minimum essential health coverage. These organizations must also provide an informational return. It is proposed that if a group health plan is fully-insured, then the carrier will be responsible for the informational return. Returns for insurance carriers and government plans, such as Medicaid, require the following slightly different information:

- The name, address and TIN of the primary insured and each individual covered under the policy.
- The dates each individual had minimum essential coverage during the calendar year.
- Insured plans must specify if they offer the coverage under a qualified health plan in the Exchange.
- If the coverage is a qualified health plan offered in the Exchange, state the amount of any advance premium credits or cost-sharing reductions provided to the covered individuals.
- If a group health plan is providing coverage, indicate the employer maintaining the plan and the amount of premium the employer pays.
- Any other information the Secretary of Health and Human Services requires.

In addition, employers, insurance carriers, government agencies and others providing minimum essential health coverage must issue a written statement to full-time employees no later than the January 31 following the prior calendar year. This statement must detail benefit information similar to the way a W-2 details wage information. It must include:

- Employer's name and address.
- The employer's contact information, including a phone number.
- Information on coverage for the employee and any applicable dependents, as the informational return discussed above requires.

For the 2014 calendar year, employers must provide the statement by January 31, 2015, and it appears likely to be referenced when employees file their taxes. A reconciliation process is conducted at tax filing time for anyone receiving advance premium credits. This information will likely be needed for that process.

Both Notices request stakeholder comments on the return. The government would like to minimize the burden on employers, insurance carriers and other parties, but it also needs access to this data in order to administer premium assistance and cost-sharing credits.

It is not yet known whether the informational return will have to be submitted electronically. In addition, with regard to fully-insured plans, it is unclear whether the insurance carrier's filing is sufficient or if the employer has to file an informational return as well.

Additional guidance will be issued after the IRS analyzes the stakeholder comments and ideas.

Verification of Access to Employer-Sponsored Coverage Bulletin: Proposed Communication Between Exchanges and Employers

The Center for Consumer Information and Insurance Oversight (CCIIO) recently published a bulletin requesting comments on communication between employers and the Exchange.

Once the 2014 requirements are in effect, a process needs to be established for the Exchange to determine whether an individual is eligible for minimum essential coverage. Those eligible for that coverage will not be eligible for premium assistance or cost-sharing credits in the Exchange. In addition, if an employee enrolls in employer-sponsored coverage that does not meet the minimum value or affordability measures, then that employee will not be eligible for premium assistance. How will employees know whether their employer-sponsored coverage is considered minimum essential coverage? How will the Exchange know whether an individual is eligible for minimum essential coverage? These are both are good questions. This bulletin asks for input on the best ways to validate minimum essential coverage.

In initial meetings with stakeholders, two potential approaches were proposed as the optimal way for Exchanges to confirm health plan information with employers:

1. **Sample Template:** The government would create a sample template of information the Exchange needs, and employers would voluntarily provide the information to employees.
2. **Database:** The government would create a database that employers could voluntarily update with relevant information. The Exchange could access the database to verify eligibility.

Exchanges could determine eligibility for premium assistance more accurately if they had real-time access to current data. However, they would need data that does not currently exist in any Department of Labor (DOL) or IRS database. The government hopes the process developed will allow for pre-enrollment verification of employer-sponsored health plan coverage. Post-enrollment verification is possible, but this time-consuming process would involve direct verification from employers.

The notice requests comments on a standard method for collecting and communicating employer-sponsored health coverage data to employees and the Exchanges. DHHS recognizes that Exchanges could verify some elements using state resources. For example, they can verify employment using a State Directory of New Hires or a state's quarterly wage and tax database. DHHS expects Exchanges to use existing data sources whenever possible.

The bulletin proposes that those applying for premium assistance in the Exchange should attest to any employer-sponsored coverage available to them. The Exchange would then verify the data by comparing it to available information. If independent sources verify the data, then the Exchange could accept the statement. If the data is inconsistent, the applicant must prove the attested information.

The CCIIO is looking for suggestions on managing this process. While it may seem cumbersome to voluntarily enter information in a common database, it will likely be less difficult than manually verifying coverage availability for any employee seeking coverage in the Exchange.

In addition to seeking comments, DHHS is also analyzing internal resources that may be used to capture certain required data elements. The goal is to minimize the employer burden by using readily available information resources.

The CCIIO is looking for both short- and long-term suggestions. It may offer a sample template for the short term because states have a tremendous amount of work ahead to launch Exchanges. But over the long term, the government is hoping to create a database to verify information.

More FAQs on SBCs

The Departments of Labor, Health and Human Services and Treasury (called the Departments) just posted an additional round of Frequently Asked Questions (FAQs) on the Summary of Benefits and Coverage (SBCs) requirements.

These FAQs included the following new information:

- The Departments adopted an additional safe harbor for plans to deliver SBCs electronically. Plans may provide SBCs electronically for online enrollment or online coverage renewal. They may also provide SBCs electronically to participants and beneficiaries who request them electronically. However, it must be clear that participants have the right to request a paper copy at no cost.
- The plan can make certain minor adjustments when displaying an SBC electronically. It can be displayed on a single web page so a viewer may scroll through the content. The printed version must still meet the SBC formatting requirements. Thus plans cannot delete rows or columns.
- Plans can combine SBCs or SBC elements so that participants can compare benefit options side-by-side. However, if the side-by-side comparisons do not meet the SBC content and presentation requirements, then the plan must provide an SBC that meets those requirements.

- The FAQs reiterate that first-year enforcement activity will emphasize helping plans meet SBC requirements. The Departments will not impose financial penalties on any plan that is working in good faith to comply with the SBC requirements.
- The Departments will provide a calculator for plans to use as a safe harbor during the first year to complete the coverage examples. Although this approach will be less accurate, it will allow a transitional tool for a key element of the SBC. The calculator is available at http://cciio.cms.gov/resources/other/index.html#sbcug.
- The FAQs confirm that insurance carriers have no obligation to provide coverage information for benefits they do not insure. If an employer provides some insurance benefits through separate insurers, then the employer can merge the SBCs these carriers provide. Similarly, the employer could contract with one of the carriers to combine the SBCs, if the carrier is willing to do this. The Departments will allow multiple partial SBCs in these circumstances, as long as all the SBCs together provide all the necessary information. The employer must make clear that the plan uses different insurers to provide various benefits. A participant with questions about the arrangement must be able to contact the plan administrator.
- Written translations of the SBC are available in Spanish, Chinese and Tagalog. The Navajo translation is expected to be ready soon. More information on the translations can be found at http://cciio.cms.gov/resources/other/index.html#sbcug.
- The Departments have made minor adjustments to the SBC sample template. They needed to correct a typographical error in the coverage examples. They also made some changes in the appearance. The updated templates, labeled as "corrected," can be found at http://www.dol.gov/ebsa/healthreform.

The SBC requirements will challenge both insurance carriers and employers. Carriers need to make system changes to generate these documents. Employers should determine whether their TPAs will help create the SBC and develop processes for distributing it. It may take some time for carriers and TPAs to determine their approaches to the SBC.

Concluding Thoughts

The government will continue to release guidance on various aspects of health care reform. It is refreshing that it is seeking input from various stakeholders. Ideally, this process will result in reasonable reporting and better communication between the Exchanges and plan participants.