



The Kinloch Link

Your Link to Employee Benefits News and Information

February 2011

In This Issue

- Health Care Reform Update
- Compliance Link
- Ask Kinloch



Compliance Link:

Massachusetts Uninsured Penalty Increases

Uninsured MA residents who are deemed able to afford health insurance will face higher penalties in 2011. Residents with incomes exceeding 300% of the Federal Poverty Level (FPL) will be charged up to \$101 for each month without health insurance, or \$1,212 annually. This represents a maximum increase of \$8 a month, or \$96 annually. Penalties for those with incomes between 150% and 300% of the FPL will remain the same as in 2010. Individuals with incomes less than 150% of the FPL are not subject to penalties.

Massachusetts Employee Health Insurance Responsibility Disclosure Form (HIRD)

The [2011 Employee HIRD form](#) is now available on the [Mass.gov](#) website. There are no substantive changes from the 2010 form. Employers subject to MA health care reform must collect HIRD forms from MA employees who decline to enroll in the employer-sponsored plan or decline to use the employer's Section 125 Cafeteria Plan to pay for health insurance. Forms must be completed and returned to the employer within 30 days from the date an employee becomes eligible for medical benefits or terminates participation in the employer-sponsored plan; and within 30 days of the close of open enrollment.

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Health Care Reform Update

House Republicans introduced a largely symbolic health reform repeal bill entitled "Repealing the Job Killing Health Care Law Act". Although it easily passed the House on January 19th with a vote of 245-189, it is unlikely to go further. Even if it passed the Democratic Senate, the bill would ultimately meet its demise with a Presidential veto. Repeal of or compromise on certain provisions of the Patient Protection and Affordable Care Act (PPACA) is a more likely scenario but until then employers must continue to implement the provisions as they become effective. We will continue to closely monitor developments.

The Department of Labor (DOL) and Health & Human Services (HHS) issued a fifth installment of [Frequently Asked Questions \(FAQs\)](#) in late December, which provided additional information on various provisions including the following:

Automatic Enrollment

PPACA's automatic enrollment provision requires employers with more than 200 full-time employees to automatically enroll full-time employees in the employer's health plan. No effective date, however, was included in the law. The FAQs note that employers do not have to comply until regulations are issued by the DOL's Employee Benefits Security Administration. This is expected by 2014.

Disclosure & Notice of Material Modifications

PPACA requires group health plans and health plan issuers to provide a summary of benefits and coverage explanation that "accurately describes the benefits and coverage" no later than 24 months after enactment (by 3/23/2012). The DOL and HHS have one year from PPACA's enactment to issue standards for these disclosures (by 3/23/2011). See [Ask Kinloch](#) for more information regarding the benefit summary's content.

Additionally, group health plans will be required to notify enrollees of any material modifications to the plan no later than 60 days prior to the effective date of the change. The FAQ notes that compliance with this provision will not be required until the summary of benefits and coverage explanation are required, as noted above (by 3/23/2012).

Value-Based Insurance Design

In general, non-grandfathered plans must provide preventive care without member cost sharing. The FAQ clarifies that plans may adopt "value-based plan designs" which incent members to use higher quality and/or value services and providers. In the example given, a plan may incent members to obtain colorectal cancer preventive screenings at an in-network ambulatory center by requiring a \$250 copayment for the same service at an in-network outpatient hospital setting. If it is deemed medically inappropriate for a member to have the service in an ambulatory setting the plan must waive the copayment for the outpatient hospital setting.

Early Retiree Reinsurance Program (ERRP)

The ERRP's website, which provides information on the application and claims submission processes, also recently updated their [FAQ section](#). The question most employers will be interested in is whether applications are still being approved. As of December 30, 2010, the answer is yes, until HHS announces otherwise. According to HHS, \$1 billion of the program's \$5 billion fund has been paid out as of December 30, 2010.

For additional information on any of this month's topics, or for any other employee benefit questions, please contact your Kinloch consultant or local Kinloch office.

Health Care Reform Update (cont.)

In addition to PPACA, the December FAQs also provide additional guidance on HIPAA and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as summarized below.

HIPAA Non-Discrimination and Wellness Programs

HIPAA prohibits discrimination in eligibility, premium or benefits based on a health factor, but includes an exception for certain wellness programs:

1. "Participatory" programs that do not require meeting a health factor standard to receive a reward (e.g., reimbursement of smoking cessation aids even if the individual does not quit smoking); or
2. "Health Contingent" programs where an individual must meet a standard to receive a reward (e.g., reward for being a non-smoker) – certain criteria apply

PPACA generally incorporates the existing parameters of HIPAA's 2006 final regulations, but the FAQs clarify that:

- A wellness program is only subject to HIPAA if it is part of a group health plan. Therefore, programs like subsidized healthy cafeteria choices and paid gym memberships are not subject to HIPAA non-discrimination.
- HIPAA's reward limitation of 20% of the total single coverage cost only applies to health contingent programs (see #2 above). For participatory programs, the maximum allowable reward is 50% of the total individual only coverage cost.
- Plans can offer both participatory and health contingent wellness programs, provided that both meet HIPAA's criteria.



Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

The FAQ clarifies that although PPACA defines a small employer as one with 100 or fewer employees, the definition of small employer for purposes of exemption from MHPAEA compliance remains an employer with 50 or fewer employees.

Under MHPAEA, an exemption exists for a plan that incurs a first year cost increase of at least 2% to comply with the law, or at least 1% in any later plan year. The FAQ provides the following interim enforcement safe harbor for implementing the exemption: if a plan has incurred an increased cost of 2% in its first compliance year, it can obtain a second year exemption by following the procedures set out in the DOL/HHS 1997 Mental Health Parity Act regulations, as modified.

"Now, I've heard rumors that a few of you have some concerns about the new health care law. So let me be the first to say that anything can be improved."

**— President Barack Obama
2011 State of the Union Address**



Ask Kinloch – February Issue

Question: Does the four-page summary of benefits and coverage required under national health care reform replace the SPD? What information needs to be included in the summary?

Answer: No, the four-page summary required by the Patient Protection and Affordable Care Act (PPACA) does not replace the ERISA-required Summary Plan Description (SPD) or Summary of Material Modifications (SMM). PPACA expands ERISA's disclosure rules by requiring issuance of the four-page summary of benefits and coverage in addition to the SPD and/or SMM.

By March 23, 2012, all insured and self-insured group health plans (including grandfathered plans) must provide a summary of benefits and coverage explanation to each enrollee at time of enrollment and at annual enrollment. Appearance and language requirements for the summary include:

- Maximum of four pages in length (a "page" is 8-1/2 x 11 inches, with normal margins), with print no smaller than 12-point
- Written in a culturally and linguistically appropriate manner
- Content must include:
 - Uniform definitions of standard insurance terms and medical terms
 - Description of the coverage, including cost sharing for "essential health benefits"
 - Exceptions, reductions, and limitations on coverage
 - Cost-sharing provisions, including deductible, coinsurance, and copay obligations
 - Renewability and continuation of coverage provisions
 - "Coverage facts label" that includes examples to illustrate common benefits scenarios
 - Statement of whether the health plan or coverage provides "minimum essential coverage"
 - Statement that the outline is a summary of the policy or certificate
 - Contact number to call with additional questions and an Internet web address

Failure to comply with these requirements may result in a penalty of \$1,000 per failure. The criteria above were included in the March 2010 PPACA legislation, but many details remain outstanding. The Department of Health and Human Services (HHS) is required to issue further regulatory guidance by March 23, 2011, which will give plans another 12 months to issue the standard summaries. **Keep watching the Kinloch Link for further analysis once additional guidance is released.**

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