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HIPAA - Final Regulations

Department of Health & Human Services issued its' privacy rule on January 17th. This rule expanded liability of business associates of

Small Group Rating

Recently, the final rule addressing small group rating under health care reform was released. This rule directs that insurers use the per-member-rating carriers use age-rated methodology in the small group market. In their comments it was said that using the individual age rating assures compliance with the requirement that age and tobacco rating only be apportioned to an individual family member's premium. States are allowed to require insurers to offer (or a small employer from electing to offer) premiums based on average employee amounts where every employee in the group is charged the same premium (composite rates).

Medicaid Expansion Update

Below you will find information reflecting each states position on Medicaid expansion as of early March:

Supporting Expansion
Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Rhode Island, Washington, Wisconsin

Opposing Expansion
Alaska, Georgia, Florida, Idaho, Indiana, Iowa, Louisiana, Mississippi,
Nebraska, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Virginia

Undecided
Kansas, Tennessee, Wyoming

Out-of-Pocket Maximums

The PPACA requires that for plan years beginning on or after Jan. 1, 2014, annual cost sharing (i.e., coinsurance,

hospitals, physicians and other HIPAA-covered entities if they release data in ways that violate patient privacy.
The 500+ pages update earlier Health Insurance Portability and Accountability Act rules with more stringent privacy and security measures.

The rule clarifies when breaches of information must be reported to the Office for Civil Rights, sets new rules on the use of patient-identifiable information for marketing and fundraising, and expands direct liability under the law for the "business associates" of hospitals and physicians and other "HIPAA-covered entities."

It also restores a limited right of consent to patients to control the release to their insurance company of records about their treatment if the pay for that treatment is out of pocket.

deductibles, copayments and similar charges) for non-grandfathered plans cannot exceed 2014 limits under the Internal Revenue Code for HSA (health savings account) out-of-pocket limits: For 2013 the limits are $6,250 for self-only coverage and $12,500 for family coverage; these amounts will be indexed annually.

The final rule released by HHS on Feb. 25, 2013 confirmed that the out-of-pocket maximum limit provision applies to all group health plans, including large group and self-insured. The out-of-pocket maximum is limited to in-network services.

The out-of-pocket maximum will also include copays and coinsurance across all benefit categories, including benefit categories that are carved out to other service. HHS did provide for a safe harbor for the first plan year beginning on or after Jan. 1, 2014, that says a group plan that uses more than one service provider to administer benefits subject to the out-of-pocket limit will be able to maintain separate out-of-pocket maximum limits for each benefit category that is carved out to a service provider (with the exception of mental health and substance use disorder benefits) under the following two conditions:

a) the group plan or group health insurer complies with the out-of-pocket maximum limit (the 2014 limits) for its major medical coverage; and

b) if a group plan or group health insurer includes an out-of-pocket maximum on coverage outside major medical coverage that separate maximum cannot exceed the out-of-pocket limit as well.

DOL Begins Audits for PPACA Compliance

The Department of Labor (DOL) has updated its audit procedures to include aspects of the PPACA. Included in the most recent audit letters are the request for:

- Samples notices relating to the enrollment opportunities for dependents to age 26.
- a list of individuals for whom coverage was rescinded
- documents showing any lifetime limits and samples of the notices stating that the lifetime limits no longer apply
- documents showing any annual limits

For grandfathered plans only:
- Grandfathered plans disclosures

The rule also spells out how the penalties for privacy and security violations unare to be applied.

- Terms of the plan in effect on March 23, 2010
Non grandfathered plans only:
- Notices regarding the right to choose any primary care physician
- Samples of adverse benefit determinations

In addition, the DOL is asking for documents regarding Mental Health Parity, HIPAA, the Newborns and Mothers Health Protection Act, the Women's Health and Cancer Rights Act and COBRA.

Deductible Limits

In a recently released FAQ from the U.S.Departments of Labor, Health and Human Services (HHS) and Treasury deductible limits under PPACA were once again addressed. For plan years beginning on or after Jan. 1, 2014, PPACA requires non-grandfathered, fully insured small group plans not have a deductible higher than $2,000 for individuals and $4,000 for families. The final rule provides some flexibility by allowing issuers to exceed the deductible limit if it cannot reasonably reach a given level of coverage (metallic level) without doing so.

The FAQs also confirms that individual plans, self-insured and large insured group health plans do not have to comply with the deductible limits.

Patient Centered Outcomes Research Institute Fees & HRA Plans

The Patient Protection and Affordable Care Act (PPACA) introduced the Patient-Centered Outcomes Research Institute (PCORI) fee. This fee is paid by health insurers and self-funded plan sponsors to promote the use of evidence-based medicine by disseminating comparative clinical effectiveness research findings. Late 2012, the IRS released final regulations and guidance on the calculation and payment of the PCORI fees.

Plans that are subject to the fee include:

Health reimbursement arrangements (HRAs)
Medical plans
Prescription drug plans
Self-insured dental or vision plans, if not stand-alone
Retiree only health plans

The fee will apply to plans that end after October 1, 2012 and before October 1, 2019. The fee is $2.00 ($1.00 for plan years ending before October 1, 2013) multiplied by the average number of lives covered under the plan/policy.

For most insurers and self-insured health plan sponsors, the first payment of the fee will be due July 31, 2013.
Employers are responsible for paying this fee for stand-alone HRA plans.

As always, we hope you enjoyed this edition of our monthly newsletter. We thank you for the confidence you have placed in our firm and look forward to servicing all of your insurance needs.

Your friends at Stuckey Insurance

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