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Healthcare Reform Compliance for Employee Benefits: Required Plan Changes, Limiting Exposure, Transparency Rules

ACA Rules and Regulations Updates, Recent State Insurance Mandates, Pay or Play, PCORI Fees, Other ACA Taxes and Fees

WEDNESDAY, APRIL 22, 2020

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

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Overview of Presentation

- Updates to ACA Regulations and Rules
- Individual State Insurance Mandates
- Health Care Reform Plan Modifications
- New Transparency in Coverage and Model Notice Rules
- Best Practices

Individual State Insurance Mandates and Health Care Reform Plan Modifications

Laura Miller Andrew
April 22, 2020

ACA Individual Mandate

- **ACA individual mandate (**"individual shared responsibility provision") required most Americans to have qualifying health insurance ("minimum essential coverage").
- ACA became law in March 2010.
  - If individuals didn't have proof of health insurance when they filed their taxes, the IRS assessed penalties.
  - In December 2017 (effective January 1, 2019), Congress repealed financial penalties for individuals not having health insurance, but Applicable Large Employers (ALEs) must still offer affordable, minimum essential to their employees.

Impact of State Individual Mandates on Employers

- With many states passing their own individual mandate, it makes it difficult for companies to keep up with all the different regulations and reporting requirements.
- Essentially, even if a company has one employee filing taxes in one of these states, a company must comply with that state's individual mandate.
- This means companies will not only have to be ACA compliant at the federal level, but also at the individual state levels

Impact of State Individual Mandates on Employers

- The process for verifying individual health coverage will be very similar to the employer ACA process.
- When filing state tax returns, taxpayers will be required to confirm if they were enrolled in health coverage during the calendar year and may also be required to submit documentation.
- Many states allow taxpayers to submit their Form 1095-C as documented proof of insurance.
- The enforcement of state individual mandates will impose a reporting obligation on employers.

State Individual Mandates

To keep their healthcare marketplaces stable and ensure coverage for individuals, some states have added state individual mandates

- California – Effective January 1, 2020.
- District of Columbia – Effective June 30, 2020.
- Massachusetts – Has been effective since 2006.
- New Jersey – Effective March 31, 2020.
- Rhode Island – Effective January 1, 2020.
- Vermont – Effective January 1, 2020.

State Individual Mandates

States that are actively considering and/or pursuing a statewide individual mandate:

- Connecticut
- Hawaii
- Maryland
- Minnesota
- Washington

California State Individual Mandate

- The State of California's individual mandate, requiring residents to have qualifying coverage, effective January 1, 2020.
- Californians who do not have health insurance coverage will owe a penalty.
  - 2.5% of salary or $695 per adult and $347.50 per child, or up to $2085 per family, whichever is greater.
  - California will offer subsidies to residents who earn less than 600% of the federal poverty level.
- No filing details are available at this time.

California State Individual Mandate

- Employers are required to file annually by March 30. For the 2020 tax year, the due date is currently March 30, 2021. *Impact of COVID?*
- In-state and out-of-state employers who employ California residents are obligated to provide the same data outlined in Section 6055 of the Affordable Care Act.
- While final details are not available, we expect fully-insured employers will rely on their insurer to provide data to the State and self-insured employers will be required to submit their own data to the State.
- The penalty for employers who fail to comply is $50 per individual not reported to the State.

District of Columbia Individual Mandate

- The Individual Tax Payer Health Insurance Responsibility Requirement, signed into law on June 26, 2018. D.C., reporting requirements released on August 9, 2019 and more information continues to be released.
- Effective January 1, 2019, residents are required to have qualifying coverage.
- Individual penalties are equal to 2.5% of salary or $700 per taxpayer.

District of Columbia Individual Mandate

- Employers are required to report annually, within 30 days after the IRS tax deadline.
  - For the 2019 tax year, the due date is extended to June 30, 2020.
- ALEs who employ D.C. residents (even if the employer does not withhold D.C. payroll taxes) are required to report.
- Requirements differ based on whether the employer offers self-insured or fully-insured coverage

District of Columbia Individual Mandate

- ALE sending 1095-C forms to employees and filing 1095-C and 1094-C forms with the IRS, file forms with state.
- Employers who only have fully-insured coverage cannot rely on the insurer to provide 1095-B forms alone, they will still need to submit 1095-C and 1094-C forms to D.C.
- For employers who employ non-D.C. residents, they must only include requested information in the file.

Massachusetts Individual Mandate

- Effective 2006, residents must have qualifying coverage went into effect in 2006 and predates the Affordable Care Act.
- Unlike the state mandates enacted after the Affordable Care Act, the only employer reporting obligation is Form 1099-HC.
- Most insurance companies issue the forms on the employers' behalf and send the state a report listing all the Forms 1099-HC they issued.
- Employers are required to report annually. The reporting period is from Nov 1 to Nov 30.

Massachusetts Individual Mandate

- Employers must file a Health Insurance Responsibility Disclosure (HIRD) form, which collects employer-level information about employer-sponsored insurance (ESI) offerings.
- The HIRD reporting is administered by MassHealth and the Department of Revenue (DOR) through the MassTaxConnect web portal.
- The HIRD form will assist MassHealth in identifying its members with access to qualifying ESI who may be eligible for the MassHealth Premium Assistance Program.

New Jersey Individual Mandate

- Individual mandate, signed into law on May 30, 2018, effective on January 1, 2019.
- Individual penalties are equal to 2.5% of salary or $695 per taxpayer.
- New Jersey will use the system employers or their vendors use to submit W-2 forms.
  - Called “MFT SecureTransport” or “AxWay,” vendors or ALEs must sign up with an account in order to be authorized to submit forms.
  - New Jersey requests the same XML file format used for submitting to the IRS.
  - However, employers must edit the file in order remove non- New Jersey residents.

New Jersey Individual Mandate

- Applies to in-state and out-of-state ALEs who employ New Jersey residents, even if the employer does not withhold New Jersey payroll taxes.
- If an ALE is sending 1095-C forms to employees and filing 1095-C and 1094-C forms with the IRS, they are required to file forms with the state.
- Employers who only have fully-insured coverage cannot rely on the insurer to provide 1095-B forms alone, they will still need to submit 1095-C and 1094-C forms to New Jersey.

New Jersey Individual Mandate

- The state released reporting requirements in June 2019 and continues to release more information.
- Employers are required to report annually. For the 2019 tax year, the due date was March 31, 2020.
- *Update*: In light of the novel coronavirus (COVID-19) outbreak, the IRS has offered an automatic extension for submitting to the State of New Jersey. The deadline to file with the state is currently May 15, 2020.

Rhode Island Individual Mandate

- Signed into law on July 5, 2019, effective January 1, 2020.
- Individual penalties are equal to 2.5% of salary or $695 per taxpayer and $347 per child.
- Rhode Island has not issued any information about individual filing details yet.
- No due dates have been set yet, but we anticipate employer reporting to begin in 2021 for the 2020 tax year.
- No guidance has been released around employer reporting obligations or filing requirements.

Vermont Individual Mandate

- Law was signed on May 28, 2018, effective January 1, 2020.
- Requires residents to have qualifying coverage throughout the year.
- No details on mandate penalties or filing requirements available at this time.
- Vermont has not issued any information about employer reporting obligations.
- No due dates have been set yet, but we anticipate employer reporting to begin in 2021 for the 2020 tax year.

Health Care Reform Plan Modifications

Expanded Coverage for COVID-19 Testing Under ACA

- The Families First Coronavirus Response Act (FFCRA) requires an employer-sponsored group health plan to provide coverage for COVID-19 diagnostic testing and services related to the diagnostic testing without any cost sharing (including deductibles, copayments, and coinsurance), prior authorization, or other medical management requirements.
- The plan must also cover the costs of a provider visit (office visit, telehealth visit, or urgent care or emergency room visit) related to the testing without cost sharing.

Expanded Coverage for COVID-19 Testing Under ACA

- Applies to all employer plans including a grandfathered plan under the ACA.
- FFCRA's requirements apply to insured and self-insured group health plans, including grandfathered plans, but they do not apply to retiree-only plans or excepted benefit plans like EAPs.

Expanded Coverage for COVID-19 Testing Under ACA

- The requirements became effective March 18, 2020 and will continue to be effective until the Secretary of HHS declares the public health emergency has ended.
- Employers should make the necessary changes to plan documents to reflect the coverage of COVID-19 testing. Employers of plans subject to ERISA should notify participants of the change by providing them with a Summary of Material Modification (SMM).

Impact of CARES Act on ACA

- On March 27, 2020, the President signed the Coronavirus Aid, Relief, and Economic Security Act (CARES Act).
- CARES Act offers flexibility for patients to access COVID-19 screening or care while avoiding exposure to others.
- In addition to economic relief for companies and individuals, the CARES Act impacts employer group health plans.
- Includes temporary policy changes relating to telehealth services including flexibility to access telehealth from a broader range of providers.

CARES Act and Preventive Services Provisions of ACA

- Generally, a plan is not required to cover a newly recommended preventive care service until at least a year after it has been issued.
- The CARES Act requires a plan to cover a "qualifying coronavirus preventive service" within 15 business days after the date on which a new qualifying coronavirus preventive service recommendation is issued.
- It is uncertain whether this provision applies to a grandfathered plan under the ACA, which is generally not required to cover preventive care services

Preventive Services Provisions Under CARES Act

- A "qualifying coronavirus preventive service" means an item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is:
  - an evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; or
  - an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

Testing Coverage Provisions

- The CARES Act also expands the diagnostic testing that is required to be covered under the FFCRA to include tests that are not approved under the Federal Food, Drug, and Cosmetic Act.
- A plan must reimburse providers of the COVID-19 diagnostic testing and related services:
  - The negotiated rate in effect between the plan and the provider if such a rate is available before the public health emergency was declared; or
  - In an amount equal to the cash price for such service as listed by the provider on a public internet website, or
  - the plan can negotiate with the provider for less than such cash price.

Intended to avoid surprise medical bills but balance billing may still occur

ACA Required Changes for 2020

- The SECURE Act extended the Patient-Centered Outcome Research Institute Fee (PCORI Fee) until September 30, 2029.
- The SECURE Act repealed the “Cadillac Plan” Tax effective January 1, 2020 and the Annual Health Insurer Fee effective January 1, 2021.
- On November 8, 2019, the agencies released new SBC templates, instructions, and Uniform Glossary to be used by group health plans and insurers for plan years beginning on or after January 1, 2021.

ACA Required Changes for 2020

- Plans with more than one service provider may structure a benefit design using separate out-of-pocket limits across multiple categories of benefits (rather than reconcile claims across multiple service providers), provided the combined amount of any separate out-of-pocket limits applicable to all EHBs under the plan does not exceed the annual limit.
- A plan that includes a network of providers may, but is not required to, count out-of-pocket spending for out-of-network and noncovered items and services toward the plan's annual maximum out-of-pocket limit.

HSA and Health FSA Changes

- For plan years beginning on or before December 31, 2021, a health plan still qualifies as a high-deductible health plan for health savings account (HSA) if it covers costs associated with telehealth without requiring the participant to pay a deductible.
- After December 31, 2019, amounts paid for non-prescribed over-the-counter drugs, as well as menstrual care products will be treated as qualified medical expenses for purposes of HSAs, healthcare flexible spending accounts (Health FSA) and Archer Medical Savings Accounts (Archer MSA).

ACA Required Changes for 2020

- In 2020, if the premium for the lowest-cost, employee-only coverage option available to employees does not exceed 9.78 percent of an employee's adjusted gross household income, the coverage will be considered "affordable" for purposes of the ACA.
  - *Lower than 9.86% threshold for 2019, some coverage options that were marginally "affordable" in 2019 may not remain so in 2020.*
- Annual out-of-pocket costs for coverage of all essential health benefits (EHBs) provided in-network may not exceed $8,150 for self-only coverage or $16,300 for family coverage.

ACA Required Changes for 2020 Employer Mandate Penalty

- Employers who fail to offer coverage to at least 95% of full-time employees and dependents may be subject to a penalty of $2,320 per full-time employee minus the first 30.
- Employers who offer coverage may still be subject to a penalty if the coverage is not affordable or does not provide minimum value. This penalty is the lesser of either $3,480 per full-time employee receiving a federal subsidy for coverage purchased on the Marketplace, or $2,320 per full-time employee minus the first 30.

Potential COVID-19 Impact on ACA

- Many employers have had to furlough employees. Many employers determine whether or not an employee is full-time by counting hours during a “look-back” measurement period and then deeming a person full-time for a subsequent stability period.
- If an employee’s hours are reduced or the person is placed on leave during a stability period, that employee continues to be full-time for ACA purposes.
- If coverage is not offered to such an employee, there is a risk of an ACA penalty.

Threat to the ACA Still Exists

- In December 2019, the 5th Circuit Court of Appeals upheld the lower court ruling in the Texas v. U.S./Azar lawsuit, striking down the ACA.
- The plaintiffs in the case are 18 GOP-led states. And the case is primarily being defended by Democratic-led states, as the U.S. Department of Justice has declined to defend the ACA.
- The U.S. Supreme Court has now agreed to review the case. Oral argument could be scheduled as soon as October 2020, although it is likely that the Court may not issue its decision until after the 2020 election.

Best Practices

Best Practices

- Every year group medical plans should be evaluated to ensure that they meet the ACA employer mandate.
  - Be careful about new classes of employees or changes in population.
  - Use updated percentages to ensure plans are still affordable.
- Review plan designs for compliance with ACA requirements.
- COVID-19 impacts cannot be understated.
  - May impact plan design requirements and documentation.
  - May impact coverage and affordability standards.

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New Transparency in Coverage and Model Notice Rules

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New Transparency in Coverage Proposed Regulations

- Background and Applicability
- Important Definitions
- Required Notice
- Methods of Disclosure
- Miscellaneous Relief Provisions
- Model Notice

Background

- Executive Order 13813
- Reforming America's health care system through choice and competition
  - Recommended price and quality transparency initiatives
  - Useful information about shoppable services

Background

- Executive Order 13877 (June 24, 2019)
- HHS required to issue regulations requiring hospitals:
  - Publicly post-standard charge information in easy to read, consumer-friendly, and machine-readable format;
  - Based on common or shoppable items and services; and
  - Posting of standard charge information for services, supplies, or fees billed by hospital or its employees.
- These regulations were one of two sets of regulations issued on November 15, 2019.

Background

- HHS, DOL, and IRS also directed to solicit comments on a proposal to require health care providers, health insurance issuers, and self-insured group health plans to facilitate access to information about expected out-of-pocket costs.
- HHS, DOL, and IRS are directed to increase access to data to make healthcare information more transparent and useful to patients.

Applicability

- Does not apply to grandfathered health plans.
- Does not apply to health reimbursement arrangements or flexible spending accounts.
- Applies for plan years beginning on or after 1 year after the effective date of final rule.
- Two relevant components: disclosure to participants and beneficiaries and disclosure to the public.

Disclosure to Participants and Beneficiaries

- Participants and beneficiaries have standard meanings under ERISA.
- Cost-sharing information must be provided.
  - Accurate at the time that a request is made with respect to a particular provider or providers.
  - To extent relevant to a participant's or beneficiary's cost-sharing liability.

Definitions

- Cost-sharing information means information related to any expenditure required by or on behalf of a participant or beneficiary with respect to health care benefits that are relevant to a participant or beneficiary's out-of-pocket costs for a particular service or item.
- Covered items or services means those items for which costs are payable, in whole or in part, under terms of a group health plan or health insurance coverage.

Definitions

- Items or services includes all encounters, procedures, medical tests, supplies, drugs, durable medical equipment, and fees (including facility fees) for which a provider charges a patient in connection with providing health care.

More Definitions

- Cost-sharing liability is amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan or contract.
  - Cost-sharing liability includes deductibles, coinsurance, and copayments.
  - Cost-sharing liability excludes premiums, balance billing amounts for out-of-network providers, and cost of items or services not covered under the plan.

More Definitions

- Out-of-network provider is a provider that does not have a contract under a participant's or beneficiary's group health plan or policy.

Specific Information to be Provided

- An estimate of the cost-sharing liability for a requested covered item or service, based upon:
  - Accumulated amounts the participant or beneficiary has accrued to date, and
  - Negotiated rate, reflected as a dollar amount, for an in-network provider for the requested covered item or service.
    - Disclosures based on percentage of Medicare rates are impermissible for this purpose.
    - Consideration should be given to removing them from welfare plan SPD.

Specific Information to be Provided

- Out-of-network allowed amount for requested covered item or service, if covered item or service will be provided by an out-of-network provider.

More Definitions

- Accumulated amount is amount of financial responsibility a participant has incurred at the time a request for cost-sharing information is made with respect to a deductible or out-of-pocket limit.
  - Accumulated amount includes any expense that counts towards deductible or out-of-pocket limit.
    - Would include copayment or coinsurance.
    - Would exclude premium payments, out-of-pocket expenses for out-of-network services, and amounts for items or services not covered under the plan.

More Definitions

- If coverage other than self only, accumulated amount would reflect both the individuals' coverage and the family group's year to date expenditures.

- If there is a cumulative treatment limitation on a covered item or service, the amount accrued toward the limit on the item or service must be disclosed.
  - Example: limit on number of visits.

More Definitions

- A negotiated rate is the amount a group health plan or health plan insurer, or a third party acting on behalf of them, has contractually agreed to pay an in-network provider, pursuant to the terms of an agreement between the provider and the plan or insurer.
- If a participant or beneficiary requests information for an item or service subject to a bundled payment arrangement, a list of the items and services for which cost-sharing information is being disclosed.

More Definitions

- A bundled payment means a payment model under which a provider is paid a single sum for all covered items and services provided to a patient for a specific treatment or procedure.
- If applicable, notice that coverage of a specific item or service is subject to a prerequisite.

Prerequisites

- Prerequisites are certain requirements relating to medical management techniques that must be satisfied before a group health plan or health insurance issuer will cover the item or service.
  - Prerequisites include concurrent review, prior authorization, step-therapy, and fail-first protocols.
  - Prerequisite does not include medical necessity or other medical management techniques.

Required Notice

- Participants or beneficiaries requesting cost-sharing information must receive a notice containing following statements:
  - A statement that out-of-network providers may bill participants or beneficiaries for the difference between a provider's bill charges and the sum of the amount collected from the plan or insurance carrier and the participant in the form of copayment or coinsurance (the difference referred to as balance billing); and
  - The cost sharing information provided to participant or beneficiary does not account for these potential additional amounts.

Additional Statements

- A statement that the actual charges for a participant's or beneficiary's covered item or service may be different from the estimate of cost-sharing liability provided, depending upon the actual items or services the participant/beneficiary receives at point of care.
- A statement that the estimate of cost-sharing liability for a given service is not a guarantee that it will be paid.

Additional Statements

- Statements must be provided in plain language.
- Additional information, including disclaimers, can be provided, that is not inconsistent with any of the three required statements.

Methods of Disclosure

- Either Internet-based self-service tool or paper method.
- Internet-based self-service tool must be available
  - in plain language,
  - without subscription or other fee,
  - Provide real-time responses, and
  - based on information that is accurate at time of request.
- Different searching options must be available for in-network and out-of-network providers.

Specific In-Network Provider or All In-Network Providers

- Search must allow search for cost-sharing information by inputting
  - a billing code or descriptive term (rapid flu test) at option of user;
    - billing codes are codes used by health plan or health insurance issuer or in-network provider to identify items and services for billing purposes.
  - Billing codes include:
    - Current Procedural Terminology (CPT) Code;
    - Healthcare Common Procedure Coding System (HCPCS) Code;
    - Diagnosis-Related Group (DRG) Code;
    - National Drug Code (NDC); and
    - Any other common payer code.

Specific In-Network Provider or All In-Network Providers

- The name of the in-network provider, if the user seeks cost-sharing information with respect to a specific in-network provider.
- Other factors utilized by the plan or issuer that are relevant for determining the applicable cost-sharing information, such as location of service, facility name, or dosage.

Search for Out-of-Network Allowed Amount or Services Provided by Out-of-Network Providers

- The out-of-network allowed amount is the maximum amount a group health plan or health insurance issuer would pay for a covered item or service provided by an out-of-network provider.
- The out-of-network search must allow the Internet user to search by inputting
  - a billing code or other descriptive term, at user's option;
  - other factors utilized by the plan or issuer that are relevant for determining the applicable out-of-network allowed amount, such as location in which the covered item or service will be sought or provided; and

Search for Out-of-Network Allowed Amount or Services Provided by Out-of-Network Providers

- To the extent that the search for covered items or services returns multiple results, to refine and reorder the search results passed upon geographical proximity and the amount of the participant's/beneficiary's estimated cost-sharing liability for the covered item or service.

Paper Method

- Participant or beneficiary can request that information be provided in paper format.
  - Must be in plain language, without fee, and provide the information in accordance with the disclosure required for the Internet self-search tool.
  - Mailed no later than 2 business days after an individual's request is received.

Avoiding Duplication of Disclosure

- A plan and health insurance carrier can enter into a written agreement under which the health insurance issuer agrees to provide the information.
- If issuer breaches the agreement and fails to provide the information, the health insurance issuer, and not the plan, is in violation of the transparency disclosure requirements.

Information to be Made Available to the Public

- Must be provided in two machine-readable files.
  - A machine-readable file means a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring that no semantic meaning is lost.
- Machine-readable files must comply with technical guidance issued by HHS, DOL, and IRS.
  - First machine-readable file must include rates negotiated for in-network providers.
  - Second machine-readable file must include information related to the historical data showing allowed amounts for out-of-network providers.

Machine-Readable Files

- Machine-readable files must be publicly available and accessible to any person free of charge and without conditions.
  - No user account, password, other credentials, or submission of personally identifiable information to access the file.
- Machine-readable files must be updated monthly.
  - Plan or issuer must indicate date files were most recently updated.

Negotiated Rate Machine-Readable File

- This file must include:
  - Name and EIN or Health Insurance Oversight System (HIOS) identifier, for each plan option or coverage offered by issuer or under plan.
  - Billing or other code used to identify covered items or services for purposes of claim adjudication and payment, and a plain language description for each billing code.
  - Negotiated rates that are

Negotiated Rate Machine-Readable File

- reflected in dollar amounts;
- associated with National Provider Identifier (NPI) for each in-network provider; or
- associated with last date of contract term for each provider specific negotiated rate, including rates for individual items and services and items and services in a bundled payment arrangement.

Out-of-Network Allowed Amount File

- Information to be provided to public the same as for in-network providers, except instead of negotiated rates, unique out-of-network allowed amounts are provided.
  - Unique out-of-network allowed amounts with respect to items or services provided by out-of-network provider must list amounts during the 90-day time period that begins 180 days prior to publication of the machine-readable file.
- Exception: If disclosure would require group health plan or health insurance issuer to report payment of out-of-pocket allowed amounts in connection with fewer than 10 different claims for payment.
- Disclosure cannot violate any applicable health information privacy law.

Special Rules for Insured Group Health Plans

- If plan and health insurance carrier enter into a written agreement under which the issuer agrees to provide the information to the public, but fails to do so, the issuer, and not the plan, violates the transparency disclosure requirements.
- Plan or health insurance issuer may enter into an agreement with a third party under which third party agrees to provide information to the public.
  - However, if third party breaches agreement, then the group health plan or health insurance carrier that entered into contract is liable for the transparency disclosure violation.

Miscellaneous Relief Provisions

- Group health plan or issuer will not be in violation of these regulations if, solely because in good faith and reasonable diligence, it makes an error in disclosure, provided that the plan or issuer corrects the information as soon as practicable.
- Group health plan or health insurance issuer will not violate these regulations solely because, despite acting in good faith and with reasonable due diligence, its Website is temporarily inaccessible, provided that the plan or issuer makes the information available as soon as practicable.

Miscellaneous Relief Provisions

- If compliance with these regulations requires a group health plan or health insurance issuer to obtain information from another entity, plan, or issuer will not fail to comply with regulations if it relied in good faith upon information from the other entity unless plan or issuer knows, or reasonably should know, that the information is incomplete or inaccurate.

Medical Loss Ratio

- Issuers could offer new plans and claim credit towards their MLR for “shared savings” when an enrollee selects a lower cost provider.
- Issuers would not be required to pay rebates based upon a plan design that provides benefits to consumers not currently captured in existing MLR revenue or expense category.
- Effective for 2020 MLR reporting year.

DOL Model Notice

- DOL issued a model notice
- Available on its website
  - https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-draft-model-disclosure.pdf
- Meets Prerequisite and Cost-Sharing Requirements of proposed regulation
- Can be utilized to meet participant request cost-sharing requirements or incorporated into the internet-based self service tool

Best Practices

- Insurance Industry hotly contested the proposed rule via the comment period
- Significant comments made regarding the public disclosure components of the proposed rule
- Comment period was extended by a 31 days to the end of January
- Most of Rule will not apply until the year following the publication of a final rule
- MLR provisions currently apply

QUESTIONS?

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