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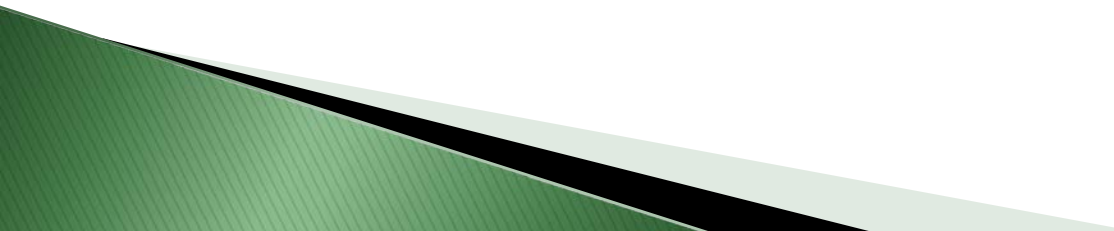
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THE AFFORDABLE CARE ACT, HIPAA AND HEALTH CARE PRIVACY

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- ▶ **Primary purpose was to make it easier for individuals to take health insurance with them when changing jobs**
 - ▶ **Additionally, set national standards for the protection of an individual's protected health information (PHI) through its Privacy Rule and electronic protected health information (EPHI) through its Security Rule**
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Omnibus Final Rule –Effective September 2013

- ▶ **Expanded compliance requirements**
- ▶ **Interpreted and implemented provisions of the HITECH Act**

HIPAA Rules

- ▶ Generally require compliance by certain “covered entities” and “business associates”
- ▶ Group health plans are “covered entities” under HIPAA and must comply with covered entities’ obligations regarding PHI

Who are Covered Entities?

- ▶ Health plans, including group health plans
 - ▶ Health care clearinghouses
 - ▶ Health care providers who transmit health information in electronic form
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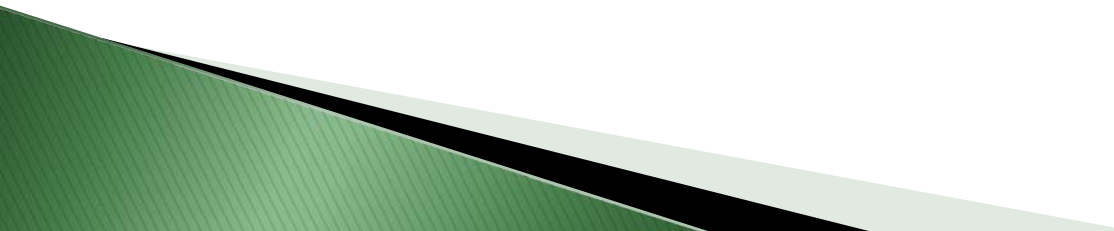
Who are Business Associates?

- ▶ **Individuals or entities that perform functions or provide services for covered entities, other than in the capacity of a member of the workforce, and that use or disclose PHI in the course of providing those services**

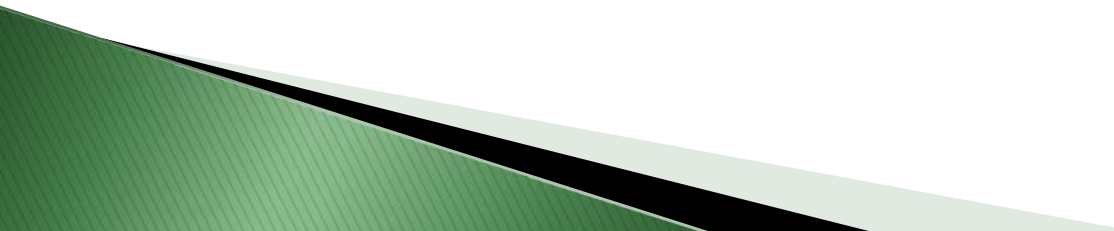
Business Associates

- ▶ **Currently, business associates are held to most of the same standards as covered entities and are directly liable for violations and impermissible disclosures**

Employee Training

- ▶ **Covered entities and business associates must train all members of their workforce on the requirements of HIPAA compliance**
 - ▶ **Must be as necessary and appropriate for the members of the workforce to carry out their functions**
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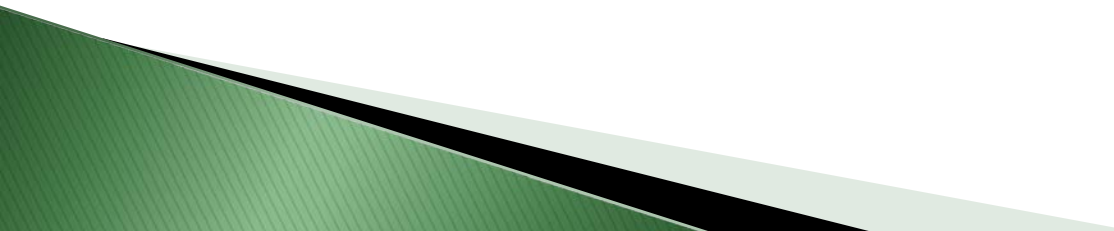
Documentation

- ▶ **A covered entity must implement policies and procedures with respect to PHI designed to comply with HIPAA**
 - ▶ **Must be changed as necessary and appropriate to comply with changes in the law**
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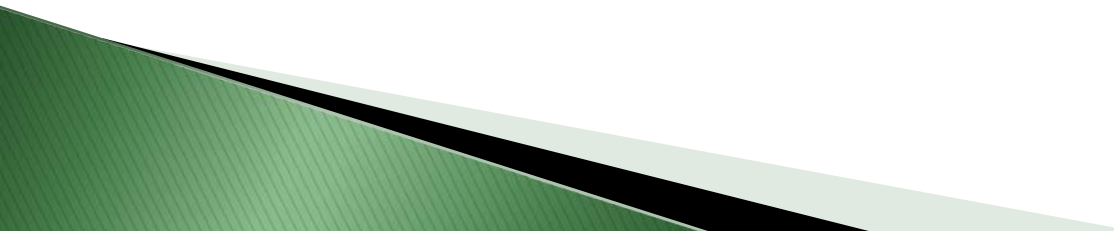
Privacy Rule

- ▶ Sets national standards for the protection of PHI
- ▶ Following the Omnibus Final Rule, both covered entities and business associates must comply with the Privacy Rule, and are both subject to penalties for failure to comply

Protected Health Information

- ▶ **PHI is individually identifiable health information**
 - ▶ **EPHI is PHI that is transmitted or maintained in electronic form**
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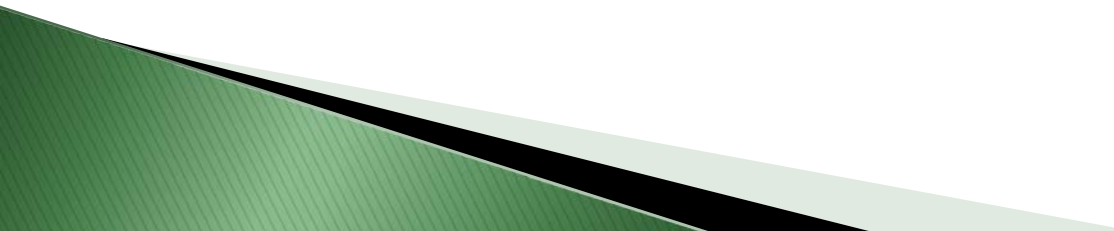
Protected Health Information–What is Health Information?

- ▶ Created or received by a covered entity
 - ▶ Relates to past, present or future physical or mental health or condition of an individual; provision of care to an individual; or past, present or future payment for the provision of health care
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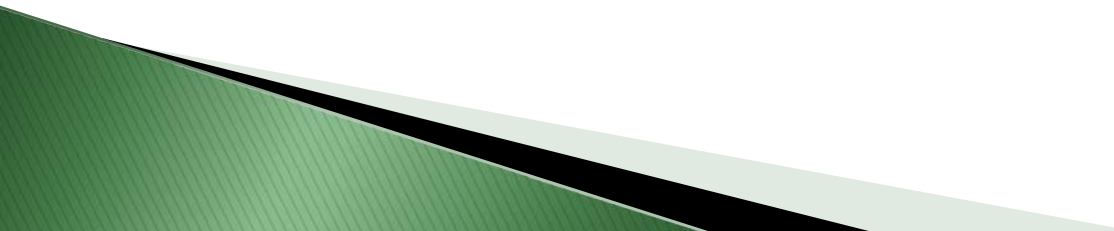
Protected Health Information–What is Individually Identifiable?

- ▶ Names
- ▶ Geographic subdivisions smaller than a state, i.e. street address, city, county, precinct, zip code
- ▶ Dates, such as birth date and date of hire, and all ages over 89
- ▶ Telephone numbers
- ▶ Fax numbers
- ▶ Email addresses
- ▶ Social security numbers
- ▶ Medical records numbers
- ▶ Health plan ID numbers

Protected Health Information–What is Individually Identifiable?

- ▶ Account numbers
 - ▶ Certificate/license numbers
 - ▶ Vehicle identifiers and serial number
 - ▶ Device identifiers and serial numbers
 - ▶ Web Universal Resource Locators (URLs)
 - ▶ Internet Protocol (IP) Addresses
 - ▶ Biometric identifiers
 - ▶ Full face photos and comparable images
 - ▶ Any other unique identifying number characteristic, or code
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Examples of PHI

- ▶ **Medical records**
 - ▶ **Dental records**
 - ▶ **Billing information or invoices**
 - ▶ **Telephone notes**
 - ▶ **X-Rays, lab reports**
 - ▶ **Oral discussions (whether in person or over the phone)**
 - ▶ **Patient appointment information**
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Privacy Rule–Permitted Uses and Disclosure

- ▶ **Covered entities may not use or disclose PHI except as the Privacy Rule permits or requires, or as authorized by the individual**
 - ▶ **Business associate may only use or disclose PHI per terms of its business associate agreement or as required by law**
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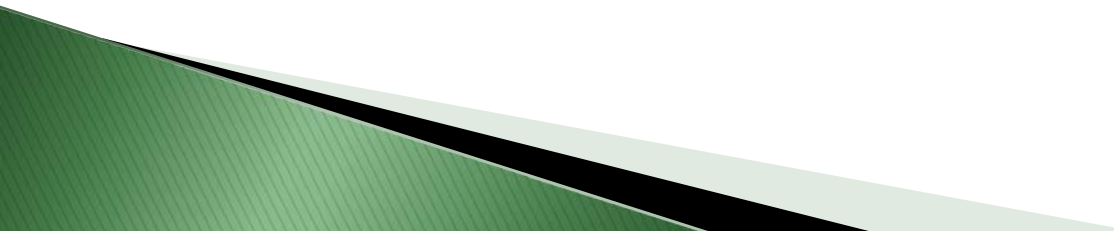
Permitted Uses of PHI Without Authorization

- ▶ **Treatment**
 - ▶ **Payment**
 - ▶ **Health care operations**
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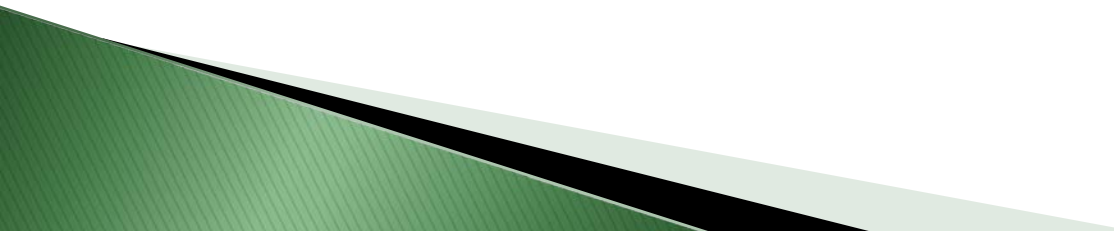
Minimum Necessary Standard

- ▶ **The Privacy Rule requires that covered entities and business associates use and disclose the minimum amount of PHI necessary to accomplish a particular purpose**

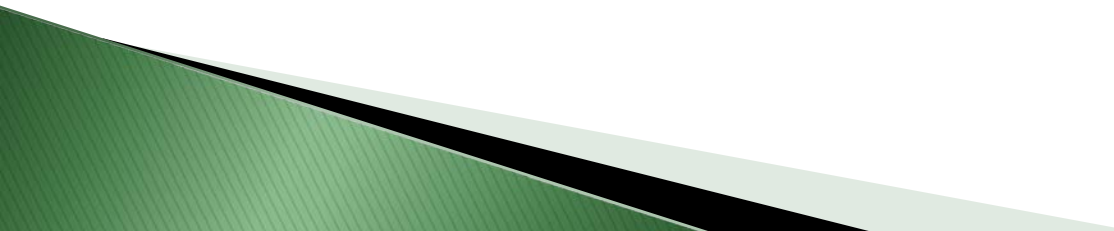
Business Associate Agreements (BAA)

- ▶ Covered entities are required to enter into a BAA with their business associates to ensure that business associates appropriately safeguard PHI
 - ▶ BAA requirements have changed under the Omnibus Final Rule, business associates and covered entities must update BAA to be in compliance with HIPAA
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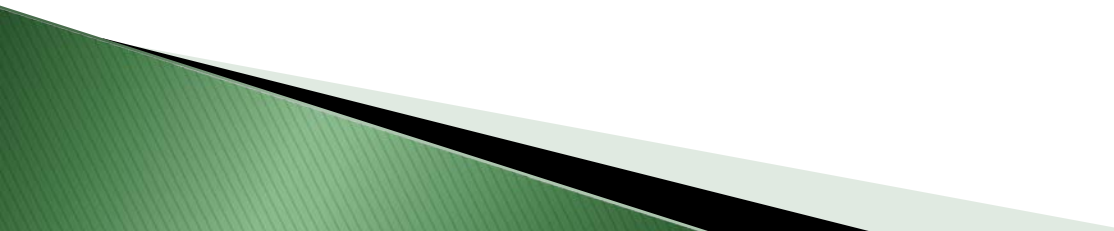
Requirements of BAA

- ▶ **Agreement clarifies and limits the permissible uses and disclosures of PHI by the business associate**
 - ▶ **Based on relationship between the parties and the activities or services being performed by the business associate**
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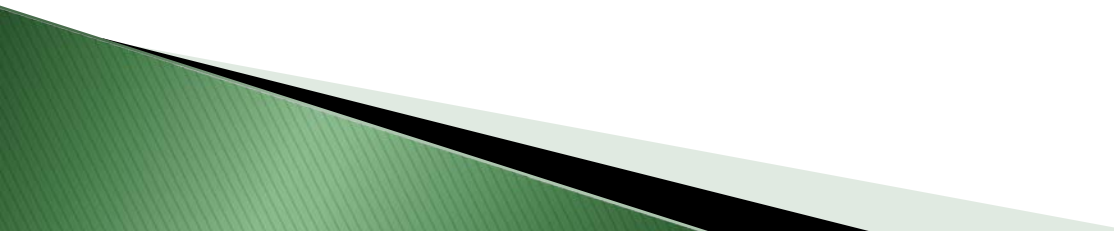
Privacy Rule–Individual Rights

- ▶ **General right to obtain and review a copy of PHI**
 - ▶ **Right to have PHI amended when information is inaccurate or incomplete**
 - ▶ **Right to an accounting of disclosures of PHI by a covered entity or business associate**
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Privacy Rule–Individual Rights

- ▶ **Right to request that a covered entity restrict use or disclosure of PHI**
 - ▶ **Right to request alternative means or location for receiving communications of PHI**
 - ▶ **Right to receive Notice of Privacy Practices**
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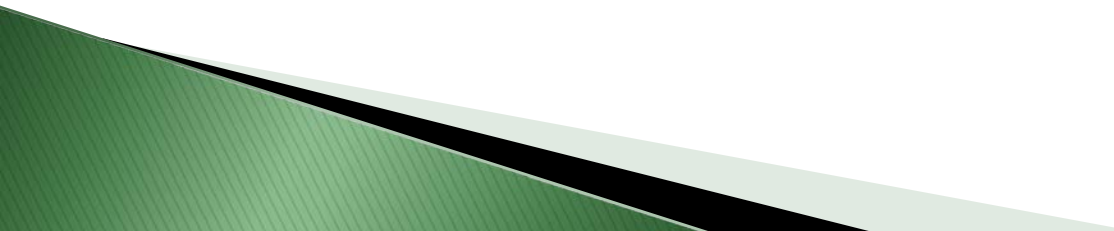
Privacy Officer

- ▶ **A covered entity or business associate must designate a privacy officer who is responsible for developing and implementing policies and procedures of the entity**
 - ▶ **Oversees HIPAA compliance for the entity**
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Security Rule

- ▶ Establishes national security standards for protecting PHI held or transferred in electronic form (E PHI)
- ▶ Goal is to protect privacy of E PHI while allowing adoption of new technologies to improve the quality and efficiency of patient care

Security Rule–Requirements

- ▶ **Ensure the confidentiality, integrity, and availability of all EPHI created, received, maintained or transmitted**
 - ▶ **Identify and protect against reasonably anticipated threats to the security or integrity of the information**
 - ▶ **Protect against reasonably anticipated, impermissible uses or disclosures**
 - ▶ **Ensure workforce compliance**
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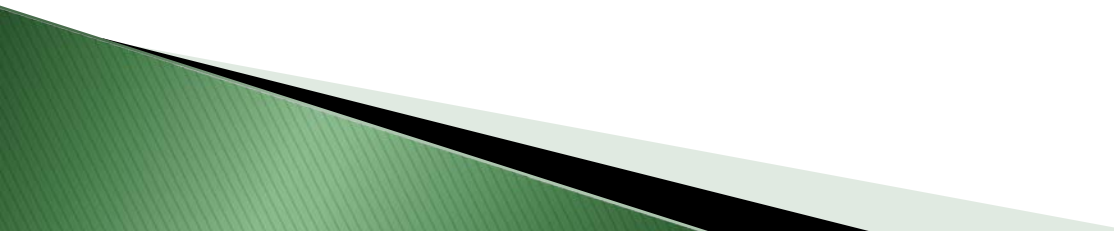
Security Rule–Flexible Approach

- ▶ **When deciding which security measures to use, covered entity and business associate should consider**
 - **Its size, complexity, and capabilities**
 - **Its technical, hardware, and software infrastructure**
 - **The costs of security measures**
 - **The likelihood and possible impact of potential risks to EPHI**

Security Rule–Safeguards

- ▶ **Must maintain reasonable and appropriate administrative, technical and physical safeguards for protecting EPHI**

Breach Notification Rule

- ▶ **Requires that covered entities and business associates provide notification following breach of unsecured PHI**
 - ▶ **Breach is generally an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of PHI**
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Breach Notification–Required Actions Following a Breach

- ▶ **Covered entities must notify:**
 - **Affected individuals**
 - **The Secretary of the U.S. Department of Health and Human Services (DHS)**
 - **The media for breaches affecting more than 500 residents of a state**
- ▶ **If a breach of PHI occurs at or by a business associate, the business associate must notify the covered entity following discovery of the breach**

Enforcement Rule

- ▶ Imposes civil money penalties for violations of HIPAA rules
- ▶ Increased penalties effective October 2009
- ▶ Previously \$100 per violation – maximum of \$25,000 for all violations of the same type in a calendar year
- ▶ Currently \$100 to \$50,000 per violation, depending on degree of culpability – maximum of \$1.5 million for all violations of the same type in a calendar year

Enforcement Rule–HITECH Audit Program

- ▶ **HITECH Act requires that DHS perform periodic audits of covered entity and business associate compliance with Privacy, Security, and Breach Notification Rules**

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Reporting Employer Provided Health Coverage on Form W2

- ▶ Employers required to report the cost of coverage under an employer-sponsored group health plan.
- ▶ Effective for calendar year 2012 (W-2's provided in January 2013) and future years.
- ▶ Certain employers and certain types of coverage exempted until the IRS publishes guidance.
- ▶ Reporting by these employers and for these types of coverages may be made on a voluntary basis.

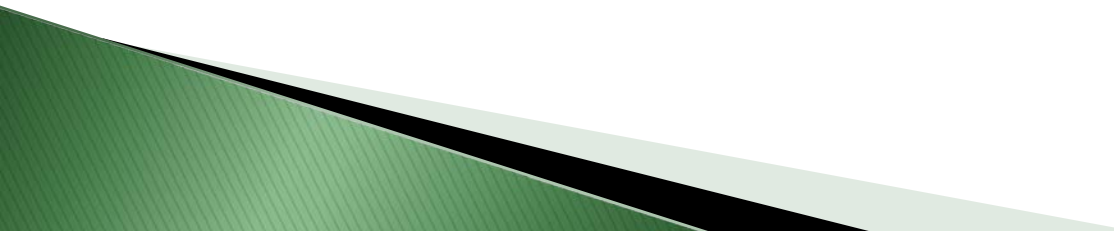
The transition relief applies to the following:

- (1) employers filing fewer than 250 Forms W-2 for the previous calendar year;**
- (2) multi-employer plans;**
- (3) Health Reimbursement Arrangements;**

The transition relief applies to the following:

- (4) dental and vision plans that either**
 - ▶ are not integrated into another group health plan or**
 - ▶ give participants the choice of declining the coverage or electing it and paying an additional premium**

The transition relief applies to the following:

- (5) self-insured plans of employers not subject to COBRA continuation coverage;**
 - (6) employee assistance programs, on-site medical clinics, or wellness programs; and**
 - (7) employers furnishing Forms W-2 to employees who terminate before the end of a calendar year and request a Form W-2 before the end of that year.**
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Collection of Additional Medicare Tax

Additional Medicare tax of 0.9% applies to wages, compensation or self-employment income exceeding

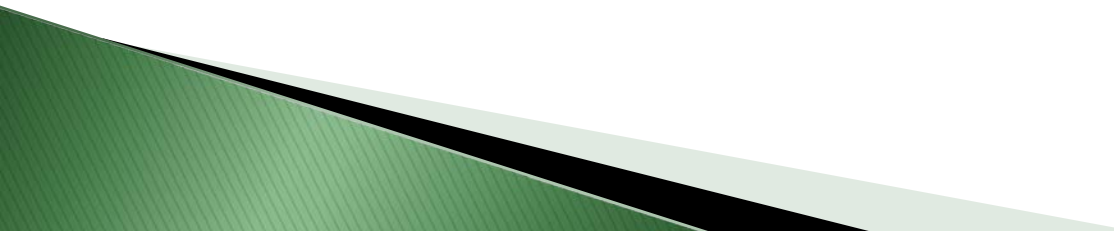
- ▶ **\$250,000.00 for married taxpayers filing jointly;**
- ▶ **\$125,000.00 for married filing separately;**
- ▶ **\$200,000.00 for singles;**
- ▶ **\$200,000.00 for head of household; or**

Collection of Additional Medicare Tax

- ▶ **\$200,000.00 for a qualifying widow with a dependent child.**

The tax must be withheld on all excess compensation in a calendar year beginning after 2012, without regard to the individual's filing status or wages paid by another employer.

Employers' Reporting on Health Coverage

- ▶ Final rules to implement the information reporting provisions for insurers and certain employers under ACA take effect in 2015.
 - ▶ Rules only apply to employers with 50 or more employees that are subject to the employer shared responsibility provisions.
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Employers' Reporting on Health Coverage

The final rules include the following key provisions:

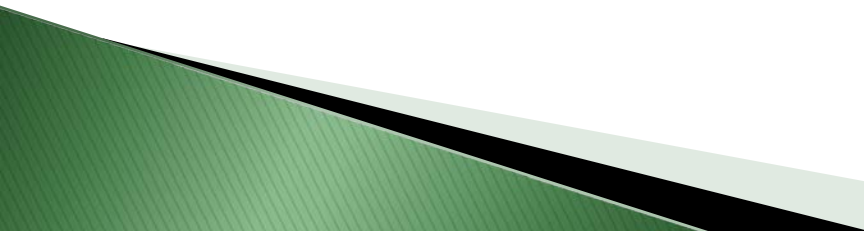
- ▶ Streamlined reporting for self-insured employers;
- ▶ Option to avoid identifying in the report which of its employees are full-time;
- ▶ Simplified reporting for employers who provide a “qualifying offer.”

Employers' Reporting on Health Coverage

What is a “qualifying offer”?

- ▶ **minimum value employee-only coverage at a cost to the employee of no more than about \$1,100.00 in 2015,**
- ▶ **combined with an offer of coverage for the employee's family.**

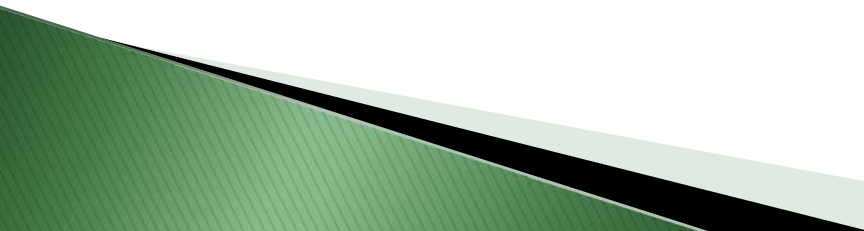
Changes in Flexible Spending Account and Health Savings Accounts

- ▶ Relaxed the health FSA “use-or-lose” rule.
 - ▶ Participants may carry over up to \$500.00 in unused funds into the next year.
 - ▶ Applies if a plan does not also incorporate an extended deadline, or grace period, after the end of the plan year to use health FSA funds.
 - ▶ Available beginning with the 2013 plan year.
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Changes in Flexible Spending Account and Health Savings Accounts

- ▶ Restricted the use of FSAs, Health Savings Accounts (HSAs), and Archer Medical Savings Accounts (Archer MSAs) to pay for over-the-counter medication, effective January 1, 2011.
- ▶ The Health Savings Account (HSA) out-of-pocket limits will be \$6,350.00 for individuals and \$12,700.00 for families in 2014.

Small Business Tax Credits

- ▶ **Final Regulations issued June 26, 2014, applicable for taxable years beginning in or after 2014.**
 - ▶ **Now available only for coverage purchased through the Small Business Health Options Program (SHOP) Marketplace.**
 - ▶ **Small businesses entitled to the credit in earlier tax years may file amended return if not claimed then.**
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Disclosure Requirements

Summary of Benefits and Coverages (“SBC”)

Insurance companies and group health plans must provide consumers with an SBC.

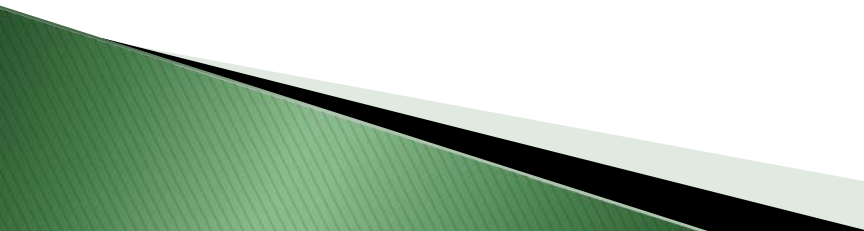
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Disclosure Requirements

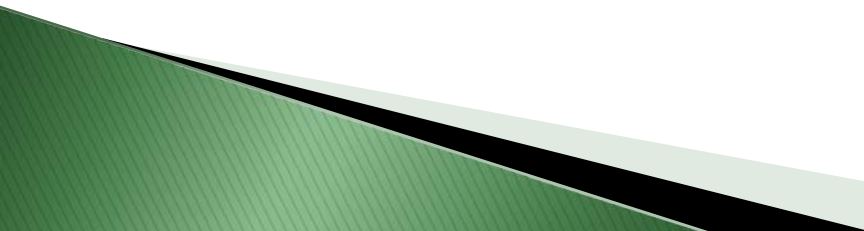
Notice of Exchange and Subsidies

- ▶ Effective October 13, 2013, employers were required to distribute a Notice of Exchanges and Subsidies to all employees.
- ▶ The notice must be provided to each new employee within 14 days of the employee's start date.

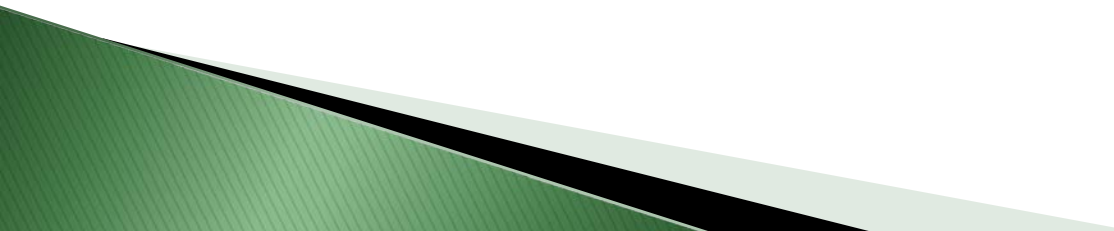
Non-discrimination in Favor of Highly Compensated Individuals

- ▶ Internal Revenue Code (IRS) Section 105(h)'s formerly prohibited self-insured plans from discrimination in favor of highly compensated individuals (“HCIs”) as to plan eligibility and benefits
 - ▶ ACA extended those restrictions to non-grandfathered insured group health plans as well.
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Non-discrimination in Favor of Highly Compensated Individuals

- ▶ Different penalties for non-compliance:
 - ▶ Self-insured plan fails to comply: highly compensated individuals lose a tax benefit.
 - ▶ Insured group health plan fails to comply: plan or plan sponsor may be subject to an excise tax, civil money penalty, or a civil action to compel it to provide nondiscriminatory benefits.
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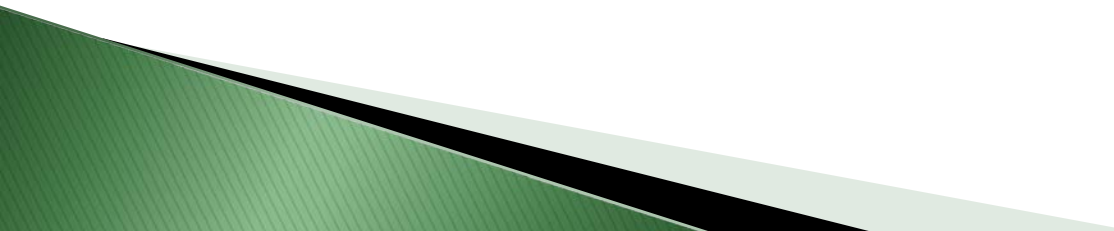
Non-discrimination in Favor of Highly Compensated Individuals

- ▶ Implementation was initially scheduled for January 1, 2014.
 - ▶ IRS has not yet finalized implementing regulations and has announced that no enforcement action will be taken until the regulations are in place.
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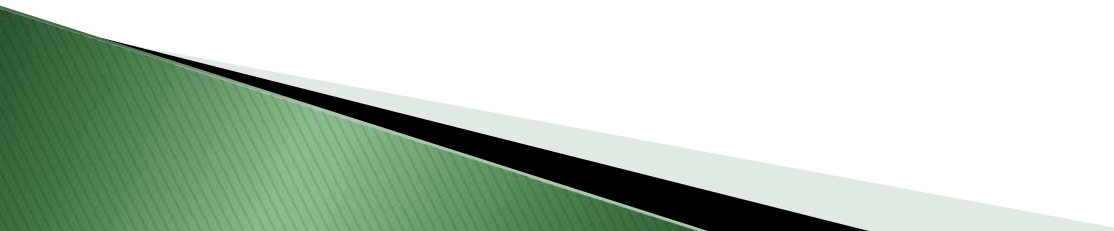
Restrictions on Waiting Periods Before Coverage Begins

- ▶ Effective April 25, 2014, maximum waiting period before coverage becomes effective is 90 days.
- ▶ Applies to both grandfathered and non-grandfathered group health plans and group insurance coverage for plan years beginning January 1, 2014.
- ▶ If the individual can elect coverage that becomes effective on a date that does not exceed 90 days, the coverage complies with the 90-day waiting period limitation.

Restrictions on Waiting Periods Before Coverage Begins

- ▶ If an individual enrolls as a late enrollee or special enrollee, any period before the late or special enrollment is not a waiting period.
 - ▶ Being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions.
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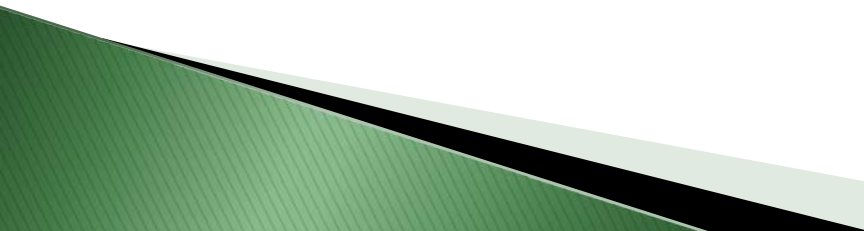
The Patient-Centered Outcomes Research Trust Fund Fee

- ▶ Fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans.
 - ▶ Fund the Patient-Centered Outcomes Research Institute (PCORI).
 - ▶ Applies to self-insured health plans with plan years ending after September 30, 2012, and before October 1, 2019.
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The Patient-Centered Outcomes Research Trust Fund Fee

- ▶ Equal to the average number of lives covered during the policy year or plan year multiplied by the applicable dollar amount for the year.
- ▶ Policy and plan years ending after September 30, 2013, and before October 1, 2014, fee \$2.00.
- ▶ Will be adjusted for inflation for policy and plan years beginning on or after October 1, 2014, and before October 1, 2019.

The Patient-Centered Outcomes Research Trust Fund Fee

- ▶ **Four alternative computation methods available to issuers of specified health insurance policies.**
 - ▶ **Three computation methods available to plan sponsors of applicable health plans.**
 - ▶ **Generally, all individuals who are covered during the policy year or plan year must be counted.**
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The Patient-Centered Outcomes Research Trust Fund Fee

- ▶ **Reported on Form 720, Quarterly Federal Excise Tax Return.**
- ▶ **Electronic filing is available but not required. Payment due at the time the Form 720 is due.**

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