What's New with the ACA?

August 10, 2017

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Today's Webinar

During the webinar, feel free to email or text Richard if you have additional questions that you would like to have addressed.

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Agenda

- The State of Obamacare
- The State of the Union—Or At Least Those in Washington
- The State of the States
- Rulings & Cases To Consider
- Compliance Attention
- Medical Loss Ratio – Employer Options for Dispersing Rebates

THE STATE OF OBAMACARE

The State of Obamacare

- It Ain't Healthy

Individual Market

- The Individual Market is the Heart of Obamacare
  - Idea was to provide those traditionally unserved *access* to *affordable care*
- Access
  - Uneven across the states
  - Many carriers exited or are threatening to exit the individual market
  - Majority of states now have less carriers offering coverage than at start of Obamacare
  - Aetna Exiting 11 States, following Humana, UnitedHealth and others

The State of Obamacare

- It Ain't Affordable in Many Markets

Average Premium Increases in Select Exchanges in 2016	
Ohio	13%
Florida	20%
North Carolina	20%
New Hampshire	30%
Wisconsin	30%
Indiana	36%
Pennsylvania	40%
Illinois	44%

Are the Exchanges in a Death Spiral?

- Recent S&P study looked at the performance of many Blue Cross across the country
- Study shows that the carriers significantly reduced their losses last year, are likely to break even this year and that most could profit in 2018
- Confirms CBO analysis

The State of Obamacare

Future Looks Grim

- President Trump Threatens to Stop CSRs
  - *What are CSRs?*
    - Cost-Sharing Reduction Payments designed to repay carriers for cost of providing low-cost health care (and subsidizing Congressional coverage)
  - *Can the President Legally Stop CSRs?*
    - Live by the sword—die by the sword
  - *What Happens if CSRs Cease?*
    - The threat has already shown us the future
    - Less access and higher cost

The State of Obamacare

Appearance & Reality

- Reports that **20 Million** *Newly Covered* Under Obamacare Will Lose Coverage Are *Grossly Exaggerated*
  - ***Real Number is Closer to ½ That***
    - 10 Million *is* a large number but it is ~ 3% of the U.S. Population
  - ***Where lies the Discrepancy?***
    - Most of the other 10 Million Had Insurance or Access to Insurance Before Obamacare
    - *Employer's Plan,* Medicaid, Parent's Plan, Student Insurance, Individual Market Were All Pre-Obamacare Sources

The State of Obamacare

Reality for Employers

- 40% to 60% of Those Receiving Subsidies are Ineligible
  - Self-Policing Doesn't Work
  - Government Just Getting Going With Cross-Checking
  - Recoupment for Funds Previously Expended is Still on The Table

The State of Obamacare

Who's to Blame

THE STATE OF THE UNION: OR AT LEAST THOSE IN WASHINGTON

115th Congress

Political Currents

Current Congress	
House:	**241 - 194**
Senate:	**52 - 48**

A Party Divided


R. Portman (OH)


R. Paul (KY)


S. Collins (ME)


M. Lee (UT)


S. Moore Capito (WV)


L. Murkowski (AK)


J. Moran (KS)


T. Cruz (TX)


R. Johnson (WI)


D. Heller (NV)


J. McCain (AZ)

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115th Congress

It's All Politics

2018 House and Senate Outlook
33 Senate seats (8/25)
All House seats

Repeal and Replace

Differing Philosophies

Democrats:	**Defined Benefit Model**
Republicans:	**Defined Contribution Model**

American Health Care Act (AHCA) Passed in the House May 4, 2017 (217-213)

Republicans:
217—YES
20–NO

Democrats:
0—YES
193—NO

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ACA vs. the AHCA

	Affordable Care Act (ACA)	American Health Care Act (AHCA)
Mandates	• Individual mandate • Employer mandate on ALE's	• No individual or employer mandate eff. retro to 1/1/16 • Insurers can impose a one year 30% surcharge on consumers with a lapse in continuous coverage
Assistance	• Income-based subsidies for premiums that limit after-subsidy cost to a percent of income • Cost sharing reductions for out-of-pocket expenses	• Age-based refundable tax credits for premiums, phased out for higher incomes • No cost sharing reductions for out-of-pocket expenses • ACA subsidies phased out after 2019; AHCA credits effective in 2020
Premium Age Differences	• 3:1	• 5:1 (MacArthur amendment would allow a ratio above 5:1)
Medicaid	• Matching federal funds to states for anyone who qualifies • Expanded eligibility to 138% of poverty level income	• Federal funds granted to states based on a capped, per-capita basis starting in 2020 • States can choose to expand Medicaid eligibility, but would receive less federal support for those additional persons
Health Savings Accounts	• $3,400/$6,750 contribution limit for 2017	• Increased to match HDHP OOP limits ($6,550/$13,100 for 2017)
"Cadillac" Tax	• Cadillac tax on high-cost plans implemented in 2020	• Cadillac tax on high-cost employer plans delayed until 2026
Other Taxes	• 3.8% tax on net investment income • 0.9% Medicare tax on individuals with income over $200,000 (or families with income over $250,000) • Limit placed on contributions to health FSAs • Annual health insurance provider tax • OTC medication excluded as qualified medical expense	• Repeal of these taxes retroactive to the beginning of 2017 (except for the repeal of the Medicare tax, which would begin in 2023)
Essential Health Benefits	• Insurers are required to offer ten essential health benefits (individual and small group plans)	• MacArthur amendment: individual and small group plans must offer the ten essential health benefits, but a waiver option is available • Mental health and substance abuse not required in some Medicaid plans
Pre-Ex/Age 26/No Limits: Same		

Amendments to AHCA

Tom MacArthur (Tuesday Group co-chair) Mark Meadows (Freedom Caucus chair)	
Insurance Market Provisions	The MacArthur Amendment would: • Reinstate Essential Health Benefits as the federal standard • Maintain the following provisions of the AHCA: — Prohibition on denying coverage due to preexisting medical conditions — Prohibition on discrimination based on gender — Guaranteed issue of coverage to all applicants — Guaranteed renewability of coverage — Coverage of dependents on parents' plan up to age 26 — Community Rating Rules, except for limited waivers
Limited Waiver Option	The amendment would create an option for states to obtain Limited Waivers from certain federal standards, in the interest of lowering premium costs and expanding the number of insured persons. States could seek Limited Waivers for: • Essential Health Benefits — States could set their own definition of EHBs for the individual and small group markets starting in 2020, and increase the age rating ratio above 5:1 starting in 2018 • Community rating rules, except for the following categories, which are not waivable: — Gender — Health Status (unless the state has established a high risk pool or is participating in a federal high risk pool) — Health status underwriting only permitted for a limited duration and only for those with a lapse in coverage (63 days)
Limited Waiver Requirements	States must explain how the waiver will benefit the insurance market in their state, such as reducing average premiums, increasing enrollment, stabilizing premiums for individuals with pre-existing conditions, or increasing the choice of health plans. Applications are automatically approved within 60 days unless denied by HHS.

Senate Response

- **Hard to find middle ground between conservatives and moderates**
- Conservatives generally don't want taxes and don't want subsidies
- Moderates concerned about the number of individuals who may lose coverage
- "Skinny Repeal" Effort Placed Obamacare on the Back Burner—or Did It?
- Lamar Alexander (R, TN) Chair of Health, Education, Labor and Pensions & Patty Murray (D, WA) said to be working on bi-partisan bill
- Hard to find middle ground between conservatives and moderates

A Way Out?

Democracy is a messy thing.

Some Modest Proposals

- Fix the Affordable Care Act—It's Broken—But Aim Small, Miss Small
  - Republicans Should Try To Avoid The Key Mistake the Democrats Made With Process
  - Fill Regulatory Positions
  - Consider Actually Addressing *The Problem*

Some Modest Proposals

Avoid Key Mistake Made By Democrats

- **Cost of Healthcare and Paying for It is a Bi-Partisan Issue**
- Democrats in 2009 – 2010 Passed ACA on a Strictly Partisan Vote
- Republicans Should Attempt to Fix ACA on a Bi-Partisan Basis
- Politics Will Get in the Way and Voters Should Make Them All Pay

Some Modest Proposals

Fill Regulatory Positions

- **At last count:**
  - **No nominee for 396 key agency posts**
  - **104 Nominees**
  - **45 Confirmed**
- Laws are interpreted by agencies

Some Modest Proposals

Consider Actually Addressing the Problem

- **Problem is not the way we pay for insurance**

- Problem is the cost of healthcare
  - Tort Reform
  - Sale of Health Insurance Across State Lines
  - Pharmaceutical Reform
  - Hospital Billing Reform
  - Enforcement of Sherman Act and Other Federal Laws—Curb Monopolization
  - Focus on Quality

THE STATE OF THE STATES

State of the States

This All Started With the States

- **Uninsured Perceived to be Driving Up HealthCare Costs**
- Massachusetts Passed Universal Health Care Law in 2006
  - Introduced Individual and Employer Mandate/Penalty Structure
  - Many of the Provisions Found Way to Obamacare
  - Individual Mandate Still the Law In Massachusetts

State of the States

State Responses

- **Vermont: Single Payer (Abandoned)**
- Colorado: Single Payer (Failed)
- California: Considering Single Payer?
- Massachusetts: Again Taking the Lead?

State of the States

State Responses

- **Massachusetts**
- Governor's Proposal: Replace State Employer Mandate (not currently in effect) With Increased Employer Assessments and Cost-Savings Changes at Mass Health
- State Legislature: OK with Increased Employer Assessments But Against Cost-Saving Measures

State of the States

State Responses

- **Massachusetts—Two Stage Approach**
- Stage 1: Transform MassHealth into an Accountable Care Organization (ACO) under the Affordable Care Act (Underway)
- Stage 2: Addresses $600M shortfall in MassHealth funding
  - Increases the maximum "employer medical assistance contribution" (EMAC), effective January 1, 2018, from $51 to $77 ($75 million in revenue in FY18)
    - Applies to employers with 6 or more employees
    - Supposed to be for two years
  - Requires employers to pay 5% of annual wages for each non-disabled employee who obtains public health insurance coverage (from MassHealth or the Massachusetts Health Insurance Connector), up to the annual wage cap of $15,000, or $750 maximum ($125 million in FY18 revenue)
  - Employers receive break on unemployment insurance
  - Legislature refused to enact cost-saving MassHealth Reforms
  - Plan leaves at least a $200M deficit issue

RULINGS & CASES TO CONSIDER

Rulings & Cases To Consider

- *OCR Fines $400,000 for HIPAA Breach*
  - Business Associate lost unencrypted PHI
  - OCR Investigated & Found BAA had not been updated since 2005
  - OCR determined that failure to update BAA constituted breach

- *Learning from OCR Action*
  - “One and Done” doesn’t do it under HIPAA
  - HIPAA’s requirements are vast and complex
  - Consider a HIPAA Audit

Rulings & Cases To Consider

- *Nieves v. Prudential Ins. Co. of America, 2017 WL 168039 (D. Ariz. 2017)*
  - Plan loses *Firestone* protection because plan document does not include discretionary review language
  - Presence of discretionary review language in SPD did not suffice

- *Learning from Nieves*
  - Plan documents matter
  - Always have documents either prepared or reviewed by competent ERISA counsel

Rulings & Cases To Consider

- *Thomas v. CIGNA Group Ins., 2015 WL 893534 (E.D.N.Y. 2015)*
  - Life insurance case
  - Disabled employee ceased making life insurance payments but did not file the available waiver
  - Carrier denied claim
  - Employee's beneficiaries claimed notice of need to file waiver was not sufficiently provided
  - Court found plan sponsor with faulty electronic delivery system did not meet ERISA's standards
- *Learning from Thomas*
  - ERISA's electronic delivery rules are complex
  - Merely placing SPDs on Company's website, without notice to participants of their availability and significance (and the right to a paper copy), will not satisfy ERISA's requirement
  - Distribution method must be reasonably calculated to ensure actual receipt and result in full distribution

Rulings & Cases To Consider

- *Hively v. Ivy Tech Community College, No. 15-1720 (7th Cir. Apr. 4, 2017)*
  - Federal appeals court held that Title VII of the Civil Rights Act prohibits workplace discrimination based on sexual orientation
  - Was the first time a federal appeals court has said that Title VII's ban on sexual discrimination prohibits bias based on sexual orientation
  - Ruling also comports with the EEOC's view that sex discrimination necessarily includes bias based on an individual's sexual orientation
  - Recent panel decisions in the 2nd and 11th circuits have held that Title VII doesn't provide such protections

- *Learning from Hively*
  - Those with discrimination claims based on sexual orientation or gender identity now have cognizable claims under Title VII
  - Provides an opportunity for employers to retrain managers on these issues, review policies and procedures
  - Supreme Court review likely

COMPLIANCE ATTENTION

ACA Reporting Update

Treasury Inspector General for Tax Administration (TIGTA) Reports
• Employer Report
• IRS intended to begin sending employer mandate penalty notices for 2015 “early in 2017”
• Funding cuts have slowed efforts to get assessments out
• IRS has begun sending “applicable large employer” notices to employers (requests for Forms 1094-C / 1095-C)
• As of October 2016, IRS processed 440,000 Forms 1094-C and 110 million Forms 1095-C
• 65,000 Forms 1094-C and 4.6M Forms 1095-C filed on paper
• IRS unable to process paper filings timely and accurately: as of October 2016, 16,000 paper Forms 1094-C and 1.4 million paper Forms 1095-C had not been processed

ACA Reporting Update

Treasury Inspector General for Tax Administration (TIGTA) Reports
• Individual Taxpayer Report
• As of March 2, 2017, IRS processed 1.7M tax returns that reported nearly $6.4B in Premium Tax Credits
• 1.8M taxpayers made shared responsibility payments – down from 2.7M the prior year (33% decrease)
• However, the amount of payments increased 20% to $1.2B
• 63,000 individuals accurately predicted their 2016 income
• 650,000 individuals were entitled to an additional tax credit
• 1,000,000 individuals had excess payments subject to repayment
• $830M in excess payments: $565M repaid, $265M outstanding

Compliance Attention

Tend to Compliance / Avoid Bad Ideas

- Hybrid Wellness / Fixed Indemnity Plans
  - IRS Memorandum (201703013) identifies potentially abusive arrangements
  - Programs that claim they can be implemented at no cost to the employer and without impact to an employee's net take-home pay and will result in:
    - Employers saving an average of $1,000 in FICA taxes per employee per year;
    - Employees receiving an average of $2,000 per year in additional benefits
- Memo provides that payments under a fixed-indemnity plan are taxable when premiums are paid pre-tax
  - Memo drafted broadly; targets plans where payment is not triggered by an unpredictable medical event giving rise to an expense
- IRS released another memo (201719025) targeting plans that involve a relatively small post-tax contribution compared to the nontaxable payments
  - Also warns that arrangements may not be considered "insurance" under the Code

Compliance Attention

Erwood v. Life Insurance Company of North America, et al

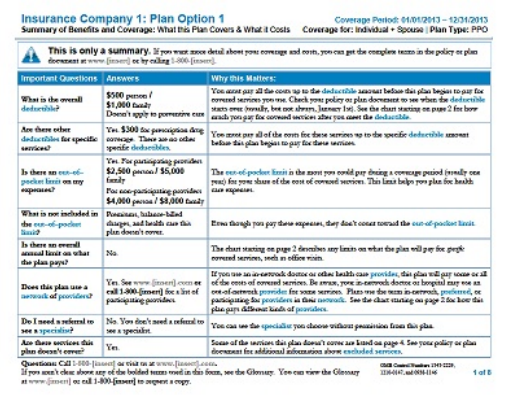
- Deceased employee's family filed a suit under ERISA to recover $750,000 life insurance payment
  - Disabled employee met with his employer to discuss benefits continuation
  - Employer mentioned COBRA for medical, dental and vision, but neglected to inform employee of the life insurance conversion benefit
- After the employee's passing, his family filed suit
  - Court found, among other things, that employer failed to fulfill its fiduciary obligations under ERISA and held the employer responsible for the $750k death benefit, as well as interest, legal fees and costs

Compliance Attention

- Summary of Benefits and Coverage

New Templates Available

- HHS has updated its SBC templates for open enrollment periods beginning on or after 4/1/17
- Existing 8 page SBCs slimmed down to 5 pages in most cases
- Many requirements remain the same – must use 12-point font and replicate all symbols, formatting, bolding and shading
- Definitions added to the Uniform Glossary, which plans may link to: https://www.healthcare.gov/sbc-glossary/



Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual + Spouse | Plan Type: PPO

This is only a summary.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 person / $1,000 family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers $2,500 person / $5,000 family For non-participating providers $4,000 person / $8,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.[insert].com or call 1-800-[insert] for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-[insert] or visit us at www.[insert].com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

OMB Control Number 1545-2229, 1210-0147, and 0938-1146

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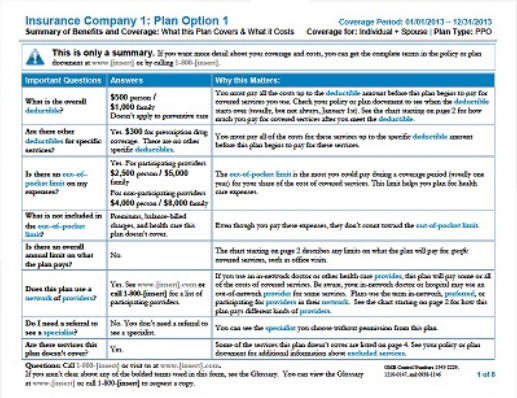
Compliance Attention

Summary of Benefits and Coverage

SBC Distribution Reminder

• Employers must provide SBC at specified times at no charge, such as:
  • With enrollment materials;
  • By the first day of coverage, if there are any changes to the initial SBC;
  • Within 90 days from enrollment for any special enrollee after a special enrollment event (marriage, etc.); and
  • Within 7 business days after receipt of request

• 60-day advance notice of material modifications required, unless changes are made in connection with the plan's renewal of coverage
• Electronic delivery of SBCs is permitted for those enrolling online or who are notified that it's available online (e.g., via postcard or email)
• Failure to comply may result in $1,105 fine per occurrence



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OMB Control Number: 1545-2229, 1210-0147, and 0938-1146

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Compliance Attention

- PCORI Fees Were Due by July 31 – Use 2nd Quarter Form 720

PCORI fee applies to fully insured and self-insured plans
• Paid by carrier for insured plans, by plan sponsor if self-insured
• Fee is $2.17 for plan years ending on or after 1/1/16 through 9/30/16 • Fee is $2.26 for plan years ending on or after 10/1/16 through 12/31/16
• Fee supposed to sunset after 2019
• Applies on a per-member basis for major medical
• Applies on a per-covered employee basis for HRAs
• Examples of due dates: • 07/01/15 – 06/30/16 – due by 7/31/17 • 01/01/16 – 12/31/16 – due by 7/31/17 • 03/01/16 – 02/28/17 – due by 7/31/18

Compliance Attention

- Affordable offers of employer-sponsored heath coverage in 2018

Rev. Proc. 2017-36 – used to determine affordability threshold
• Under the ACA, Applicable Large Employers who wish to offer "affordable" coverage cannot charge more than **9.5% (as indexed)** of an employee's household income or other metric as determined under the "safe harbor" provisions (e.g., W-2 income, Rate of Pay, Federal Poverty Level) for employee-only coverage
• 2015: 9.56% • 2016: 9.66% • 2017: 9.69% • 2018: 9.56%
• Draft 2017 ACA Reporting Forms available
• Few changes, mostly relating to removal of Transition Relief • Draft instructions should be issued in the coming weeks

Compliance Attention

New Claims Procedures For Disability Claims in 2018

- Apply to claims filed on or after 1/1/18 – largely adopt procedural protections for health claims added by the ACA, and ensure:
  - Independence and impartiality of decision-maker
  - Denial notices discuss the standards behind the decision
  - Claimants can access claim file and present evidence during review process
  - Claimants can respond to any new evidence in advance of an appeal decision
  - Final denials are not based on new rationales unless claimants can respond
  - Failure to follow claims procedures is deemed to be exhaustion of administrative remedies, unless *de minimis*

MEDICAL LOSS RATIO – EMPLOYER OPTIONS FOR DISPERSING REBATES

What is Medical Loss Ratio?

- The Affordable Care Act (ACA) requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR).
- It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards. If an issuer fails to meet the applicable MLR standard in any given year, the issuer is required to provide a rebate to its customers.

How is Medical Loss Ratio Calculated?

Requires insurers to pay out at least 80% of premium revenue, as claim payments or quality improvement expenses, for the small group and individual policies; 85% for large group policies

If not → must issue rebates to insureds

$$MLR = \frac{\text{Claims + Quality}}{\text{Premiums – (Taxes + Fees)}}$$

Potential Employer Options for Dispersing Rebates to Members

- There are multiple ways of calculating the rebates to the employees.
- Department of Labor guidance generally requires employers to distribute employees' share of any rebates in a manner in which they deem was taken in best interest of their employees.
- Decisions on how to apply or expend the plan's portion of a rebate are subject to ERISA's general standards of fiduciary conduct.

Potential Employer Options for Dispersing Rebates to Members

- The Employer portion of the rebate could be proportionate to either:
  - the current percentage or premium that the employer is contributing, or
  - the overall 2016 percentage of premium that the employer contributed.

Potential Employer Options for Dispersing Rebates to Members

- An average rebate to all currently enrolled employees (regardless of 2016 member status).
- A pro-rata rebate based on currently enrolled (if an employee only vs a family is on the plan the funds will allocated based on their deductions).
- An average rebate to those currently enrolled, but to those who were only enrolled on the 2016 calendar year.
- A pro-rata rebate based on currently enrolled, but to those who were only enrolled on the 2016 calendar year.

Potential Employer Options for Dispersing Rebates to Members

- An actual 2016 analysis of who was on the plan, based on plan and tier and paid deductions – should make a good faith effort to send to termed employees if using this method and can disregard sending to termed employees only if the check is “de minimis” in comparison to the time it could take to verify home address, print and mail check.
- An average rebate check to those enrolled in 2016 calendar year – should make a good faith effort to send to termed employees if using this method and can disregard sending to termed employees only if the check is “de Minimis” in comparison to the time it could take to verify home address, print and mail check.

Potential Employer Options for Dispersing Rebates to Members

- The rebate check would be taxable unless paid as a premium reduction in which case it would not be taxed.

Frequently Asked Questions (FAQ)

Must rebates be distributed in cash to participants?

- Administrative costs related to rebate distribution cannot be deducted from the portion of the rebate that is considered a plan asset that must be shared with participants.

Frequently Asked Questions (FAQ)

Can the cost of administration and distribution be deducted from the MLR rebate?

- Administrative costs related to rebate distribution cannot be deducted from the portion of the rebate that is considered a plan asset that must be shared with participants.

Frequently Asked Questions (FAQ)

What are the tax consequences for an employee who receives these rebates if the employees' share of premium was paid on a pre-tax basis?

- If an employee paid his or her portion of the insurance premium on pre-tax basis , then distribution of the rebate as cash will generally be taxable to the employee, and withholding rules will apply.
- Additionally, the amount of the rebate must be reported on a Form W-2 issued to the employee, given that the rebate distribution generally will be considered a supplemental wage.
- If the rebate is used to offset the employee's share of a premium that is paid on a pre-tax basis, then the employee's taxable income will increase by the amount of the premium reduction.

Frequently Asked Questions (FAQ)

Must an employer pick 2016 participants to refund?

- Absent plan language to the contrary, employers should be permitted to provide the employees' share of the rebate to current plan participants
- Alternatively, an employer may distribute the rebate in cash to plan participants who were covered by the policy in 2016, which may include people who are no longer covered by the plan
  - If it is not cost-effective to track down former employees who are no longer covered by the plan, or if the amounts to be distributed are de minimis, such amounts may instead be allocated to current plan participants who are covered by the policy when the rebate is received

Next Steps

- Decide which options best fits your needs.
- Consult with your Tax Adviser to assist with your decision.
- Rebates must be handled and employees notified within 3 months of receipt.
- Additional information and sample notices can be found on the CMS website: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html

Questions?

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Upcoming Events - Webinars

AUGUST 23, 12PM – 1PM EST

Stop Loss Underwriting: A Look Under the Hood

Upcoming Events – Baltimore Area

2017 MID ATLANTIC BENCHMARKING SURVEY

If you are a Mid Atlantic employer with 50 or more employees, then you are invited to participate in the 2017 Mid Atlantic Benchmarking Survey by August 25th.

www.silbs.com/benchmarking

SEPTEMBER 15TH: 2017 Benchmarking Results & Compliance Update Seminar

Speakers: Ron Cornwell, Principal & Consulting Actuary, Milliman
Stacy Barrow, Partner, Marathas Barrow Weatherhead Lent LLP

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