Compliance*Weekly*

July 14th, 2014

Health Care Reform Updates

Under Health Care Reform, most group health plans that cover dependents have been required to make the coverage available until a child reaches the age of 26 since plan years beginning on or after September 23, 2010. However, a **temporary exception** allowed grandfathered plans to exclude adult children who were eligible to enroll in employer-based coverage other than the group health plan of a parent.

As a reminder, the temporary exception for grandfathered plans **no longer applies for plan years beginning on or after January 1, 2014.** As a result, both grandfathered and non-grandfathered group health plans that cover dependents

Inconsistencies in States' Reporting of the Federal Share of Medicaid Drug Rebates

The following report is an audit on how the states did not consistently report the Federal share of Medicaid drug rebates at different Federal financial participation rates.

WHY WE DID THIS REVIEW
The Social Security Act (the Act) established higher Federal financial participation (FFP) rates for certain medical assistance services, such as those related to family planning, Indian Health Services, and breast and cervical cancer care. On the basis of prior Office of Inspector General work, we were concerned that States may not always use the higher FFP rates when refunding to the Federal Government its share of drug rebates that drug manufacturers paid to the States.

OBJECTIVE
Our objective was to determine whether States and the District of Columbia (States) reported drug rebates at the applicable FFP rates for the period July 1, 2011 through June 30, 2012.

BACKGROUND
Medicaid Program

must make coverage available until a child reaches age 26, regardless of other coverage options.

Read **on** ...

Medicare Fraud:

Testimony Before the OIG, Committee on Energy and Commerce and the House of Representatives

Why GAO Did This Study
GAO has designated Medicare as a high-risk program, in part because the program's size and complexity make it vulnerable to fraud, waste, and abuse. In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about $604 billion. The deceptive nature of fraud makes its extent in the Medicare program difficult to measure in a reliable way, but it is clear that fraud contributes to Medicare's fiscal problems. More broadly, in fiscal year 2013, CMS estimated that improper payments-some of which may be fraudulent-were almost $50 billion.

This statement focuses on the progress made and important steps to be taken by CMS and its program integrity contractors to reduce fraud in Medicare. This statement is based on relevant GAO products and recommendations issued from 2004 through 2014 using a variety of methodologies. Additionally, in June 2014, GAO updated information based on new regulations regarding enrollment of certain providers in Medicare by examining public

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

As part of the implementation of their Medicaid programs, States may submit waiver requests to CMS. These waivers, when approved, allow exceptions to certain requirements or limitations of the Act. Many States operate their Medicaid program using a combination of a fee-for-service payment system and waivers.

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IRS ALERT

IRS Finalizes Regulations for Health Insurance Tax Credits for Small Employers

The Internal Revenue Service has issued final regulations on the tax credit available to certain small employers that offer health insurance coverage to their employees under the Affordable Care Act.

As under the original law, the final regulations in TD 9672 define an eligible small employer as an employer that has no more than 25 full-time equivalent employees, or FTEs, for the taxable year, whose employees have average annual wages of no more than $50,000 per FTE (as adjusted for inflation for years after 2013), and that has a qualifying arrangement in effect that requires the employer to pay a uniform percentage of not less than 50% of the premium cost of a qualified health plan offered by the employer to its employees through the Small Business Health Options Program, or SHOP exchange. Consistent with the proposed regulations, the final regulations

documents.

Read the entire study **here** ...

further provide that employees (determined under the common law standard) who perform services for the employer during the taxable year generally are taken into account in determining FTEs and average annual wages.

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