Healthcare Reform

Getting Prepared for the end of 2014, 2015 and 2016

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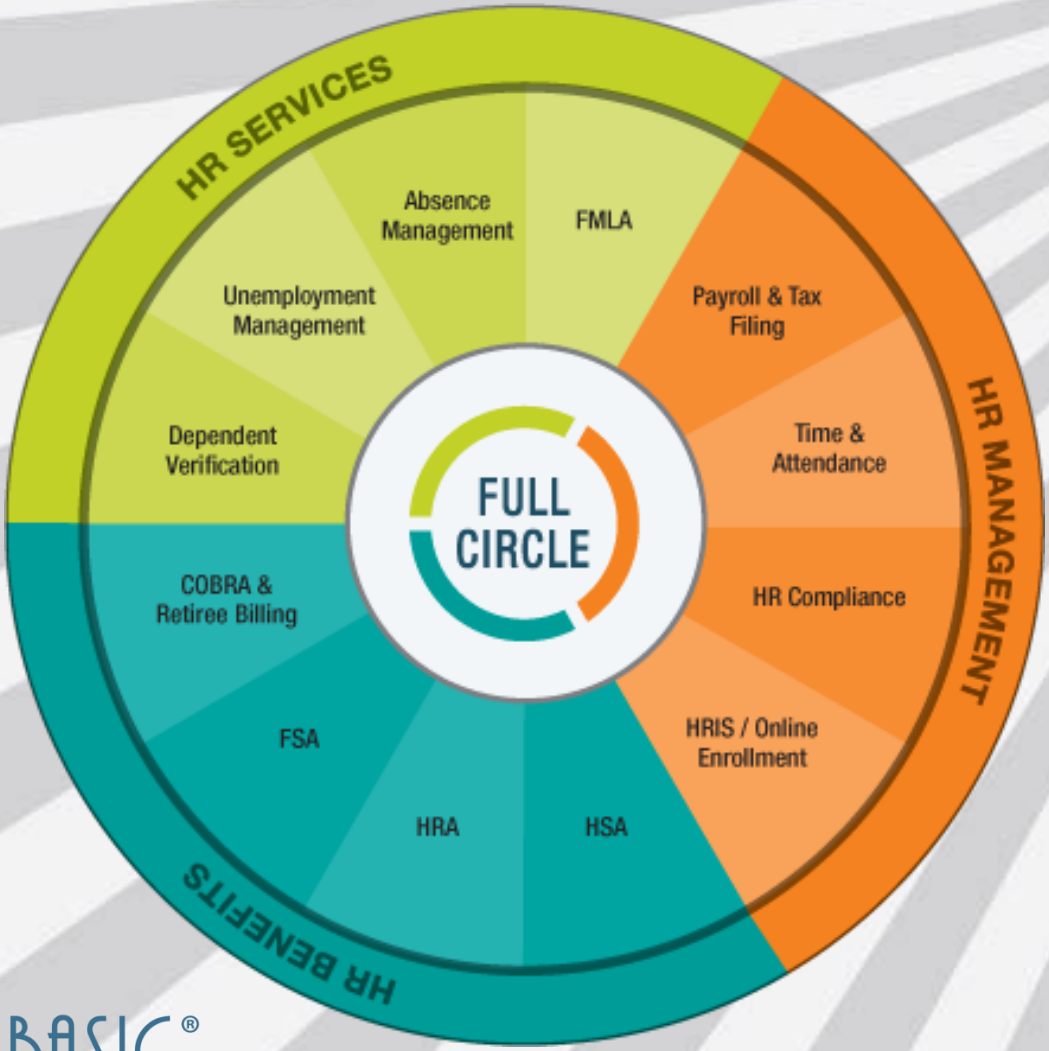

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Healthcare Reform: Getting Prepared for the end of 2014, 2015 and 2016

Presented by Larry Grudzien, JD, LLM

Larry has over 28 years of experience as an attorney, practicing exclusively in the field of employee benefits.

Agenda

- All Employers
- Large Employers
- Small Employers
- Fully-insured Employers
- Self-insured Employers

All Employers

Fees/Taxes

Comparative Effectiveness Research Fees

(a.k.a PCORI Fee/CERF)

What is it?

- Health care reform created a new nonprofit corporation, the Patient-Centered Outcomes Research Institute, to support clinical effectiveness research.

- This entity will be funded in part by fees (sometimes referred to as “PCORI fees” or “CER fees”) paid by certain health insurers and applicable sponsors of self-insured health plans.

- These fees do not apply to plans that provide "excepted benefits.”

Who Pays it and When?

- Fees are payable in connection with policy/plan years ending after September 30, 2012, but stop applying for policy/plan years ending after September 30, 2019.
- While insurers will file reports and pay the fees for insured policies, self-insured plan sponsors must file reports and pay these fees.
- Plan sponsors and insurers will file IRS Form 720 to report the fees and make annual payments.
- This return must be filed each year by July 31 of the calendar year immediately following the last day of the policy year (for insured plans) or the plan year (for self-insured plans).

The Amount of the Fee

- These fees will be calculated as the average number of covered lives under a policy or plan multiplied by $1 for plan years ending after October 1, 2012.

- The multiplier increases to $2 for the next plan year, then may rise with health care inflation through plan years ending before Oct. 1, 2019, when the fees are slated to end.

- To determine the average number of covered lives, plan sponsors generally can use any reasonable method in the first plan year and will choose from several proposed approaches in later years.

Required Contributions Toward Reinsurance Payments

(a.k.a. Transitional (*Temporary*) Reinsurance Fee)

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What is it?

- Under the ACA, each state is required to establish a transitional reinsurance program to help stabilize premiums for coverage in individual market inside and outside of Marketplaces (a.k.a. Exchanges) during the years 2014 through 2016.

- The program is funded through a reinsurance assessment on all health insurance carriers and self-insured plan sponsors.

- The collected fee is used to support reinsurance payments to carriers that cover high-cost individuals in non-grandfathered individual market plans.

Who Pays it and When?

- **For self-insured plans**, self-insured group plans sponsors are ultimately liable for reinsurance contribution fees.
- The self-insured ERs can use a TPA or ASO contractor to transfer the fees.
- Exempt certain self-insured, self-administered plans from making reinsurance contributions for 2015 and 2016.
- A self-insured health plan must make reinsurance contributions for major medical coverage, with certain exceptions.
- For this purpose, HSAs, health FSAs, expatriate health plans, and prescription drug plans are expressly excluded
- **For fully-insured plans**, carriers are responsible to pay the fees.

The Amount of the Fee

- HHS will establish a national reinsurance contribution rate each year.
- The annual per capita contribution rate for 2014 announced by HHS is **$63 and $44 for 2015**.
- HHS will collect all contributions and allocate reinsurance payments on a national basis.
- The same contribution rate applies to self-insured group health plans, although those plans are excluded from receiving reinsurance payments under the program.
- Enrollment data must be provided to HHS by November 15 (generally calculated based on January through September data, even for non-calendar-year plans).

The Amount of the Fee

- Contributing entities are to make reinsurance contributions in two installments:
  - *First installment:* HHS will notify the covered entity of the fee amount allocated to reinsurance payments and administrative expenses for the benefit year.
  - Contributing entities will be notified by December, and the payment is due within 30 days.
  - *Second installment:* In the fourth quarter of the year after the benefit year, HHS will notify the contributing entity of the contribution amount allocated for payments to the U.S. Treasury.
  - This installment is also due within 30 days after the notification.

Health Insurance Industry Fee

(a.k.a. Annual Insurance Fee)

What is it?

- Health care reform imposes an annual fee to insurers beginning in 2014 for the purpose of funding federal and state Exchanges.

- The total fee collected in the first year, 2014, will be $8 billion; gradually increasing to $14.3 billion in 2018 and indexed for rate of premium growth in 2019 and thereafter.

- The fee applies to fully-insured plans including dental and vision plans; but self-funded plans are excluded from this requirement.

Who Pays it and When?

- **Who pays the fees?**
  Insurers
  (Note: Self-insured employers are exempt from this requirement.)

- **When is the fee due?**
  Each insurer will make its payment by September 30 of each applicable calendar year to the Secretary of the Treasury.

- **Will the fee have any impact on fully-insured group health plan premiums?**
  - YES. It is expected that this requirement will increase group health premiums in coming years.
  - Some insurers have already indicated that the full amount of about 2 - 2.5% of premium would be added upon the upcoming renewal as early as February 2013; and may be increasing to 3 - 4% of premium in future years.
  - Each insurer is expected to have its own calculation method to allocate its insurer's fee into the groups' premiums.

The Amount of the Fee

- **How is the fee determined?**
  - Each insurer's fee will be determined based on its respective market share of premium revenue from the previous calendar year.
  - For example, the 2014 fee will be based on an insurer's 2013 premium revenue and the percentage of the market it represents among all health insurers of US health risks.
  - Then, the market share of the insurer is used to determine its share of the total $8 billion (for 2014).

- **What types of coverage does the fee apply to?**
  - The fee applies to most health insurance coverage including dental and vision plans.
  - However, self-insured plans, accident, disability income, specific disease and illness, and long-term care are not subject to this requirement.

90 Day Waiting Periods

Effective Date

- Effective as of plan years beginning on or after January 1, 2014, group health plans and insurers are prohibited from applying a waiting period that exceeds 90 days.
- This prohibition applies to group health plans and insurers but not to certain “excepted benefits.”
- Grandfathered health plans must also comply with the waiting period requirements.
- Can impose a 30 day orientation period before the waiting period begins.

What is it?

- **Definition of "Waiting period":** the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.

- **Cumulative service requirement**

  If a group health plan or health issuer conditions eligibility on an employee having a completed a number of cumulative hours of service, up to 1,200 hours may be required; more than 1,200 hours would be considered designed to avoid compliance with the 90-day waiting period limitation.

- **Counting days**

  All calendar days are counted beginning on the enrollment date, including weekends and holidays.

Examples

- **Example 1**: A group health plan provides that full-time employees are eligible for coverage under the plan. Employee Bill begins employment as a full-time employee on January 19.

  Conclusion. Any waiting period for Bill would begin on January 19 and may not exceed 90 days. Coverage under the plan must become effective no later than April 19 (assuming February lasts 28 days).

- **Example 2**: A group health plan provides that only employees who have completed specified training and achieved specified certifications are eligible for coverage under the plan. Employee Lisa is hired on May 3 and meets the plan's eligibility criteria on September 22.

  Conclusion. Lisa becomes eligible for coverage on September 22, but for the waiting period. Any waiting period for Lisa would begin on September 22 and may not exceed 90 days. Coverage under the plan must become effective no later than December 21.

Examples (Cont.)

- **Example 3**: A group health plan provides that employees are eligible for coverage after one year of service.

  Conclusion. The plan's eligibility condition is based solely on the lapse of time and, therefore, is NOT allowed because it exceeds 90 days.

- **Example 4**: A group health plan is a calendar year plan. Prior to January 1, 2014, the plan provides that full-time employees are eligible for coverage after a 6-month waiting period. Employee Sarah begins work as a full-time employee on October 1, 2013.

  Conclusion. The first day of Sarah's waiting period is October 1, 2013 because that is the first day Sarah is otherwise eligible to enroll under the plan's eligibility rule. Beginning January 1, 2014, the plan may not apply a waiting period that exceeds 90 days. Accordingly, Sarah must be given the opportunity to elect coverage that begins no later than January 1, 2014 (which is 93 days after Sarah's start date) because otherwise, on January 1, 2014, the plan would be applying a waiting period that exceeds 90 days. The plan is not required to make coverage effective before January 1, 2014 under the rules of this section.

Out-of-Pockets Limits

Overall Cost-Sharing Limitation

(Out-of-Pocket Maximum)

- A plan must not impose cost-sharing in excess of the maximum out-of pocket amount in effect for high deductible health plans for 2014.

- For 2014, the HDHP maximum out-of-pocket expense limit (that is, the sum of the plan's annual deductible and other annual out-of-pocket expenses (other than premiums) that the insured is required to pay, such as co-payments and co-insurance for an HDHP) cannot exceed $6,350 for self-only coverage and $12,700 for family coverage.

- For 2015, the limit can not exceed $6,600 for self-only coverage and $13,200 for family coverage.

Approved Clinical Trials

Overview

- Group health plans providing coverage to a qualified individual may not deny the individual participation in an approved clinical trial, deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with the trial, or discriminate against the individual based on participation in the trial.
- A group health plan may not:
  - deny any qualified individual the right to participate in a clinical trial as described below;
  - deny, limit, or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial; and
  - may not discriminate against any qualified individual who participates in a clinical trial.
- It does not apply to grandfathered plans

Cafeteria Plans & HRAs

Reimbursing Premiums for Individual Policies

- IRS Notice 2013-54 prohibits the reimbursement of premiums for individual medical policies from health reimbursement arrangements and premium only plans.

- Premiums for other types of individual coverage's can be reimbursed.

- Rules are effective for plan years beginning in 2014.

Free Standing HRAs

- IRS Notice 2013-54 requires that HRAs be integrated with group health plans for plan years beginning in 2014.
- Rules vary depending on whether the group health plan is of minimum value.
- Free standing HRAs can still reimburse premiums and expenses for “excepted benefits.”

Health FSAs

- For health FSAs to avoid the requirements of Health Care Reform, they must meet the requirements of an “excepted benefit.”
- Free standing health FSAs are still possible if reimburse excepted benefits.
- What requirements apply if a Health FSA is not an excepted benefit?

Health FSAs

- Allow up to $500 carryover to 2014 and later
- Carryover can allowed to be used for all or the next plan year
- Many unanswered questions from guidance
- Cafeteria plan must be amended to allow

Repeal of Defense of Marriage Act ("DOMA")

Repeal of DOMA

- May recognize same sex spouses, but not required.
- If do not, may be in violation of other federal laws.
- May require proof, but have to require of all married couples.

Repeal of DOMA

- **Cafeteria plans**:
  - May allow employees who are married as of June 26, 2013 to change existing elections.
  - Change can be made at any time during the cafeteria plan year that includes June 26, 2013 or cafeteria plan year that include December 16, 2013.
  - May wait until 2014 to make change.

Repeal of DOMA

- If an employer decides to offer same-sex coverage:
  - make any necessary amendments to the definition of “spouse” in the cafeteria and wrap plan documents (and possibly amend the definition of “children” and “dependents” as well).
  - confirm with that the third-party administrators/providers are updating policies and providing required notices to same-sex spouses (e.g., initial COBRA notices and notices to those already in the COBRA election period).
  - make sure the insurance policies are consistent with the decisions.
  - determine how same-sex spouses will be identified.
  - ensure the payroll systems are updated to reflect proper tax treatment of group coverage for same-sex spouses (and their children).

Large Employers

Employer Mandate

What is the Employer Mandate?

- Beginning in 2015, certain large employers may be subject to penalty taxes for failing to offer health care coverage for all full-time employees (and their dependents), offering minimum essential coverage that is unaffordable, or offering minimum essential coverage under which the plan's share of the total allowed cost of benefits is less than 60%.

- The penalty tax is due if any full-time employee is certified to the employer as having purchased health insurance through an Exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee.

Introduction

- The Employer Mandate is effective on January 1,2015, but the IRS has provided three transition rules for noncalendar-year plans:
  - **Relief for employees eligible on February 9, 2014**. An employer will not face penalties for full-time employees who were eligible for coverage as of February 9, 2014, as long as the employer offers them affordable coverage with a minimum 60% value by the first day of the plan year that starts in 2015, as long it is same plan year as of December 27,2012.
  - **Relief if coverage offered to at least one-third (one half) of employees**. For employees not eligible for the above plan as of February 9, 2014, the same penalty relief applies if the employer offered at least one-third or more of its employees (one-half of full-time employees) coverage during the most recent open enrollment period before February 9, 2014
  - **Relief if at least one-quarter (one- third) of employees covered**. The penalty relief also would apply if at least one-quarter (one-third of full-time employees) of employees were covered form an open enrollment before February 9, 2014 under one or more noncalendar-year plans that had the same plan year on Dec. 27, 2012.

Introduction

- The last two safe harbors would be available for employees who are offered affordable coverage with a minimum 60% value by the first day of the plan year that starts in 2015 and were not – or would not have been – eligible for coverage under any calendar-year plan operating on February 9, 2014.

- In all cases, an employer could determine the percentage of covered employees as of the end of the most recent enrollment period before February 9 2014.

Who is a Large Employer?

- An employer is large if it employed an average of at least 100 full-time employees on business days during the preceding calendar year for 2015.
- The controlled group rules in IRS 414 (b),(c), (m) and (o) apply to determine of an employer is subject to this provision.
- In determining the number of full-time employees, an employer must add up the total number of hours worked in a month by part-time employees, divide by 120, and add that number to the number of full-time employees.
- A “full-time employee” for any month is an employee who is employed for an average of at least 30 hours of service per week.

Who is a Large Employer?

- For 2015, the final regulations provide an important new transition relief for employers with less than 100 employees. If the following conditions are met, no penalty tax will apply until 2016 for employers with 50 to 99 employees:
  - Limited Workforce Size.
  - Maintenance of Workforce and Aggregate Hours of Service.
  - Maintenance of Previously Offered Health Coverage.
  - Certification of Eligibility for Transition Relief.

Who is a Large Employer?

- A special rule enables an employer that has more than 100 full-time employees solely as a result of seasonal employment to avoid being treated as an applicable employer.
- Under this rule, an employer will not be considered to employ more than 100 full-time employees if (a) the employer's workforce only exceeds 100 full-time employees for 120 days, or fewer, during the calendar year; and (b) the employees in excess of 100 who were employed during that 120-day (or fewer) period were seasonal workers.
- A “seasonal worker” means a worker who performs labor or services on a seasonal basis as defined by the DOL, including agricultural workers covered by 29 CFR § 500.20(s)(1) and retail workers employed exclusively during holiday seasons.

The Penalty Taxes

- The play or pay penalty tax actually consists of two separate taxes.

- The first applies when the employer fails to offer full-time employees the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan.

- The second applies when the employer offers minimum essential coverage under an eligible employer-sponsored plan to full-time employees, but the coverage is not affordable or does not provide minimum value.

Who is a Full-Time Employee?

- For determining the penalty, a full-time employee is anyone who works on average at least 30 hours per week or – under expected regulations – 130 hours per month (sometimes referred to as the “minimum-hours threshold”).

- Full-time status is easy enough to determine when an employee is hired to work a regular number of hours each week on an ongoing basis.

- But for variable-hour employees, such as part-time or seasonal staff, the task is more challenging.

Who is a Full-Time Employee?

- **Who are considered employees?**
  - Use common law standard control
- **How are hours of service counted?**
  - Hourly employees. To determine the full-time status of employees paid on an hourly basis, employers must use actual hours of service (including leave) for which payment is made or due.
  - Nonhourly employees. Employers may choose from three methods to determine the full-time status of nonhourly employees:
    - Actual hours of service. Count actual hours of service worked for which payment is made or due.
    - Days-worked equivalency. Credit an employee working at least one hour of service in a day with eight hours of service for that day.
    - Weeks-worked equivalency. Credit an employee working at least one hour of service in a week with 40 hours of service for that week.

Safe Harbors

- There are three safe harbors that employers can use to decide if an employee has averaged 30 or more hours per week.
- One applies on a monthly basis.
- The others apply a “look back” measurement period of 3 to 12 months for to ongoing employees and to new employees.
- The safe harbors are complex, but both rely on some defined time periods that generally must be measured in a uniform fashion for all employees.

Safe Harbors

- Under the monthly measurement method, employees will be identified as a full-time employee of initial eligibility using their hours of service of each calendar month and not based on averaging over a prior look back measurement period.

- These employees must be offered coverage at the beginning of the month after three full calendar months of employment.

Safe Harbors

- ***Look Back Defined time periods.*** The look back safe harbors allow employers to use these time periods to predict whether an employee will qualify as full-time for shared-responsibility purposes:

    - **Look Back Measurement period.** Employers select a fixed three- to 12-month look back measurement period for determining whether an employee has averaged at least 30 hours of service per week.

Safe Harbors

- **Stability period**. After meeting the minimum-hours threshold during the look back measurement period, employees must be treated as full-time – regardless of actual hours worked – during a subsequent "stability period," provided they remain employed.

- Employees who fail to meet the minimum-hours threshold during the look back measurement period do not have full-time status during the stability period and will not trigger shared-responsibility penalties.

Safe Harbors

- The stability period can't be shorter in duration (number of months) than its associated prior look back measurement period.

- If an employee meets the minimum-hours threshold during the look back measurement period, then the ensuing stability period for coverage availability must last at least six full, consecutive calendar months.

- If the employee did not meet the minimum-hours threshold, the stability period cannot be longer than the look back measurement period.

Safe Harbors

- **Optional administrative period.** Employers may need time after the look back measurement period ends to decide which employees must be offered coverage during the ensuing stability period.

- The safe harbor allows an optional “administrative period” between the look back measurement and stability periods so employers can notify employees qualifying for coverage and handle enrollment tasks.

- The administrative period can’t exceed 90 days or be applied in a way that imposes a gap in employees’ coverage.

Safe Harbors

- **Uniform periods, except between certain employee groups.** An employer generally must apply its selected look back measurement and stability periods on a consistent basis to employees.

- But an employer's look back measurement and stability periods can vary in length and/or in starting and ending dates for different specified categories of employees:
  - Collectively bargained versus noncollectively bargained employees,
  - Each group of collectively bargained employee covered by separate collectively bargaining agreement
  - Salaried versus hourly employees,, and
  - Employees located in different US states.

Safe Harbor for Ongoing Employees

- One of two main look back safe harbors for determining full-time status applies to “ongoing employees”: those who have worked for the employer throughout at least one “standard” look back measurement period.

- **Standard look back measurement and stability periods**. The look back measurement and stability periods that an employer selects to apply to its ongoing employees are called its “standard” look back measurement and stability periods.

- **Optional administrative period**. Where employers decide to use this option, the administrative period adopted can’t reduce or increase the length of the standard look back measurement or standard stability period.

- To prevent the administrative period from causing any gaps in a person’s coverage (once the periods have completed a full cycle), the administrative period must overlap with the prior standard stability period.

Safe Harbor for Ongoing Employees

- **Example of ongoing employee safe harbor and calendar-year plan:**
- **Standard Look Back measurement period:**
  - 10/15/2013 -10-14-2014
- **Administration Period:**
  - 10/15/2014- 12/31-14
- **Standard Stability Period:**
  - 1/1/15-12/31/2015

Safe Harbor for New Employees

- A second safe harbor applies for determining which new employees must be treated as meeting the minimum-hours threshold.
- This safe harbor has a simple rule for new hires expected to meet the threshold from their start dates, plus a series of more complex rules for new variable-hour and seasonal employees.
- In addition, an employer must establish separate “initial” look back measurement and stability periods for new hires that may overlap with its “standard” look back measurement and stability periods for ongoing employees.

Safe Harbor for New Employees

- **New hires expected to work full time:** If a new employee in an eligible class is reasonably expected to average at least 30 hours of service per week, offering qualifying coverage that takes effect by the end of the employee's initial three full calendar months of employment satisfies the shared-responsibility mandate.

- But that may not satisfy the 90-day cap on waiting periods.

- Interaction with 90-day maximum waiting period.

  - The waiting-period guidance sets stricter timelines than the shared-responsibility safe harbor for these new employees.

  - Coverage for new hires expected to meet the minimum-hours threshold must become effective by the first of the month after the employee becomes eligible (assuming the employee timely completes any enrollment steps).

Safe Harbor for New Employees

- **Initial look back measurement and stability periods**. The initial look back measurement and stability periods are unique to each new variable-hour or seasonal employee, reflecting the individual's actual start date or, alternatively, the start of the first calendar month after that date.

- Many employers might want to have all look back initial measurement periods start on the first of a calendar month; otherwise, every day of the year potentially could start a new look back measurement period.

Applicable Rules

- Several limitations, however, must be considered in setting these periods and measuring variable-hour and seasonal employees' status for shared-responsibility purposes.

- These restrictions are highlighted below, followed by examples illustrating the key principles:

  - The initial look back measurement period and administrative period, combined, can't extend beyond 13 months, plus a fraction of a month. Specifically, the combined periods must end by the last day of the calendar month that starts on or immediately after the first anniversary of an employee's start date.

  - New employees' initial stability periods can't be shorter than the standard stability period for ongoing employees.

  - In operation, this restriction will generally require a 12-month initial stability period for new employees if an employer uses a 12-month standard stability period.

Applicable Rules

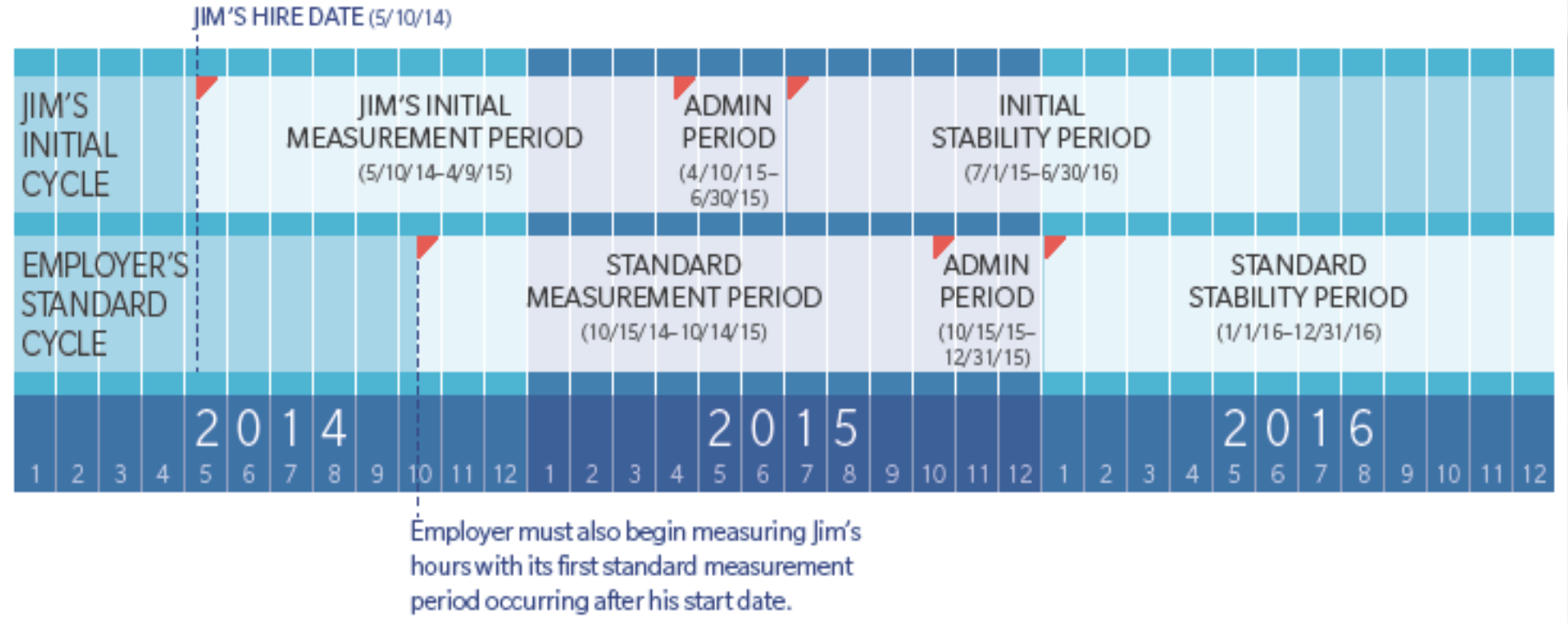
- Once a new employee has completed an initial look back measurement period and stability period, the employee must be tested for full-time status using the standard look back measurement period.
- Starting with that standard look back measurement period, the employee's full-time status is determined at the same time and using the same conditions applied to other ongoing employees.
  - An employee who meets full-time status during the initial look back measurement period must be treated as full-time for the entire initial stability period.
  - This is so even if the employee's hours drop below the full-time threshold during the overlapping or immediately following standard look back measurement period.

Important Conditions

- If an employee fails to meet full-time status during the initial measurement period, then both of these conditions apply:
  - The initial stability period can't be more than one month longer than the employee's initial measurement period and can't extend beyond the standard look back measurement period (plus any administrative period) in which the employee's initial Look back measurement period ends.
  - If the employee meets full-time status during the overlapping or immediately ensuing standard look back measurement period, the employee must be treated as full-time for the entire stability period associated with that standard look back measurement period.
  - This is so even if that stability period starts before the close of the employee's initial stability period.

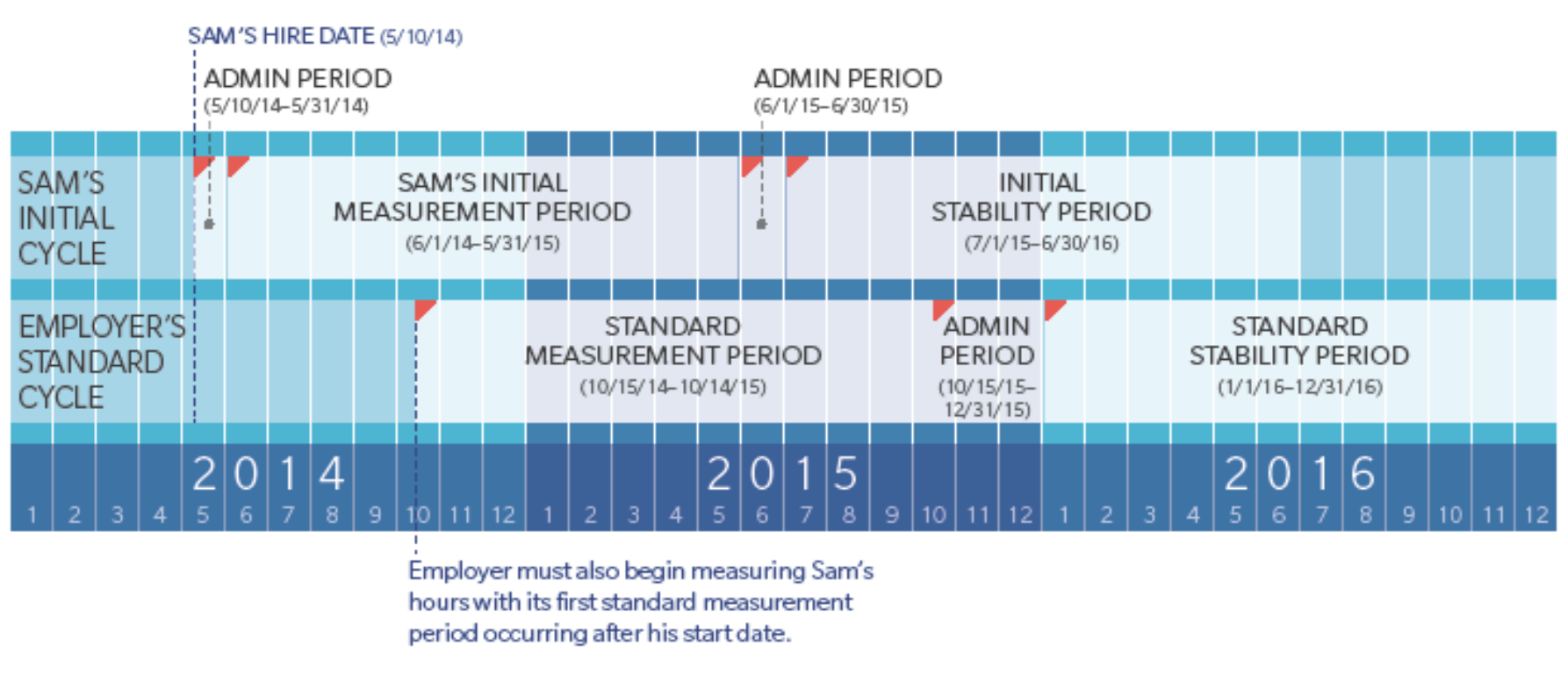
Example

- Example of variable-hour employee safe harbor and calendar-year plan: 11-month initial measurement period followed by single administrative period:



Example

- Example of variable-hour employee safe harbor and calendar-year plan: 12-month initial measurement period using split administrative period



Special Rules for Unpaid Absences

- New rules to prevent certain unpaid absences from inappropriately restarting an employee's initial measurement period or triggering a new 90-day waiting period for coverage.

- Absences of 13 or more weeks. If the period with no hours of service is at least 13 consecutive weeks, the employer may treat the employee as having been terminated and then rehired as a new employee.

- For educational employers , the period is still 26 weeks.

Special Rules for Unpaid Absences

- Rule of parity for absences shorter than 13 (26) weeks. An employer may choose to apply a “rule of parity” for periods of no service lasting less than 13 (26) weeks.

- An employee rehired after terminating employment may be treated as a new employee if the break in service is at least four weeks long and exceeds the employee’s period of employment immediately preceding the absence.

Special Rules for Unpaid Leave

- IRS has released two methods for averaging hours when lookback measurement periods include certain types of unpaid leave – that is, unpaid Family and Medical Leave Act (FMLA) leave, jury duty leave, or military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

- Under the proposal, employers may choose to apply one of these methods:
  - Exclude leave. Exclude the period of special unpaid leave to determine the average hours of service per week during the entire measurement period.
  - Credit hours. Credit an employee's special unpaid leave with hours of service at a rate equal to the employee's average weekly rate during weeks when no special unpaid leave is taken.

Transition Measurement Period

- Solely for purposes of stability periods beginning in 2015, employers may adopt a transition measurement period that is shorter than 12 months but that is no less than 6 months long and that begins no later than July 1, 2014 and ends no earlier than 90-days before the first day of the plan year beginning on or after January 1, 2015 (90- days being the maximum permissible administrative period).

The Penalty Taxes

- Both taxes hinge on whether an employer offers eligible employer-sponsored health coverage to “full-time employees,” but the nature of the penalty will depend on the cost to employees and the terms of coverage.

- The final regulations clarify that for a calendar year or plan year during which an employer is an applicable large employer, the employer mandate standards generally are applied separately to each person that is a member of the controlled group comprising the employer (with each person referred to as an “applicable large employer member”) in determining liability for, and the amount of, any assessable payment .

Large Employers who do not offer Coverage

- Large employers who do not offer “minimum essential coverage” to substantial all of its full-time employees and have at least one full-time employee who receives premium tax credits would be assessed a fee of $2,000 for every full-time employee beyond the first 80 employees.
- The “applicable payment amount” for 2014 is $166.67 with respect to any month (that is, 1/12 of $2,000).
- The amount will be adjusted for inflation after 2014.
- **80-Employee Reduction for 2015**
  - The number of individuals employed by an applicable large employer as full-time employees during any month is reduced by 80 for purposes of calculating the penalty tax on large employers not offering a health care plan.
  - While this reduction may decrease the amount of the penalty tax that may otherwise be due, it does not change the employer's status as an applicable employer.
  - Application to controlled groups on a pro rata basis.

Large Employers who do not offer Coverage

- The determination of whether an employer is subject to an assessable payment and the amount of any such payment is determined on a member-by-member basis.
- The liability for, and the amount of, any assessable payment is computed and assessed separately for each applicable large-employer member, taking into account that member's offer of coverage (or lack thereof) and based on that member's number of full-time employees.
- An applicable large-employer member will be treated as offering coverage to its full-time employees (and their dependents) for a calendar month if, for that month, it offers coverage to all but 30% of its full-time employees (provided that an employee is treated as having been offered coverage only if the employer also has offered coverage to that employee's dependents).

Large Employers who do not offer Coverage

- Coverage must be offered to the full-time employees and their dependents .
- The final regulations define an employee's dependents for purposes of Code § 4980H as an employee's child (as defined in Code § 152(f)(1)) who is under 26 years of age.
- A child attains age 26 on the 26th anniversary of the date the child was born.
- The term "dependent," for purposes of Code § 4980H, does not include any individual other than children, including an employee's spouse.

Employer Mandate

- An applicable large employer will pay a penalty tax (i.e., make an assessable payment) for any month that:
  - (1) the employer offers to its full-time employees (and their dependents) the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored plan for that month; and
  - (2) at least one full-time employee of the employer has been certified to the employer as having enrolled for that month in a QHP for which a premium tax credit or cost-sharing reduction is allowed or paid.

Large Employers who do offer Coverage

- Even though an applicable large employer offers minimum essential coverage to all full-time employees, a large-employer member may still be liable for a penalty.

- Employees eligible for minimum essential coverage under an employer-sponsored plan may still qualify for the premium tax credit if the plan fails the minimum value or affordability requirement.

Large Employers who do offer Coverage

- The penalty tax (assessable payment) is equal to $250 (1/12 of $3,000, adjusted for inflation after 2014) times the number of full-time employees for any month who receive premium tax credits or cost-sharing assistance (this number is not reduced by 80).

- This penalty tax (assessable payment) is capped at an overall limitation equal to the “applicable payment amount” (1/12 of $2,000, adjusted for inflation after 2014) times the employer's total number of full-time employees, reduced by 80.

Large Employers who do offer Coverage

- The liability for penalty for a calendar month with respect to a full-time employee applies solely to the applicable large-employer member that was the employer of that employee for that calendar month.

- If the employee was an employee of more than one applicable large-employer member during that calendar month, the liability for the assessable payment is allocated among the different members in accordance with the number of hours of service the employee had from each such member for that calendar month.

Large Employers who do offer Coverage

- Employees eligible for minimum essential coverage under an employer-sponsored plan may still qualify for the premium tax credit if the plan fails either of the following tests:
  - Minimum Value Test. The plan's share of the total allowed costs of benefits provided under the plan is less than 60% of those costs.
  - Affordability Test. The premium exceeds 9.5% of the employee's household income.

Affordability

- Three are three affordability safe harbors to determine whether an employer's coverage satisfies the 9.5 percent affordability for purposes of the penalty tax.

- These safe harbors include:

  - the Form W-2 wages safe harbor,

  - the rate of pay affordability safe harbor , and

  - the Federal poverty line safe harbor.

Minimum Value

- An employer-sponsored plan provides minimum value if the plan's share of the total allowed costs of benefits provided under the plan is at least 60% of such costs.

- Both the IRS and HHS have provided preliminary guidance on how minimum value will be determined and anticipate allowing three separate approaches.

- The three potential approaches for determining minimum value have been provided.

Notice to Employer of Premium Assistance

- The penalty tax is triggered, in part, by the employer receiving a certification that one of its employees is determined to be eligible for a premium assistance credit or a cost-sharing reduction.
- The employee may be eligible because the employer does not provide minimal essential coverage through an employer-sponsored plan.
- Or the employee may not be eligible because the coverage the employer offers either is not affordable, or the plan's share of the total allowed cost of benefits is less than 60%.
- The employer must also receive notification of the appeals process established for employers notified of potential liability for penalty taxes.

Notice to Employer of Premium Assistance

- When the Exchange determines an applicant is eligible to receive advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that his or her employer does not provide minimum essential coverage, or provides coverage that is not affordable, or does not meet the minimum value standard, the Exchange is required to notify the employer and identify the employee.

- This notice include the employee's identity, that the employee has been determined eligible for advance payments of the premium tax credit, that the employer may be liable or a shared responsibility payment, and that there is an opportunity to appeal.

Making Employer Mandate Payment

- The IRS will contact employers to inform them of their potential liability and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made.

- The contact for a given calendar year will not occur until after employees' individual tax returns are due for that year claiming premium tax credits and after the due date for employers that meet the 100 full-time employee (plus full-time equivalents) for 2015 threshold to file the information returns identifying their full-time employees and describing the coverage that was offered (if any).

Making Employer Mandate Payment

- If it is determined that an employer is liable for a penalty payment after the employer has responded to the initial IRS contact, the IRS will send a notice and demand for payment.
- That notice will instruct the employer on how to make the payment.
- Employers will not be required to include the payment on any tax return that they file.

Reporting of Health Insurance Coverage

- Certain employers are required to report to the IRS whether they offer their full-time employees and their employees' dependents the opportunity to enroll in “minimum essential coverage” under an eligible employer-sponsored plan and to provide certain other information.

- Reporting employers must also provide a related written statement to their full-time employees.

Reporting of Health Insurance Coverage

- The reporting and statement requirements apply to coverage provided on or after January 1, 2015.
- The first information returns will be filed in early 2016.
- The IRS will use the information that employers report to verify employer-sponsored coverage and to administer the employer mandate provisions.

Which Employers are Subjected to this Reporting Requirement?

- This requirement applies to “applicable large employers,” which are specifically defined under health care reform.

- An employer is an “applicable large employer” for a calendar year if it employed an average of at least 50 full-time employees on business days during the preceding calendar year.

What Information must be Reported to the IRS?

- The employer's return, which must in the form be set out by the IRS, must contain the following information—

The employer's name, date, and employer identification number (EIN);

- A certification of whether the employer offers its full-time employees and their dependents the opportunity to enroll in “minimum essential coverage” under an eligible employer-sponsored plan (as defined in Code § 5000A(f)(2)).
- The number of full-time employees the employer has for each month during the calendar year.
- The name, address, and taxpayer identification number (TIN) of each full-time employee employed by the employer during the calendar year and the months (if any) during which the employee and any dependents were covered under a health benefit plan sponsored by the employer during the calendar year.
- Any other information required by the IRS.

What Information must be Reported to the IRS?

- According to the IRS, these forms will be available in draft form in the near future. A return will include filing of:
  - Form 1094-C (a transmittal form).
- Annual returns must be filed with the IRS by February 28 (March 31, if filed electronically) of the year following the year to which the return relates.
- This is the same filing schedule that applies for Forms W-2 and 1099.

Written Statements to Full-Time Employees

Employers required to submit a report of health insurance coverage to the IRS must also furnish a written statement to each of their full-time employees whose name was required to be included in the report.

This statement must include—

- the name, address, and contact information of the reporting employer; and
- the information required to be shown on the return with respect to the individual.

The written statement must be furnished to full-time employees on or before January 31 of the year following the calendar year for which the information was required to be reported to the IRS.

Form 1095-C (an employee statement that will permit combined reporting).

Small Employers

Insurance Mandates

Fair Health Insurance Premiums
(Individual & Small Group Market)

- Premiums charged by insurers in the individual & small group market may vary with respect to a particular plan or coverage only by:
  - whether the plan or coverage covers an individual or family,
  - the rating area, as established under state standards,
  - age, except that the rate may not vary by more than a factor of 3 to 1 for adults, and
  - tobacco use, except the rate may not vary by a factor of more than 1.5 to 1.

Comprehensive Health Coverage Requirement

- Effective for plan years beginning on or after January 1, 2014, health insurance insurers offering coverage in the individual or small group market must ensure that such coverage includes the “essential health benefits package.”

- This requirement does not apply to “excepted benefits.”

- Insurance coverage and health plans that qualify as grandfathered health plans are not required to comply with comprehensive health coverage requirement.

Comprehensive Health Coverage Requirement

- To provide the essential health benefits package, a plan must—
  - provide essential health benefits,
  - limit cost-sharing, and
  - provide either bronze, silver, gold, or platinum level coverage (that is, benefits that are actuarially equivalent to 60%, 70%, 80%, or 90% (respectively) of the full actuarial benefits provided under the plan), as or a catastrophic plan (also known as “young invincible” coverage).

Comprehensive Health Coverage Requirement

- What precisely constitutes “essential health benefits” is to be defined by regulations, but they include minimum benefits in ten general categories and the items and services covered within those categories—
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care.

Cost Sharing Limits

Cost Sharing Requirements

- Health care reform requires that “cost-sharing” be limited.
- This requirement applies to all individual and small nongrandfathered group insured health plans
- Cost-sharing includes deductibles, co-insurance, co-payments or similar charges, and any other required expenditure which is a qualified medical expense with respect to essential health benefits covered under the plan.
- Cost-sharing does not include premiums, balance billing amounts for non-network providers, or spending for noncovered services.

Cost Sharing Requirements

- **Limit on Annual Deductible:**
  - For non grandfathered plans, the annual deductible must not exceed:
    - - $2,000, in the case of a plan covering a single individual, or
    - - $4,000 in the case of any other plan.
  - This requirement was repealed
  - The maximum deductible amounts may be increased by the maximum amount of reimbursement reasonably available to a participant under a "flexible spending arrangement."
  - It does not apply to grandfathered plans.

Fully-Insured Plans

Reforms that Apply to Insured Health Plans

- Guaranteed-Availability Rules Applicable to Small and Large Group Markets
- Guaranteed-Renewability Rules Applicable to All Insurance
- Process for Review and Disclosure of Rate Increases
- Fair Health Insurance Premium Requirement (Rating Limitations)—Applicable Only in the Individual and Small Group Markets
- Comprehensive Health Coverage Requirement (Essential Health Benefits Package)—Applicable Only in the Individual and Small Group Markets
- Medical Loss Ratio (MLR) Requirements
- New Nondiscrimination Rules
- Annual Insurance Fee (a.k.a. Health Insurance Industry Fee)

Self-Insured Plans

Reforms that Apply to Self-Insured Plans

- Dependent coverage for adult children up to age 26;
- Coverage of preventive health services without cost-sharing (grandfathered plans are exempt);
- No rescissions of coverage, except in the case of fraud or intentional misrepresentation of material fact;
- No lifetime limits on essential health benefits and annual limits are restricted until 2014 (in 2014, all annual limits are prohibited); and
- Improved internal claims and appeals process and minimum requirements for external review (grandfathered plans are exempt).

Reforms that Apply to Self-Insured Plans

- Essential Health Benefits Package
- Medical Loss Ratio Rules
- Small Employer Tax Credit
- Review of Premium Increases
- Annual Insurance Fee (a.k.a. Health Insurance Industry Fee)
- Guaranteed availability/ renewability
- Limit on Annual Deductible
- Actuarial value (i.e. bronze, silver, gold, or platinum level coverage)

Questions ???

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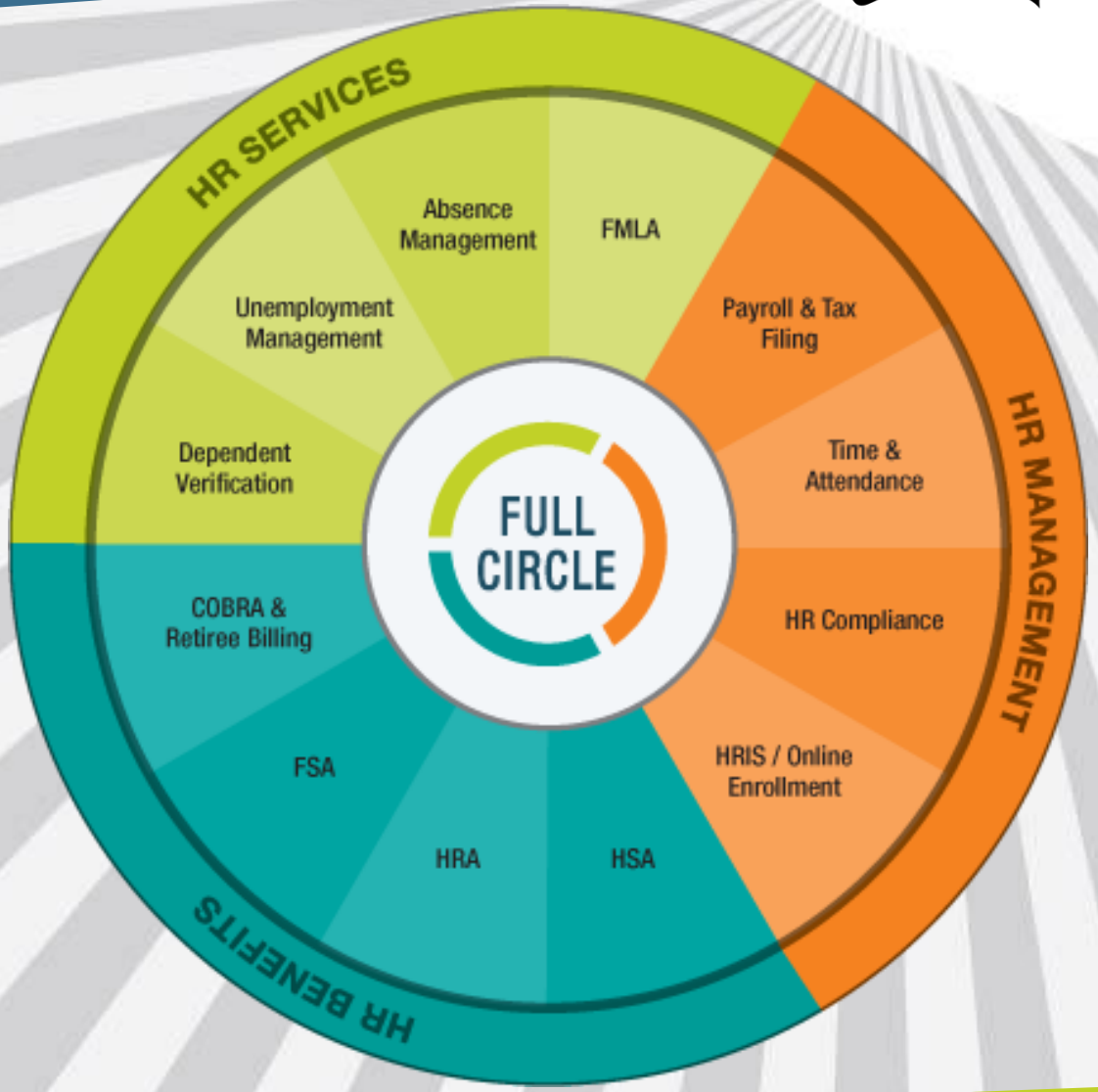

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