Form W-2 Reporting

- **Effective:** Calendar year 2012 - Cost must be reported on the W-2s issued in January 2013—and also reported in subsequent years

- The employer must disclose on the employee's W-2 the **aggregate cost** of employer-sponsored coverage (employer & employee contributions)

- **Exceptions:**
  - Small employers (those that filed fewer than 250 Forms W-2 for the 2011 calendar year) are not subject to the reporting requirement for Forms W-2 for the 2012 calendar year
  - Multiemployer plans, dental and vision plans that are "excepted" benefits, HRAs, health FSAs funded only by employee

- **Action Items:**
  - Compliance continues every year
  - Communicate what it means to employees

Medicare Tax Increase

- **Effective**: January 1, 2013

- The Medicare payroll tax on higher-income taxpayers will increase by 0.9 percentage points from 1.45% to 2.35%
- Tax will apply to those who earn more than $200,000/individual and $250,000/couple
- Withhold additional Medicare tax in the pay period in which employer pays employee in excess of $200,000
- No employer match
- No new notice required

- **Action Item**: Work with payroll department or vendor

Summary of Benefits (SBC)

- **Effective:** Compliance periods begin on or after September 23, 2012

- Uniform Summary of Benefits and Coverage (SBC):
  - A standardized summary of medical benefits & coverage (4 pages, front and back)
  - Model forms available (http://www.dol.gov/ebsa/healthreform/)

- Applies to grandfathered & non-grandfathered , fully insured & self-funded plans
- Does not replace existing ERISA plan documentation requirements

- **Action Items:** Employer must draft (self-funded plans) distribute (self-funded and fully insured plans)
  - Know the distribution deadlines
  - May distribute electronically (follow the rules)

Summary of Benefits: Distribution Deadlines

Triggering Event	Timing
Upon Application (Initial Enrollment): If a plan distributes application materials	Provide SBC with application materials
Upon Application (Initial Enrollment): If a plan does not distribute application materials	Provide no later than the 1st day on which the participant is eligible to enroll in coverage
Changes: If there is a change in content of SBC after application and before first day of coverage	Provide an updated SBC no later than first day of coverage
Upon Renewal (Open Enrollment): If during open enrollment a participant must actively elect to maintain or change coverage	Provide SBC with open enrollment materials
Upon Renewal (Open Enrollment): If there is no requirement to renew (evergreen) or change options, renewal is automatic	Provide no later than 30 days prior to the first day of the new plan or policy year
Special Enrollees	Provide no later than the date SPD must be provided (90 days from enrollment)
Upon Request	Within 7 business days

Summary of Benefits: Distribution

- Must distribute to both participants & beneficiaries, including COBRA QBs and recently terminated employees

- May distribute electronically (follow the rules)
  - One set of rules for those who are eligible but not enrolled for coverage
  - Another set of rules (existing ERISA electronic distribution rules) for those who are already covered under a plan
  - Safe harbor for on-line enrollment

- Provide in a culturally & linguistically appropriate manner http://cciio.cms.gov/resources/factsheets/clas-data.html

Women's Preventive Services

- **Effective**: For non-grandfathered plans, effective as of the first plan year that begins on or after August 1, 2012
- Non-grandfathered plans and issuers must provide without cost sharing
  - Includes coverage of such items as contraceptive methods and counseling and breastfeeding support, supplies, and counseling
  - Cost sharing includes deductibles, co-payments, and coinsurance
- May impose cost-sharing on out-of-network services
- May use reasonable medical management
- **Action Items:** Be prepared to communicate impact

Health FSAs

- **Effective:** First cafeteria plan year after 12/31/12
- For cafeteria plan years beginning after 12/31/12, employee FSA contributions are capped at $2,500 (to be indexed)
- Non-calendar year health FSAs may reduce contribution effective the first of plan year (for example, May 1, 2013)
- **Action Items:**
  - Should amend cafeteria plan before start of plan year
  - Should communicate the change in plan terms to employees before they make their elections before the start of plan year

Medical Loss Ratios

- **Effective:** Paid each August
- Only applies to fully insured plans, not self-funded
- Insurers must report costs that exceed certain ratios beginning for calendar year 2011
  - 85% for large groups
  - 80% for small groups
- If costs exceed limits, insurers must rebate the difference
- If rebates are "plan assets," there are restrictions on how the rebates may be used and when the rebates must be distributed
- **Action Item:** Employers need to plan how the rebates will be used or distributed

Notice of Exchange

- Employers must notify employees regarding health care coverage
- **Effective date**: Delayed until summer or fall of 2013
- Notice must include information about 2014 changes:
  - Existence of health benefit exchange
  - Potential eligibility for subsidy under exchange if employer's share of benefit cost is less than 60 percent
  - Risk of losing employer contribution if employee buys coverage through an exchange
- More guidance and model notice forthcoming

Comparative Effectiveness Research Fee

- **Effective:** Applies to plan and policy years ending on or after October 1, 2012, and before October 1, 2019
- Applies to fully insured and self-funded plans, including grandfathered plans
  - May apply to EAPs and wellness programs
  - May apply to HRA or health FSA
  - Does not apply to "excepted benefits"
- Who pays? Insurer or plan sponsor, depending on whether fully insured or self-funded
- Patient-Centered Outcomes Research Institute: http://www.pcori.org/

Comparative Effectiveness Research Fee

- Applies to covered lives (include dependents)
- Methods for counting covered lives by self-funded plan:
  - Actual count, snapshot, or Form 5500 method

- How much?
  - $1 per covered life for 2012
  - $2 per covered life for 2013 (indexed in the future)

- Process? Self-funded plan must file IRS Form 720

- **Action Item: Timing:**
- The fee must be paid and filed with the IRS by July 31 of the calendar year immediately following the last day of the plan or policy year
- For self-insured calendar year plans, payment on IRS Form 720 is due 7/31/13

Transitional Reinsurance Program Fee

- **Effective: 2014-2016**
- Applies to fully insured and self-funded plans
  - Applies to HRAs if not integrated with major medical coverage
  - Applies to some EAPs and wellness programs
  - Does not apply to "excepted benefits" (including health FSAs) or HSAs
- Who pays? Insurer or administrator, depending on whether fully insured or self-funded
- Based on the average number of covered lives (include dependents) for the year (two alternative methods available for counting covered lives)

Transitional Reinsurance Program Fee: Self-Funded Plans

- How much? Estimated cost is $63 per covered life

- **Action Item:**
  - Budget for amount that will be due
  - Adjust plan costs accordingly

- **Action Items: Process & Timing:**
  - Submit annual enrollment count no later than 11/15/14 (11/15/15 & 11/15/16) to HHS
  - Within 15 days plan will be told what it owes
  - Within 30 days plan must pay

On-Going Compliance Tasks in 2013

- W-2 Reporting
- Medicare Tax Increase
- SBCs
- Women's Preventive Services
- Health FSA Contribution Limits
- Medical Loss Ratio Rebates
- Notice of Exchange
- Comparative Effectiveness Research Fee
- Transitional Reinsurance Fee
- Planning for 2014 Pay-or-Play Penalties
- Planning for 2014 Plan Design Changes

- **Constantly Evolving**: Watch for developments on the federal and state level

Coverage Mandate: Individual

- **Effective 1/1/14**, individuals must have "minimum essential coverage" for themselves and their dependents or pay a penalty (some exceptions apply)

- The penalty is **the greater of**
  - $95 in 2014, $325 in 2015, and $695 in 2016 (capped at 3x the annual flat dollar amount per year) **or**
  - 1% of income for 2014, 2% for 2015, and 2.5% by 2016

- "Minimum essential coverage" includes
  - An eligible employer-sponsored plan
  - A grandfathered health plan
  - An individual health plan
  - Medicare Part A, Medicaid, or CHIP

The Exchange: Covered California

- **Effective:** January 1, 2014
- Who is eligible?
  - Individuals
    - Cost calculator at www.coveredca.com
  - SHOP Exchange for small employers
    - 50 or fewer F/T employees
    - In January 2016, 100 or fewer F/T employees
- Will indentify participating insurers and HMOs mid-May
- Initial **open enrollment** will be October 1, 2013 through February 28, 2014

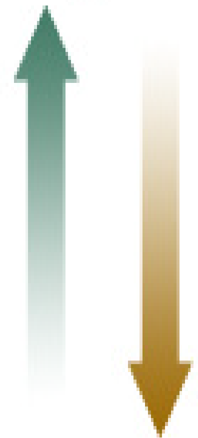
Exchange Plans Will Cover “Essential Health Benefits”

- Ambulatory patient Services
- Emergency Services
- Hospitalization
- Maternity & Newborn Care
- Mental Health & Substance Use
- Prescriptions
- Rehabilitive and Habilitive Services
- Laboratory Services
- Preventive & Wellness
- Pediatric Services (including Oral & Vision)

The Metal Levels

Category	Percentage of expenses paid by health plan	Percentage of expenses paid by individual
Platinum	90%	10%
Gold	80%	20%
Silver	70%	30%
Bronze	60%	40%

Higher percentage of expenses paid by plan



Lower monthly premium payment

Sample Plan Designs

	Platinum Co-Pay	Gold Co-Pay	Silver Co-Pay	Bronze Co-Pay
Office Visit	$20	$30	$45	$60
Diagnostic Test (blood work)	$20	$30	$45	30%
ER (waived if admitted)	$150	$250	$250	$300
Generic Drugs	$5	$20	$25	$25
Non-preferred Brand Drugs	$25	$70	$70	$75
Hospital Room	$250/day, up to 5 days	$600/day, up to 5 days	20%	30%

SHOP Plans for Small Employers: Cost

- For plan years on/after 1/1/14, insurers must not discriminate in setting rates for **individual and small group non-grandfathered plans**
- Rates may vary based on:
  - Individual or family coverage
  - Rating area (geographic regions)
  - Age, except that the rate shall not vary by more than 3 to 1 for adults
  - Tobacco use, except the rate shall not vary by more than 1.5 to 1

The Individual Mandate & the Exchange

- What happens if an individual cannot afford to buy coverage on the Exchange?
  - Individuals may apply for a premium tax credit

- Why do employers need to know how the premium tax credit works?
  - If an employee qualifies for the premium tax credit, it might result in the employer paying a penalty, **if** the employer has 50 or more full-time equivalent employees
  - Employees will look to HR to answer their questions

Premium Tax Credit

- **Premium Tax Credits**: Effective 1/1/14, tax credits available to individuals to purchase coverage through the American Health Benefit Exchanges
- Available to individuals & families with incomes between 100% and 400% of the FPL
- However, individual cannot receive premium tax credit if **eligible** for **employer coverage**, Medicare, **Medicaid**
  - In California, those who earn up to 138% of FPL may be eligible for Medicaid/Medi-Cal
- What if employee is eligible for employer coverage, but it is not "**affordable**" or does not provide "**minimum value**"—could the employee then be eligible for the premium tax credit? Yes.

Determining Minimum Value

- Coverage does not provide "**minimum value**" if allowed cost of benefits under plan is less than 60% of those costs; the actuarial value is a measurement of the total % of benefits available to the participant that are paid for by the plan

Determining Affordability

- Employer coverage is **not affordable** if employee portion of self-only premium for the employer's lowest-cost plan that provides "minimum value" exceeds 9.5% of "household income"

- How do I determine affordability if I do not know my employees' household income?
  - Determine affordability based on one of the three safe harbor methods

Determining Affordability

- Form W-2 safe harbor--use Box 1 wages
  - Determined after the end of the calendar year on an employee-by-employee basis
  - For 2014, look at 2014 Form W-2 (issued in January 2015)
- Rate of pay safe harbor
  - Take rate of pay for each eligible hourly employee, multiply that rate by 130 hours, and determine affordability
  - Allows employer to determine affordability prospectively
- Federal poverty line safe harbor
  - Disregard employees whose income qualifies them for Medicaid (cannot receive premium tax credit if earn below 100% of FPL)
  - Determine affordability using FPL for a single individual

Coverage Mandate: Employers

- **Automatic Enrollment**: Employers with **200** or more F/T employees must automatically enroll everyone; the employee may opt out; waiting period applies
  - Awaiting guidance before implementation

- **Coverage Mandate**: No specific coverage mandate for employers in health care reform law
  - But, penalties may be imposed if employers do not offer coverage or coverage is not affordable

Effective Date

- If you have a calendar year plan, January 1, 2014
- If you have a "fiscal year" plan, and you maintained that fiscal year plan as of December 27, 2012, the penalties will start to apply with respect to employees who would be eligible for coverage as of the first day of the first fiscal year of the plan that begins in 2014 (under the eligibility terms in effect 12/27/12)

Applicable Employer

- Pay or play penalties only apply to employers with **50** or more full-time equivalent employees
- Employer employs an average of at least 50 full-time employees on business days during the preceding calendar year
  - Who is a full-time employee? 30 hours per week
  - Do you include part-time employees? Full-time equivalent
    - Add all the hours worked per month by part-time employees and divide by 120
  - Do you include seasonal workers? Not always
    - Not counted if work less than 120 days in a year
- Aggregation rules apply

Employers Near 50: Transition Relief

- Transition relief for 2014:

- May determine status as large employer by using a period of at least 6 consecutive calendar months, chosen by you, during 2013, rather than the entire calendar year

Penalties: No Coverage Offered

- If the employer does not offer "minimum essential coverage" coverage to F/T employees (and their dependents)
  - Dependent is defined as a child, but not a spouse
- And at least 1 F/T employee who has enrolled in an Exchange receives health coverage assistance (premium tax credit or cost-sharing reduction)
- The employer will be assessed a penalty
  - Penalty is $2,000 per year ($166.67 per month) per F/T employee, but you do not count the first 30 F/T employees
- Example:
  - 200 F/T employees – 30 = 170 F/T employees
  - 170 x $2,000 = $340,000

Penalties: Offer Coverage

- Employer offers enrollment in "minimum essential coverage" to full-time employees (and their dependents)
  - A dependent is defined as a child, not a spouse
- But the value of coverage is less than 60% of costs, or coverage is unaffordable (so that the person qualifies for the tax credit or cost-sharing reduction), and at least one F/T employee has enrolled in an Exchange
- The employer will be penalized:
  - The **lesser of** $2,000 per F/T employee (less 30 F/T employees) **or** $3,000 per F/T employee receiving tax credit

What Will the Impact Be?

- Determine the amount of the potential penalty if you do or do not maintain coverage
- Determine what changes, if any, you will have to make to your plan, eligibility, or contribution levels to avoid a penalty
- Consider other factors that drive the decision to offer group health coverage:
  - Tax consequences
    - Business expense deduction
    - Payroll taxes
  - Salary increases/workers’ compensation
  - Being competitive
    - Are benefits standard in your industry
    - Will benefits help to retain and attract the best employees
  - Absenteeism and presenteeism

Who Is a Full-Time Employee?

- A person employed an average of 30 hours per week
- Regulations treat 130 hours of service as the monthly equivalent of 30 hours of service per week ((52 x 30) ÷ 12 = 130)
- Calculate on a monthly basis, not payroll period
- Hours of service include hours for which employee paid or entitled to be paid, including vacation, holiday, illness, disability, military duty, leave of absence, jury duty, or layoff

Who Is A Full-Time Employee?

- For employees not paid on an hourly basis, use one of 3 methods:
  - Calculate actual hours of service
  - Use a days-worked equivalency method (8 hours for each day worked)
  - Use a weeks-worked equivalency of 40 hours of service per week for each week for which the employee would be required to be credited with at least one hour of service
- May use different methods for different groups of employees
- Do not use a method that substantially understates an employee's hours

Who Is A Full-Time Employee?

- Optional look-back measurement period may be used for those with variable hours
- For an on-going employee, choose a look-back measurement period of between 3 and 12 months (the "standard measurement period")
  - If worked full-time during the standard measurement period, treat as full-time for the "standard stability period" (which is the greater of 6 months or the length of the standard measurement period)
- New employees expected to work full-time are treated as full-time
- If new employee is a variable hour employee, may use a look-back measurement period followed by a stability period

Action Plan: Step 1 for All Employers

- What is your **effective date** for the pay or play penalties?
  - Are you a calendar or fiscal year plan?

- Are you a **large employer**?
  - Do you have 50 or more full-time equivalent employees?

Step 2 for Small Employers

- If you are a **small employer**, you are not subject to the pay or play penalties; consider:
  - Will you offer coverage in 2014?
  - Will you purchase coverage on the Exchange or not?
  - Will you be able to meet insurer contribution and participation mandates?
  - As the new plan year approaches, consider coverage options, plan design changes, cost, contribution levels, and eligibility terms

Action Plan: Step 2 for Large Employers

- If you **do not** offer coverage to eligible F/T employees (and their dependents) in 2014
  - Calculate potential penalty
  - Assess fiscal and other impacts of decision not to offer coverage

Action Plan: Step 3 for Large Employers

- If you **will offer** coverage to eligible F/T employees (and their dependents)
  - Determine who qualifies as a F/T employee
  - Do you currently define eligibility as working more than 30 hours per week
    - Will you have to change hourly requirement for eligibility?
    - Expanding eligibility will mean higher premium contributions by employer (add to cost of offering coverage in 2014)
- Determine methodology for determining hours worked by variable hour employees
    - Establish look back and stability periods
    - Begin planning and establishing periods in **2013**

Action Plan: Step 4 for Large Employers

- Determine whether any F/T employees may qualify for the premium tax credit
  - Employees who qualify for Medicaid (up to 138% of the FPL in CA) will not be eligible for the premium tax credit
  - Employees in CA earning between 138% and 400% of the FPL may qualify, unless employer coverage is affordable and meets the minimum value threshold
    - Determine whether plan meets minimum value threshold
    - Establish methodology for determining whether coverage is affordable
    - Calculate whether, based on the amount they contribute, coverage will be unaffordable for some of your employees

Action Plan: Step 5 for Large Employers

- Calculate potential penalty if employees qualify for premium tax credit
  - Assess fiscal and other impacts of a potential penalty
- Determine what changes to plan may have to be made to avoid penalties:
  - Changing definition of eligibility (defining F/T as 30 hours a week, expanding categories of employees who are eligible)
  - Increasing the employer contribution
  - Changing contributions for dependent coverage (grandfather rules)
  - Changing plan design (remember grandfather rules)
  - Assess fiscal impact of any resulting costs
- Plan for plan design changes that will take effect in 2014 (including limit on waiting periods)
- Add to cost of coverage any penalties or fees (such as reinsurance fee)

Plan Design Changes in 2014

- **Waiting Periods**: For plan years on or after 1/1/14, plans cannot have waiting periods over **90 days** (applies to grandfathered & non-grandfathered plans)

- **Guarantee Issue and Guarantee Renewal**: For plan years on or after 1/1/14,
  - Insurers must accept every small employer or individual who applies for coverage (guarantee issue)
  - Insurers must renew all plans (large or small) if the employer or individual wants to renew (rates can go up)
  - Applies if plan loses grandfather status
  - Insurer may impose employer contribution and minimum participation requirements

Plan Design Changes in 2014

- **Cost-Sharing Limits**: For plan years on or after 1/1/14, annual cost-sharing limits will be imposed on plans and issuers (applies to small plans if lose grandfather status):

- Overall out-of-pocket maximum (deductibles, copayments) cannot exceed HSA compatible HDHP limits; for 2010:
  - $5,950 self-only
  - $11,900 family

- In addition, deductibles cannot exceed:
  - $2,000 self-only
  - $4,000 family

Plan Design Changes in 2014

- **Annual Limits**: No annual limits on "essential health benefits" – to be defined by states (including grandfathered plans)

- **Pre-Existing Conditions:** No pre-existing condition exclusions for all participants (including grandfathered plans)

Plan Design Changes for 2014

- **Wellness Programs** that offer a reward:
- The amount of the reward employers may offer those who participate in a wellness program will increase from 20% to 30% of the cost of coverage
  - 50% for programs to prevent or reduce tobacco use
- Must promote health or disease prevention
- Participants must be able to qualify for reward once a year
- Available to all
- Must provide a reasonable alternative standard (& provide notice)
- Does not apply to grandfathered individual health insurance coverage

- Non-discrimination rules for fully insured plans
- Automatic enrollment
- Additional reporting & disclosure requirements
- The Exchanges (proposed regulations issued) & other 2014 design changes

Break Time for Nursing Mothers

- Employers are required to provide
  - Reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth
  - A place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk
- Fact Sheet #73: Break Time for Nursing Mothers under the FLSA: http://www.dol.gov/whd/regs/compliance/whdfs73.htm

Whistleblower Protection

- An employer may not discharge or in any manner retaliate against an employee because he or she:
  - Provided information relating to a violation of PPACA
  - Assisted n a proceeding concerning a violation of PPACA
  - Objected or refused to participate in an activity he or she reasonably believed to be in violation of PPACA
  - Received a premium tax credit or a cost sharing reduction
- Complaints must be filed within 180 days of a violation
- Violations could result in reinstatement, back pay, restore benefits, and other possible relief
- In 2014, the whistleblower provisions will extend to insurers

Compliance Action Plan

- Broker's role
- On-going compliance obligations
- Preparing for plan design changes
- Preparing for cost changes
- Preparing for pay-or-play penalties
- Preparing for open enrollment and communicating changes and information to employees

Resources

- Department of Labor PPACA Resource Page (links to FAQs, regulations, and guidance):

http://www.dol.gov/ebsa/healthreform/

- The Center for Consumer Information and Insurance Oversight (within CMS): http://cciio.cms.gov/
- IRS: Affordable Care Act Tax Provisions:

http://www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6

- Consumer Information on PPACA: www.healthcare.gov
- California Exchange: www.healthexchange.ca.gov; www.coveredca.com