HEALTH CARE REFORM NEWS

...From the Employer Perspective
September 29, 2014

Affordable Care Act Checklist for Employers—Countdown to 2015

Are you ready for 2015? For employers with 100 or more full-time (FT) or full-time equivalent (FTE) employees, 2015 is a big year – it marks the implementation of the much anticipated, and perhaps angst-inducing, Affordable Care Act (ACA) Employer Shared Responsibility requirement ("the employer mandate"). The employer mandate has been the focus of strategic planning efforts of many employers for some time now and those that will be affected in 2015 are undoubtedly working to finalize their plans for addressing the mandate's requirements.

In addition to the employer mandate, there are a number of other ACA-related items employers should be thinking about in preparation for 2015. To assist employers with ensuring all their near-term ACA responsibilities are met, we have compiled the following checklist of ACA items that may impact employers between now and the end of 2015. In addition, following the checklist we've highlighted a number of lesser-known or often misunderstood details about certain ACA requirements – fine print, so to speak.

PROVISION	EFFECTIVE DATE	REQUIREMENT
Notice of Coverage Options	As soon as possible	Within 14 days following hire date, employers must provide to new employees a written notice regarding the health insurance Marketplace created by the ACA. While the Department of Labor (DOL) has not issued new template notices, certain information in the existing DOL templates is now outdated. Therefore, employers should update their notices to reflect that: • The next Marketplace open enrollment will be 11/15/14 – 2/15/15 for coverage starting as early as 1/1/15; and • The Marketplace subsidy eligibility affordability threshold for the cost of single coverage offered by the employer will increase from 9.5% of household income in 2014 to 9.56% in 2015.
Preventive Care	***Plan years beginning on or after 9/24/14***	***As a result of a new U.S. Preventive Services Task Force "Grade B" recommendation, non-grandfathered health plans must cover, with no cost-sharing, breast cancer risk-reducing medications such as tamoxifen or raloxifene when prescribed to women who are at increased risk for breast cancer and at low***

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		risk for adverse medication side effects (subject to reasonable medical management).
Minimum Loss Ratio (MLR) Rebates	Within 90 days of receipt (approx. late Oct.)	Unless held in a trust, ERISA health plan sponsors must distribute any portion of a MLR rebate that is a plan asset within 90 days of receiving the rebate (insurers are required to issue any required rebates by 8/1 each year.) In general, ERISA plan sponsors may apply rebates that are plan assets toward refunds, premium holidays or plan enhancements for plan participants.
Health Plan Identifier (HPID)	11/5/14	Group health plans that meet the definition of a large controlling health plan are required to obtain a HPID no later than 11/5/14. This requirement is delayed until 11/5/15 for small health plans ($5 million or less in annual receipts). **There are outstanding concerns regarding the HPID application process, specifically for self-insured health plans. Because of these concerns, a self-insured health plan sponsor may want to wait until closer to their deadline to apply for their HPID to see if additional CMS guidance is provided that will** streamline the application process.
Transitional Reinsurance Program Fee	11/15/14	Health plans must pay fees to a transitional reinsurance program created by the ACA for the first three years of health insurance Marketplace operation (2014-2016), which will be used to help stabilize premiums for coverage in the individual market. For 2014, the fee is $63 per covered life per year. Self-insured health plan sponsors must file calendar year 2014 enrollment data electronically using Pay.gov by 11/15/14. Payment for 2014 may be made in one installment (1/15/15) or two installments (1/1/15 and 11/15/15), but these ACH payments must be scheduled in advance no later than 11/15/14. Insurers are responsible for paying the fees for insured health plans.
Health Flexible Spending Account (FSA) Amendment	12/31/14	Under the ACA, the maximum annual contribution limit permissible under a health FSA for plan years on or after 1/1/13 is $2,500. Plan sponsors have until 12/31/14 to amend plan documents to reflect this limit. At the option of the plan sponsor, plans can also be amended to provide for a rollover of up to $500 in unused FSA contributions to subsequent plan years. Plans that allow a rollover may not have a grace period feature. If selected, plan sponsors must also amend plan documents to reflect the rollover option.
Out-of-Pocket (OOP) Cost-sharing Limits	Plan years beginning on or after 1/1/15	Non-grandfathered health plans must limit total participant in-network OOP cost-sharing for essential health benefits (EHB) to $6,600 for self-only coverage and $13,200 for other than self-only coverage (increased from $6,350/$12,700 in 2014 plan year). Plans may structure a benefit design using separate OOP limits for different benefits; however, unlike under the 2014 transition relief, all EHB must have an OOP limit (even if administered by a separate vendor) and the total of the separate OOP limits *combined* cannot exceed the ACA limit. For example, a plan could have an integrated OOP limit of $6,600/$13,200 for all EHB (regardless of whether provided by one or multiple vendors) or a plan could have a medical limit of $5,000/$10,000 and a separate Rx limit of $1,600/$3,200 (or some other combination of OOP limits totaling $6,600/$13,200 or

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		less).
Employer Shared Responsibility ("Employer Mandate")	1/1/15	In general, an Applicable Large Employer (ALE) will be assessed penalties if Minimum Essential Coverage is not offered to substantially all (70% for 2015) of its FT employees (avg. 30+ hrs/wk) and their children and at least 1 FT employee receives a Marketplace subsidy. ALEs that meet the minimum threshold for percentage of FT employees offered coverage can still be assessed penalties if 1 or more FT employee receives a Marketplace subsidy because the employer coverage is not offered to that employee or does not meet ACA minimum value and/or affordability standards. In preparation, it is recommended that employers do the following prior to 1/1/15: • Determine whether employer is an ALE (100+ FT/FTE employees (50+ after 2015)) • If employer has a non-calendar year health plan, determine if employer is eligible for temporary transition relief in 2015 • Adopt a monthly measurement or look-back measurement method to determine status of PT, variable, temporary and seasonal employees who might qualify as FT under ACA • Test health plan designs and employee single-tier contributions to determine whether any meet ACA affordability and minimum value standards • Determine whether to modify eligibility rules, plan designs and/or contributions to ensure compliance with mandate requirements and avoid potential penalties
Waiting Periods	Final regulations apply for plan years beginning on or after 1/1/15	In general, a health plan may not impose a coverage waiting period that exceeds 90 days from the date an employee is otherwise eligible for coverage (has met the plan's substantive eligibility conditions). A plan's substantive eligibility conditions may include completion of a bona fide employment-based orientation period of up to 1 month (but it cannot be a subterfuge for avoiding compliance with the 90-day limit). All calendar days count toward the 90-day limit, including weekends and holidays. If a health plan conditions eligibility on regularly working a specific number of hours per pay period and it cannot be determined whether a newly hired employee is reasonably expected to regularly work that number of hours, the plan may take a reasonable period of time to make that determination (no longer than the last day of the month that begins on or after the employee's 1-year anniversary).
W-2 Reporting	1/31/15	Employers that filed 250 or more W-2s for calendar year 2013 are required to report the aggregate cost of employer-sponsored group health plan coverage on employee W-2s for calendar year 2014. Employers that were not required to file in the past because they were below the 250 form threshold should confirm whether they were still below the threshold in 2013.
Patient-Centered Outcomes	7/31/15 for plan year ending in	Health plans must pay a fee to finance a research program established by the ACA to determine the best medical treatments for certain chronic illnesses. The fees apply for each plan year ending between 10/1/12 and 9/30/19. (For calendar year plans,

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Research Institute (PCORI) Fee	2014	applicable for 2012 through 2018 plan years.) The fee is $1 per covered life per year for the first year, $2 for the second year, and will be indexed for inflation in the remaining years. Self-insured health plan sponsors must pay the fee by July 31st of the year following the last day of the plan year for which the fee is being paid by filing IRS Form 720. (Insurers are responsible for paying the fees for insured health plans.)
Annual Employer Reporting	1/31/16	To enable the IRS to determine whether ALEs are in compliance with the employer mandate and whether individuals are eligible for Marketplace premium tax credits, ALEs are required to submit Section 6056 reporting containing information about the health care coverage they offered FT employees. To enable the IRS to determine whether individuals are in compliance with the individual mandate, health insurers, self-insured health plan sponsors, and others that provide minimum essential coverage (MEC) are required to submit Section 6055 reporting containing information about individuals who were covered and when they were covered. Reporting is first due in early 2016 for the 2015 calendar year, but employers will need to begin tracking the necessary data in 2015. Employers should review the draft reporting forms and instructions and begin formulating plans for data collection.
Grandfathered Status	Every plan year	A sponsor of a grandfathered health plan should review the plan's status annually and confirm that any changes made to the plan design or premium contribution structure continue to conform to grandfathering requirements.
Wellness Incentives	Every plan year beginning on or after 1/1/14	Employee rewards under a health-contingent wellness program (one that requires individuals to satisfy a standard related to a health factor) may not exceed 30% of the cost of individual coverage if the program is not related to tobacco use or 50% if the program includes tobacco-related component. For incentives that include dependents, the total reward for family members combined cannot exceed the applicable percentage (30% or 50%) of the cost of the coverage tier in which the employee and dependents are enrolled. A reward is defined as either obtaining a financial gain or avoiding a financial penalty. Employers should keep these limits in mind when developing and revising annual wellness incentive strategies and meeting employer mandate affordability requirements.

AS THEY SAY, SOMETIMES THE DEVIL IS IN THE DETAILS – DON'T MISS THE FINE PRINT!

OOP Cost-Sharing Limits – ACA vs. High Deductible Health Plans (HDHPs)

Long before the ACA, the IRS instituted plan design requirements for HDHPs paired with Health Savings Accounts, which include a maximum limit on annual OOP spending for all covered in-network services. In 2014 the ACA implemented a restriction on all non-grandfathered health plans that caps participant OOP limits for all covered in-network EHB. In that first year the ACA

maximum OOP limit for non-grandfathered health plans and the IRS maximum OOP limit for HDHPs were the same – $6,350 for single and $12,700 for other than single coverage. One might think it logical that the ACA OOP limits and the IRS HDHP OOP limits would continue to mirror one another in the future. Well, that would be logical…but it's not the case.

The ACA calls for the ACA OOP limits to be adjusted each year by the percentage increase in the average U.S. per capita health insurance premium. The IRS limits for HDHPs are adjusted annually based on changes in the Consumer Price Index (CPI). So, while the 2015 plan year ACA OOP limits will be $6,600/$13,200, 2015 HDHP OOP limits will be $6,450/$12,900. Because health insurance premiums generally increase more rapidly than CPI, the gap between these limits is likely to grow in future years. Plan sponsors whose offerings include a HDHP should keep these differences in mind when devising plan designs for 2015 and beyond.

Affordability – Individual Subsidy Eligibility vs. Employer Mandate Safe Harbors

It's been widely reported that the IRS recently increased the percentage of income threshold for determining whether contributions for employer-sponsored health coverage are affordable from 9.5% to 9.56%. Well, this is true…if one is speaking of the threshold for determining whether an individual is eligible for a Marketplace premium tax credit. The threshold under safe harbors for determining whether an employer might be subject to a penalty for not offering affordable coverage, however, remains 9.5%.

The ACA statute provides that in 2014, for the purpose of determining whether an individual is eligible for a Marketplace premium tax credit, an employer offer of coverage is unaffordable if the employee's required contribution for self-only coverage exceeds 9.5% of the employee's *household income*. The statute also provides that the percentage will be indexed in years after 2014.

The employer affordability safe harbors came along later, in regulatory guidance issued by the IRS after employers expressed concern about their inability to assess affordability of coverage because employees' household incomes are unknown to an employer. So the IRS regulations introduced three affordability safe harbors – Form W-2, Rate of Pay, and Federal Poverty Line – for the purpose of determining whether an employer could be assessed a penalty for a particular employee due to unaffordable coverage, which are based on *individual income*. The calculations outlined for each of these safe harbors also use an affordability threshold of 9.5%; however, these regulations do not include a provision for annual indexing nor do they cross-reference the percentage in the ACA statute. So, until such time the IRS issues updated guidance on this matter, employer safe harbor thresholds remain 9.5%.

Affordability – Wellness Incentives vs. No Wellness Incentives

For employers whose wellness program strategies include employee contribution incentives, initial regulatory guidance on affordability and the employer mandate left them wondering whether affordability calculations would be based on employee cost with the incentive or without. Given that wellness program regulations ensure everyone eligible for an incentive has a reasonable

opportunity to obtain it if they so choose (not to mention that a goal of the ACA is to encourage employer-based wellness programs), many people expected the affordability equation would take into account the lower cost after incentive. Well, it does and it doesn't…it depends on the program.

Subsequent guidance clarified that affordability of an employer-sponsored plan will be determined by assuming that each employee would fail to satisfy the requirements for earning a wellness program contribution incentive, except if the wellness program is related to tobacco use. In other words, only tobacco-related incentives can be factored into the employee cost used for the affordability calculation.

Dependents to Age 26 – Coverage Until Birth Date vs. End Of That Month

Under the "Patient Bill of Rights" provisions of the ACA, as of plan years that began on or after 9/23/10, health plans had to extend eligibility for a member's child at least until the child's 26th birthday (but did not have to cover through the end of that month). Curiously, while the final regulations for the employer mandate also define a dependent as "a child of an employee who has not attained age 26", those regulations go on to say, for the purposes of the employer mandate, a child is treated as a dependent for the entire calendar month during which he or she attains age 26.

So must health plans currently ending coverage as of the 26th birthday change their practice in 2015? Well, not necessarily...only if you *need* to. The employer mandate regulations do not require that a health plan cover children age 26 until the end of the month; the regulations simply mean an employer could potentially be liable for a penalty if it doesn't. In reality though, the risk of that alone triggering a penalty would be minimal in most cases.

Under "Part A" of the mandate, in any calendar month, if an employer does not offer MEC for the entire month to at least 95% (70% in 2015) of that month's FT employees and their dependents and at least one FT employee receives a Marketplace subsidy, the employer will be assessed 1/12 of the annual Part A penalty. So, if the plan does not offer coverage for the whole month to a child who turns 26, the employer is considered to have not offered MEC to that employee and his or her dependents that month. But given the small volume of dependents that might turn 26 in a given month, this would only be a concern for an employer that is within a very narrow margin of the required percentage.

Under "Part B" of the mandate, a penalty can only be triggered if an employee receives a Marketplace subsidy. If a dependent age 26 were to lose coverage on his or her birthday and obtain subsidized Marketplace coverage for the remainder of that month, it would not trigger a penalty for the employer because the dependent is receiving the subsidy, not the employee. Employers should consider their facts and circumstances and determine whether they need/want to offer coverage through the end of the month that a dependent reaches age 26.

Annual Employer Reporting – Entire Month vs. Any Day That Month

The IRS recently released draft forms for required annual ACA reporting and draft instructions for completing those forms. As employers begin sifting through the details, it's important to keep in mind that little words can have big meaning. Take for example, the words 'for' and 'in' – as in 'for the month' or 'in the month'. Is there a difference? Well, yes…in the context of ACA reporting there's a big difference.

IRS Form 1095-C will be used by ALEs to report information about coverage offered to FT employees and, if the ALE is also a self-insured health plan sponsor, information about individuals enrolled in the self-insured health plan. Section II of the form has a column for each month of the year where, among other things, ALEs are required to provide codes to describe the coverage offered to the employee and dependents each month. Section III of the form also has a column for each month of the year where self-insured plan sponsors must check boxes to indicate which months an employee and any covered dependents had coverage under the self-insured health plan.

To the IRS' credit, the instructions for Section III are obvious – check the box for each month in which the individual was enrolled in the self-funded health plan *for at least one day* 'in that month'. The instructions for Section II, however, are less than clear – 'for each calendar month', enter the code identifying the type of coverage offered to the employee. Those who are diligent and read the 14 pages of instructions attentively from cover-to-cover will find tucked away in the definition section a very important detail regarding Section II, which is the fact that an employer is only considered to have offered coverage 'for a month' if the offer would have provided coverage *for every day of that month* (subject to continued employment). It is important that employers keep this difference in mind when devising plans for capturing and compiling the data needed to comply with the various elements of the annual ACA reporting.

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Your Trion Strategic Account Managers are here to answer any questions you might have as you prepare to comply with upcoming ACA requirements. If you are not currently a Trion client and would like assistance navigating the changes required by health care reform, please contact us today by emailing trionsales@trion-mma.com.

PPACA REGULATIONS & GUIDANCE ISSUED IN THE LAST 3 MONTHS

Jul. 2014: ACA FAQs Part XX – Preventive Services Disclosure Regarding Contraceptives
Jul. 2014: IRS Issues Draft Forms for Employer Reporting (1094-B, 1095-B, 1094-C & 1095-C)
Aug. 2014: IRS Issues Instructions for Employer Reporting Forms 1094-B & 1095-B and 1094-C & 1095-C
Sep. 2014: IRS Issues Notice 2014-49 Guidance on Employer Shared Responsibility Look-Back Method Changes in Measurement Period
Sep. 2014: IRS Issues Notice 2014-55 Guidance on Additional Permitted Cafeteria Plan Election Changes
Sep. 2014: IRS Issues Notice 2014-56 Guidance on Adjusted 2014 PCORI Fee

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