PRESENTATION

# Health Care Reform Compliance: An Employer Perspective

L& E Breakfast Briefing

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EXPAND YOUR EXPECTATIONS℠

# Select ACA Provisions Affecting Employers

| 2011 Plan Year | 2011 | 2012 | 2013 | 2014 | 2018 |
|---|---|---|---|---|---|
| Lifetime dollar limits on Essential Health Benefits (EHB) prohibited* | OTC medicines not reimbursable under Health FSAs, HSAs, or HRAs without prescriptions, except insulin | Employer distribution of SBCs to participants* | Notice to inform employees of coverage options on health exchanges (DELAYED) | Individual mandate to purchase insurance or pay penalty | Excise tax on high-cost coverage |
| Preexisting condition exclusions prohibited for children under 19* | HSA Excise Tax increase | Medical Loss Ratio rebates (insured plans only)* | Limit of health Care FSA contributions to $2500 (indexed) | State Insurance exchanges | |
| Limits on annual dollar limits on EHB* | | Employer reporting of health coverage on Form W-2 (due 1/31/13) (only for employers with ≥ 250 W-2s) | Medicare tax on high income (employers begin withholding on wages over $200,000) | Transitional reinsurance contributions (approx.. $63 per participant) | |
| Extension of adult child coverage to age 26* | | | Addition of women's preventive health requirements to no cost sharing and coverage for certain in-network preventive health services** | Preexisting condition exclusions prohibited* | |
| Enhanced appeals procedures** | | | | | |
| No cost sharing and coverage for certain in-network preventive health services** | | | | Annual dollar limits on EHB prohibited* | |
| Nondiscrimination rules on fully-insured health plans** (DELAYED) | | | | Limit of 90-day waiting period for coverage | |
| | *Denotes changes applicable to all group health plans<br>** Denotes changes NOT applicable to grandfathered health plans<br>***This requirement applies to "full time employees"(discussed below) Delayed to 2015 for employers with ≥ 100 FTEs; to 2016 for employers with ≥ 50 to 100 FTEs | | | Increased cap on rewards for participation in wellness program** | |
| | | | | Limits on deductibles and out-of-pocket maximums** | |
| | | | | Employer responsibility to provide affordable minimum essential health coverage**** | |

# ACA– Requirements That Are Currently Effective

Beginning for 2014 Plan Year:

- Preexisting condition exclusions prohibited for all participants.
- Annual dollar limits on “essential health benefits” prohibited. (Lifetime limits were prohibited beginning in 2011).
- Limit of 90-day waiting period for coverage – coverage must start on 91st day.
- Increased cap on rewards for participation in wellness program.

# ACA– Requirements That Are Currently Effective

- Limits on deductibles and out-of-pocket maximums (not applicable to grandfathered plans)
  - Deductible limits apply to small group plans (2-50 FTEs) of $2000/$4000.
  - 2014 plan year: out-of-pocket max is same as for HDHP. The HDHP maximums are $6,350 for single coverage and $12,700 for family coverage. Indexed for 2015+.
  - All cost sharing (deductible, coinsurance and copayments) must apply to Out-of-Pocket maximum amount.
  - Applies only to In-Network services.
  - All services must count to OOP max, including medical, prescription drug, mental health and substance abuse services. But have transition rule for plans using multiple claims payers for services such as Rx services. Have until 2015 to design a single Out-of-Pocket maximum and coordinate vendor arrangements.

# ACA– Requirements That Are Currently Effective

- Reporting of aggregate cost of health coverage on W-2s for calendar year 2012.
- For insured plans, proper handling of any medical loss ratio rebates for 2011 (to be distributed by insurers by August 1, 2012).
- Coverage of employees' adult children up to age 26 (for plans that allow coverage of dependents).
- First-dollar coverage of preventive care services (grandfathered plans excepted).

# ACA Requirements That Are Currently Effective

- Patient protection provisions (e.g., choice of primary care provider, coverage of out-of-network emergency services) (grandfathered plans excepted).

- Prohibition on health FSA reimbursements for over-the-counter drugs and medicines without a prescription, except insulin.

- Enhanced requirements for claims and appeals, including the addition of external review, the treatment of eligibility decisions as subject to claims and appeals and external review in many instances, and inclusion of notices of availability of non-English language services and documents depending on the county to which the claim or appeal information is sent (grandfathered plans excepted).

# Transitional Reinsurance Program

- The Transitional Reinsurance Program provides for fees to be levied on employers and insurers that will be used to stabilize premiums in the individual market. The fee will be collected for 2014, 2015 and 2016.
- The program is funded through fees to be paid by employers (for self-insured plans administered by a TPA) and insurers (for insured plans).
- The fees for 2014 will be $5.25 a month(or $63 for the year) for each individual covered under a health care plan.
- The fee may be paid from plan assets.

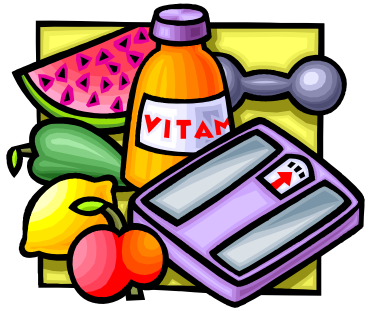
# Transitional Reinsurance Program

- Fees are due in the year following the benefit year. HHS proposes to allow payment in two installments: the first for reinsurance payments and administrative expenses, and the second for the U.S. Treasury.

- For example, of the $63 per capita contribution rate for the 2014 benefit year, $52.50 will be allocated to reinsurance payments and administrative expenses, and $10.50 to the U.S. Treasury. The enrollment count is due from the employer by November 15, 2014, and HHS will invoice in December 2014. The first 2014 installment will be due in January 2015. HHS will invoice another fee payment of $10.50 per covered life in the fourth quarter of 2015, which will be due roughly 30 days later.

# Wellness Programs – New Nondiscrimination Rules

- ACA increased maximum permissible reward under a health-contingent wellness program from 20% to 30% of the cost of health coverage, and that further increase the maximum reward to as much as 50% for programs designed to prevent or reduce tobacco use;
- New regulations set forth revised nondiscrimination rules that turn on whether program is "Participatory" or "Health Contingent"
- If "Participatory" only, exempt from HIPAA bona fide wellness program rules
- If "Health Contingent", then subject to HIPAA wellness rules, based on whether "activity-based" or "outcome-based"



# Participatory Wellness Programs

PARTICIPATORY WELLNESS PROGRAMS

Reward Is Not Based on Individual Satisfying Standard Related to a Health Factor

Not Required to Meet 5 Requirements of HIPAA Wellness Rules

Examples:

- Reimburse fitness center membership cost
- Reward to participate in diagnostic testing, not based on outcomes
- Deductible or copayment waiver to encourage preventive care, such as prenatal care or well-baby visits
- Reward or reimbursement for smoking cessation program, regardless of whether employee quits smoking
- Reward for attending monthly, no-cost health education seminar
- Reward to complete health risk assessment without further action required by employee (educational or otherwise) with regard to identified health issues

# Health-Contingent Wellness Program

| HEALTH-CONTINGENT WELLNESS PROGRAMS<br><br>Individual is Require to Satisfy a Standard Related to a Health Factor to Obtain Reward<br><br>The Programs Must Meet All FIVE Requirements of HIPAA Wellness Rules | |
|---|---|
| **NEW! Activity-Based** | **NEW! Outcome-Based** |
| Requires individual to perform or complete an activity related to health factor to obtain reward, but does not require individual to attain or maintain specific health outcome.<br><br>Examples<br><br>Walking, diet, or exercise programs where some individuals may be unable to or have difficulty participating or completing due to a health factor, such as asthma, pregnancy, or recent surgery<br><br>  | Requires individual to attain or maintain specific health outcome in order to obtain reward.<br><br>Examples:<br><br>• Reward for not smoking<br><br>• Reward for attaining certain results on biometric screening<br><br>• Biometric screening that tests for risk factors (e.g., high cholesterol, high glucose level) and provides reward to individuals within healthy range, while requiring individuals outside health range or at risk to take additional steps to obtain same reward, such as to meet with health coach |

# Wellness Rule #1: Annual Qualification

| HEALTH-CONTINGENT WELLNESS PROGRAMS | |
|---|---|
| **Activity-Based** | **Outcome-Based** |
| Must give individuals opportunity to qualify | Same |

# Wellness Rules #2: Limit on Amount of Award

| HEALTH-CONTINGENT WELLNESS PROGRAMS | |
|---|---|
| **Activity-Based** | **Outcome-Based** |
| NEW! Non-Tobacco Programs (e.g., BMI, cholesterol) — Limit is up to 30% of cost of coverage<br><br>NEW! Tobacco Programs — Limit is up to 50% of cost of coverage<br><br>NEW! Limit on total reward is 50% of cost of coverage<br><br>• 30% reward for BMI + 20% for tobacco use — Meets Limit<br><br>• 10% reward for BMI + 40% for tobacco use — Meets Limit<br><br>• 0% for BMI + 50% for tobacco use — Meets Limit<br><br>• 30% for BMI + 50% for tobacco use — Not Allowed (only allowed up to 50% total when include tobacco) | Same<br><br>  |

# Wellness Rule #3: Reasonable Design

| HEALTH-CONTINGENT WELLNESS PROGRAMS | |
|---|---|
| **Activity-Based** | **Outcome-Based** |
| • Must be reasonably designed to promote health or prevent disease<br>• Program will satisfy standard if has reasonable chance of improving health or preventing disease, is not overly burdensome, is not a subterfuge for discrimination based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease<br>• Based on all relevant facts and circumstances | Same (but additional rules related to Reasonable Alternative below) |

# Wellness Rule #4: Reasonable Alternative

- Activity-Based programs must follow the "Medical Reasonable Alternative."
- Outcome-Based programs must follow the "Reasonable Alternative for All."

| HEALTH-CONTINGENT WELLNESS PROGRAMS | |
|---|---|
| Activity-Based | Outcome-Based |
| Medical Reasonable Alternative Only<br>Must provide alternative for individuals for whom it is unreasonably difficult due to a medical condition to satisfy standard or medically inadvisable to attempt to satisfy standard | NEW! Reasonable Alternative Required for all<br>• Must provide alternative for any individual" who does not meet the initial standard based on a measurement, test, or screening that is related to a health factor<br>• Alternative required regardless of medical Condition |

# Wellness Rule #4: Reasonable Alternative Guidelines

Not required to determine alternative in advance, may determine upon request by individual. May decide to waive medical standard altogether (rather than determine alternative).

Based on all facts and circumstances, with following guidelines:

- If alternative is completion of educational program, plan must make program available or assist employee in finding program (instead of requiring individual to find program unassisted). Plan may not require employee to pay for cost of program.
- If time commitment required, must be reasonable (example: requiring nightly attendance at one-hour class would be unreasonable).
- If alternative is diet program, plan must pay any membership or participation fee (not required to pay for food).
- If individual's personal physician says plan standard is not medically appropriate for individual, plan must provide alternative that accommodates recommendations of personal physician.
- Plan may impose cost sharing for medical items or services furnished pursuant to physician's recommendation.

# Wellness Rule #4: Reasonable Alternative – Doctor's Notes

| | HEALTH-CONTINGENT WELLNESS PROGRAMS | |
|---|---|---|
| | **Activity-Based** | **Outcome-Based** |
| Doctor's Note Allowed? | Yes — if reasonable under circumstances, plan may seek verification from individual's personal physician that health factor makes it unreasonably difficult or medically inadvisable to satisfy Activity-Based wellness program.<br><br>Reasonable under circumstances if medical judgment required to evaluate validity of request for alternative. | No — since alternative for Outcome-Based standards must be provided to all who fail test (regardless of health reason).<br><br>But if alternative is Activity-Based, go back to Activity-Based column, where doctor's note may be allowed. |

# Wellness Rule #4: Reasonable Alternative, If Alternative is Activity-Based or Outcome-Based

| Health Contingent Wellness Program | |
|---|---|
| **Activity-Based** | Outcome-Based |
| • **If alternative is a second Activity-Based standard, must start at top of Activity-Based column and may need to offer another alternative due to medical reasons.**<br><br>**Example: If Activity-Based standard is to run 3 miles, and individual has medical reason cannot run, may set alternative as Activity-Based standard of walking twice a week. If individual also cannot walk due to medical reasons, would need third alternative.**<br><br>• **If alternative is Outcome-Based, run through analysis in Outcome-Based column to determine whether additional alternative needed.** | • If alternative is Activity-Based, run through analysis in Activity-Based column to determine whether additional alternative needed.<br><br>• If alternative is second Outcome-Based standard, must start at top of Outcome-Based column and may need to offer another alternative, plus two special rules below.<br><br>Special Rules if Alternative is Also Outcome-Based:<br><br>• If alternative is to meet different level of same standard, must give additional time to comply.<br><br>Example: If standard is BMI, and alternative is BMI that is easier to reach, must give realistic time to reach, such as within year. Individual then earns same reward as if met initial standard (so plan may need to pay reward retroactively).<br><br>• Must allow individual to request that alternative will be to comply with recommendations of personal physician (if personal physician "joins in"). Individual can make request at any time, and personal physician can adjust recommendations at any time, consistent with medical appropriateness. |

# Wellness Rule #5: Notice of Reasonable Alternative

| HEALTH-CONTINGENT WELLNESS PROGRAMS | |
|---|---|
| **Activity-Based** | **Outcome-Based** |
| • Must disclose in all plan materials describing wellness program the availability of reasonable alternative to earn reward or waiver of standard<br>• Must include contact information and statement that recommendations of individual's personal physician will be accommodated<br>• Updated sample language | Same<br><br>Also must include in any disclosure to individual that he or she did not satisfy Outcome-Based standard (such as in screening results) |

# Ninety Day Maximum Waiting Period For Coverage

- For plan years beginning on or after January 1, 2014, a group health plan or health insurance issuer offering group health insurance coverage is barred from applying any waiting period that exceeds 90 days.
- Coverage must be effective by 91st day and if that falls on weekend or holiday, then coverage must be effective before 91st day.
- A waiting period is defined as “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.”
- For newly-hired employees, a plan may take a reasonable period of time to determine whether the employee meets the plan’s eligibility condition, including a measurement period.
- The measurement period can be no later than 13 months from the employee’s start date (or, if the employee’s start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month).

# Restrictions on HRAs and Minimum Essential Benefits

Stand-alone HRAs will likely violate ACA requirements such as minimum essential benefits, preventive coverage and dollar limits. Thus, HRAs will need to be integrated with group health plans to comply with ACA. To satisfy ACA:

- The employer offers a group health plan that provides minimum value;
- The employee receiving the HRA is actually enrolled in the group health plan providing minimum value (regardless of whether the employer sponsors the plan); and
- The HRA is available only to employees who are actually enrolled in the non-HRA minimum value group coverage

# Minimum Essential Coverage – Reporting Obligation

Beginning for the 2015 plan year, employers that sponsor self-insured health plans that provide “minimum essential coverage” will have to comply with reporting obligation under IRC § 6055. On Form 1095-B, employers must report:

1. Name of each individual enrolled;
2. Name and address of the primary insured or responsible individual who submits the application for coverage (such as a parent or spouse);
3. Taxpayer Identification Number for each covered individual;
4. Months of coverage for each covered individual;
5. Name, address and Employer Identification Number of the employer maintaining the plan; and
6. Whether coverage was enrolled through the Small Business Health Insurance Options Program (or "SHOP").

The form is due 3/31/16 if file electronically.

# Large Employer – Reporting Obligation

Employers with 50 or more "FTEs" will have to comply with reporting obligation under IRC § 6056. On Forms 1094-C and 1095-C (or a substitute form if certain requirements are met), employers must report:

1. Name, address and EIN of the employer;
2. Certification as to whether the employer offers its FTEs and their dependents the opportunity to enroll in minimum essential coverage under the employer's plan;
3. The number of FTEs for each month during the calendar year;
4. For each FTE, the months during the calendar year for which coverage under the plan was available;
5. For each FTE, the employee's share of the lowest cost monthly premium (self-only) for coverage, providing minimum value offered to that FTE under the employer's plan. This information must be provided for each calendar month; and
6. Name, address, and Taxpayer Identification Number of each FTE during the calendar year and the months, if any, during which that employee was covered under an eligible employer-sponsored plan.

# Employer Shared Responsibility Payment (Commonly Called “Pay or Play” Penalty Tax)

- For plan years beginning on or after January 1, 2015, employers with 100 or more employees are required to provide health insurance or pay penalty tax (1/1/16 for smaller employers):
  - If employer **doesn't offer health coverage** and at least one low income FTE enrolls in health coverage on an exchange and obtains a premium credit, employer must pay an annual penalty of $2,000 multiplied by all FTEs, disregarding the first 30
    - The penalty is payable on a monthly, pro-rata basis
  - If employer **does offer health coverage** but it is not "affordable" or is not of "minimum value" and a low income full-time employee enrolls in health coverage on the exchange and obtains a premium credit, employer must pay an annual penalty of $3,000 for each exchange enrolled FTE (Penalty capped at $2,000 multiplied by all FTEs, disregarding the first 30)

# Shared Responsibility – 50 Employee Requirement

- Count all employees regularly scheduled to work 30 or more hours per week as FTE
- Count part-time employees as partial FTE:

$$\frac{\text{actual hours worked per month}}{120}$$

- The sum of all FTEs equals your Total FTE. If your Total FTE calculations result in a decimal (i.e. 10.75), round down to the nearest whole number. Total FTE = 10.75 --> Total FTE = 10
- Special rule for seasonal employees:
- If average > 50 FTEs for 120 days or less per year, and the reason is because of the seasonal employees, employer will not be considered a large employer

# Shared Responsibility Rules (continued)
# What Does It Mean to "Offer Coverage"?

- Employer that provides at least **95% of FTEs with health coverage**, or if greater, **coverage to all but five of its full-time employees,** is considered to offer health coverage for purposes of the pay or play penalty

- So, if an employer offers health coverage to 98% of its full-time employees:

  - Not subject to the $2,000 penalty

  - But is subject to the $3,000 penalty with respect to each low income FTE who isn't eligible for the employer's health plan and who enrolls in health coverage on the exchange and obtains a premium credit. (This is in addition to the penalty with respect to each low income FTE who is eligible for the employer's health plan but where the plan isn't "affordable" or not of "minimum value")

# Shared Responsibility Rules (continued)
# What Does It Mean to “Affordable"?

Health coverage must be "affordable" and of "minimum value" in order to avoid the $3,000 penalty

**There are 3 safe harbors for "affordability" test**:

1. **W-2 safe harbor:** Employee's contribution for single coverage under the lowest cost medical option does not exceed 9.5% of employee's Box 1 W-2 pay for that year
2. **Rate of pay safe harbor:** Take an hourly employee's hourly pay rate in effect at the beginning of the year and multiply by 130 (the benchmark for FTE status for a month under the pay or play penalty). If employee's contribution for single coverage under the lowest cost medical option does not exceed 9.5% of employee's monthly wage amount, the affordability test is satisfied. A similar safe harbor is available for salaried employees based on the employee's monthly salary in effect at the beginning of the year
3. **Federal poverty line safe harbor:** Test met if employee's cost for single coverage does not exceed 9.5% of the federal poverty line for a single individual as in effect as of the beginning of the year

# Shared Responsibility Rules (continued)
# Minimum Value Test

A plan will satisfy minimum value test if it covers 60% or more of the cost of covered benefits

**Proposed regulations offer three methods of determining minimum value:**

1. **Calculator Method** HHS and the IRS will, in the future, offer a calculator. The plan will enter information about the plan's cost-sharing to determine whether the minimum value test is satisfied
2. **Safe Harbor Checklists Method** The safe harbors will be published by HHS and the IRS in the form of checklists to determine whether a plan provides minimum value. Each checklist will describe cost-sharing attributes of a plan in four categories of benefits:
    - Physician and mid-level practitioner care
    - Hospital and emergency room services
    - Pharmacy benefits*; and*
    - Laboratory and imaging services
3. **Actuarial Certification Method** If the plan contains non-standard features that aren't suitable for the calculator or do not fit the safe harbor checklists, the plan's minimum value can be determined by an actuarial certification

# Shared Responsibility Rules (continued)
# Who is the "Employer"?

- Apply common-law test to determine who is an "employee."

- All members of a "controlled group" under IRC § 414(b) or (c) are treated as a single employer.

  If a parent owns ≥ 80% of the equity in a subsidiary, or if the same 5 or fewer persons own ≥ 80% of the equity in another company or collectively own > 50% of both companies, the companies will be considered controlled groups and all employees must be combined together for purposes of calculating whether an employer is above or below the 50 FTE threshold.

- All members of an "affiliated service group" under IRC § 414(m) are treated as a single employer.

# Shared Responsibility Rules (continued)
# Who is a Full-Time Employee (FTE)?

**ACA defines FTE as an individual who works, on average, at least 30 hours per week. IRS guidance provides permissible safe harbor methods for applying rule:**

- **New Hires.** Only count new hires as FTEs if employee is reasonably expected to work full-time as of date of hire
- **Variable Hour and Seasonal Employees.** Can generally exclude, unless the employee actually works, on average, at least 30 hours per week during a "measurement period" of between three and 12 months. If employee works the required number of hours during the measurement period, the worker must be treated as FTE during a subsequent "stability period" which must be a period of at least six months, and no shorter than the initial measurement period
- **On-Going Employees.** Can apply a measurement period/stability period test similar to above. An employee is treated as an ongoing employee (vs. a new hire) after the initial measurement period. If an on-going employee doesn't satisfy the "on average, at least 30 hours per week" test for a measurement period, employer will not be subject to penalty if it does not offer the employee health coverage for the subsequent stability period (which can't be longer than the measurement period). This is true regardless of the employee's actual hours of work during the stability period

# Shared Responsibility Rules (continued)
## Measurement Periods/Administration Period/Enrollment

- Measurement Periods
  - Standard Measurement Period
    - Applies to all on-going employees classified as variable hour employees.
    - Set period of 3-12 months.
    - Calculate average hours worked during measurement period for all variable hour employees employed as of first day of measurement period.
  - Initial Measurement Period
    - Applies to variable hour (including seasonal) employees hired after start of standard measurement period.
    - Number of months in period is same as for standard measurement.
    - Initial measurement period calculated from employee's date of hire. If employee not an FTE after initial measurement period, calculate under standard measurement period thereafter.
- Administration Period
  - Period commences after end of measurement period and is used to conduct enrollment of eligible FTEs.
  - Period cannot exceed 90 days.
- Enrollment
  - FTEs must be eligible for coverage for period $\geq$ measurement period, but not less than 6 months.

# Shared Responsibility Rules (continued)
# Summary of Tax

- $3,000, adjusted for inflation after 2014, multiplied by the number of FTEs who receive premium tax credits or cost-sharing assistance (this number is not reduced by 30)

- Penalty tax is capped at $2,000 multiplied by total number of FTEs, reduced by 30

- If an employee is offered affordable minimum essential coverage, employee generally ineligible for a premium tax credit and cost-sharing reductions for insurance purchased through an Exchange

- Employer reporting requirements (plan, type of coverage, number of full time employees)

# QUESTIONS?