Health Care Reform Update

An overview of the Affordable Care Act and what you can expect as an employer and employee
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This document is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

Sources are cited at the end of each section. For more information regarding each section, reference the cited source.
Health Care Reform Timeline

Key Elements of Health Reform

On March 23, 2010 the Patient Protection & Affordable Care Act was enacted. The law puts in place health care reform laws that will out over the next 4 years and beyond, with many of the changes taking place in 2014. Several components have been enacted already. Use this timeline to learn about what is changing and when.

2010

- Medicare prescription drug “doughnut hole” beneficiary rebate
- Early retiree medical reinsurance
- Change in tax treatment for over age dependent coverage
- Accounting impact of change in Medicare retiree drug subsidy tax treatment

2011

- Pre-existing conditions exclusions removed for children under age 19
  - Plans may not impose a lifetime limit on essential health benefits; annual limits that meet certain thresholds are allowed
- No health FSA/HRA/HSA reimbursement for non-prescribed drugs
- Penalty for non-qualified HSA distributions increased to 20%
- Income based Medicare Part D premiums
- Medicare, Medicare Advantage benefit and payment reforms to begin
- Non-grandfathered plans must provide coverage for certain preventive care services, immunizations and screenings without any employee cost-sharing
- Non-grandfathered plans must include certain patient protections
- Non-grandfathered plans must implement certain processes for internal claims appeals and external review
- Insurers subject to medical loss ratios

2012

- Employers must distribute uniform summary of benefits, SBC, and coverage to participants
  - W-2 Form reporting of health coverage for employers issuing 250 or more (optional for employers filing less than 250 W-2 Forms)
- 60-day advance notice of mid-year material modifications to SBC content
- Expanded coverage for additional women’s preventive care services begins for plan year beginning on or after August 1, 2012
- Health plan fee to fund clinical effectiveness begins ($1 per life covered per year for the first year; $2 per life covered for the second year)
2013

- $2,500 per plan year health FSA contribution cap (plan years on or after January 1, 2013)
- Annual dollar limits on essential health benefits can not be lower than $2 million
- Employers must provide notice to employees that includes information on health insurance exchanges, premium subsidies and employer contributions
- Change in Medicare retiree drug subsidy tax treatment takes effect
- Health insurance exchanges initial enrollment period to begin

2014

- Health insurance exchanges open
- Insurance market reform takes effect; Pre-existing condition exclusions can not be applied to any individual; Health insurance guaranteed availability and renewability
- Waiting period for health plans can not exceed 90 days
- Individual mandate takes effect
- Automatic enrollment of employees into group health plan for employers with more than 200 employees
- Employer play-or-pay penalties may apply to employers that do not provide coverage to eligible full-time employees, that offer inadequate or unaffordable coverage
- States may expand Medicaid
- HIPAA wellness limit increases to 30%
- Additional employer reporting and disclosure
- Temporary reinsurance fees

2018

- 40% excise tax on high cost “Cadillac Coverage”
Essential Health Benefits

Health service categories that must be covered in health plans by 2014

The PPACA ensures health plans offered in the individual and small group markets, both inside and outside of the Exchanges offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services in the following 10 categories:

- Ambulatory patient care
- Emergency services
- Hospitalization
- Maternity & newborn care
- Mental health & substance abuse
- Prescription drugs
- Rehabilitative & habilitative services
- Laboratory services
- Preventive & wellness services & chronic disease management
- Pediatric services

Insurance policies must cover these benefits in order to be considered adequate, certified and offered in the Exchanges in 2014.

Preventive Health Services

Plan years beginning on or after September 23, 2010

Section 2713 of the PHS Act, as added by the Affordable Care Act, requires qualified health plans to provide at a minimum without cost-sharing, no co-pay, coinsurance, or subject to deductible, for preventive services rated A or B by the U.S. Preventive Services Task Force, recommend immunizations, preventive care for infants, children, young adults, and additional preventive care and screenings for women. For a complete list of covered preventive services visit: [Healthcare.gov](http://www.healthcare.gov).

Employer Requirements

It is the responsibility of the insurance carrier to be sure health plans offer coverage for specific preventive services, dependant on age and gender, at no cost to the plan member.

What This Means for You and Your Employees

Depending on your age and health plan type, you may have easier access to such preventive services as:

- Blood pressure, diabetes, and cholesterol tests
- Many cancer screenings
- Counseling on topics such as smoking cessation, weight loss, healthy eating, depression and more.
- Routine vaccinations for diseases such as measles, polio, or meningitis
- Flu and pneumonia shots
- Counseling, screening and vaccines for healthy pregnancies
- Regular well-being and well-child visits, from birth to age 21

Source:
Medical Loss Ratio Requirements (MLR)
2011 Calendar Year

Section 278 of the PHS Act, as added by the Patient Protection and Affordable Care Act, PPACA, mandates health insurers to issue rebates to consumers/employees if they do not spend the required percentage of premium dollars on medical care and health care quality improvement during the plan year. The required percentages are as follows:

- 80% of premium dollars for small groups (2-50 employees)
- 85% of premium dollars for large groups (51+ employees)

In order to prevent the rebates to be a taxable income for consumers/employees, the final ruling declared that rebates must be paid to the group policyholder-typically the employer-in order for the rebates to become plan assets, which then can be distributed to the individuals within the plan without being taxed.

**Employer Requirements**
Employers offering group health insurance plans must be aware of their responsibilities as policyholder when it comes to handling and disbursing rebates due to employees under the MLR rules. These plan assets become subject to the requirements of [Title I of ERISA](#). Anyone with authority over plan assets must be aware of their fiduciary responsibility as defined in sections 3(21) and subject to the responsibilities provisions of ERISA section 404 and the prohibited transaction provisions of ERISA section 406.

**What This Means for You and Your Employees**
Employees who are entitled to a rebate from the insurer will not have to pay income tax regardless of whether the rebate is received as a premium credit or a lump sum check. Employers must distribute rebate proportionately among eligible employees. Employers are not required to distribute a rebate if the value is less than $5 per employees.

**Source:**
Summary of Benefits & Coverage (SBC)

Beginning on or after September 23, 2012

As of September 23, 2012, health insurers and self insured employers must comply with the benefits communication mandates. This mandate is designed to make health insurance communications, benefit summaries, easier to understand and free of complicated industry jargon. The SBC does not have to be a stand alone document, as the law initially required. It can be a part of the health plan’s summary plan description, as long as the required information is presented together and is displayed at the beginning of the summary description. The summary does not have to provide information of premiums.

SBC Provided by Issuer to a Plan

The Final Rule requires a health insurance issuer to provide an SBC to an insured group health plan upon an application by the plan for coverage following receipt of the application, but in no event later than seven business days following receipt of the application. If there is any change to the information required to be in the SBC before the first day of coverage, the issuer must update and provide a current SBC to the plan no later than the first day of coverage. The SBC must be provided upon request and no later than seven business days after the request. The SBC must be provided upon renewal as follows:

- **Renewal when a reapplication is required:** The proposed rule required that, if written application materials are required for renewal, the SBC must be provided no later than the date on which the materials are distributed.

- **Automatic Renewal:** The Final Rule requires that if renewal or reissuance of coverage does not require reapplication, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year. The Final Rule provides flexibility with the 30 day rule when the terms of coverage are finalized in fewer than 30 days in advance of the new policy year (e.g., negotiation of coverage terms).

Employer Requirements

Employers who are self-insured and/or create their own benefit documents must meet federal guidelines for 2012 benefit enrollments. For employers who rely on agencies and health insurers to provide benefit communications, the employer is responsible for distributing these documents to employees if the agency or insurer does not.

**Benefit summaries must include the following information:**

- Covered benefits
- Cost-sharing provisions
- Coverage limitations and exceptions
- Coverage example expenses the health plan will cover if the insured is pregnant or has type II diabetes

**Benefit summaries must be provided to employees:**

- When employees are applying for coverage
- Every year when coverage is renewed (60 days in advance)
- At least 60 days before changes in coverage take effect
- At employee request. A Summary of Benefits and Coverage must be received within 7 days of employee request.
The Summary of Benefits and Coverage must be in the following format:

- Be provided in a consistent 4, double-sided page format
- Use 12-point font for text (8 pages total)
- Include a customer service phone number and internet address
- Include copies of plan documents

If creating your summary, use the Summary of Benefits and Coverage Template provided by the federal government to ensure compliance. For more information on how to complete the SBC view Instruction Guide for Group Coverage. To view a completed sample click here.

Employers must also provide, upon employee request, a glossary of commonly used healthcare coverage terms. Click here for the uniform glossary.

**Penalties**

Insurers and self-insured employers who do not comply will have to pay penalties of up to $1,000 for each individual enrolled in the plan.

**What This Means for You and Your Employees**

Employees should benefit from the clearly written benefit summaries and have a better understanding of how their coverage works. These materials can help employees compare coverage more easily. In 2014, when the Health Insurance Exchanges open, these communications will make it easier for employees to compare their workplace plan with coverage available through the exchange.

*Source:*
United States Department of Labor. “Summary of Benefits and Coverage and Uniform Glossary.”
www.dol.gov/ebsa/healthcarereform/

Unum. “Final Summary of Benefit Coverage Guidelines Released.”
W-2 Reporting: Cost of Employer Sponsored Health Coverage
2012 taxable year (must send W-2s no later than January 31, 2013)

The Affordable Care Act requires employers to report the cost of coverage under an employer-sponsored group health plan. Reporting the cost of health coverage on the Form W-2 does not make the coverage taxable; this reporting is used for informational purposes only and will provide employees with comparable consumer information on the cost of their health coverage.

For employers who have filed fewer than 250 Form W-2 in 2011 (given to employees in early 2012), certain types of coverage, and other circumstances, there is a transitional relief (see question 4) from the requirement to report the value of coverage on the 2012 forms (the forms that employers generally provide employees in 2013). This transition relief will apply to future calendar years until further guidance is provided. Review the chart below for which health plan coverage is required to be reported on 2012 Forms W-2.

Employer Requirements

Employer will be required report the value of their health care coverage in box 12, with code DD, on the Form W-2. The amount reported should include both the portion paid by the employer and the portion paid by the employee. The employer is not required to issue a Form W-2 solely to report the value of coverage for retirees, former employees or other employees to whom the employer would not otherwise issue a Form W-2

Only employers who are filing more than 250 Form W-2 are required to report. For those employers filing less than 250 Form W-2 reporting remains optional until further guidance from the IRS. The IRS must give 6 months advance notice of any changes to transition relief.

Employer Reporting FAQs

The following questions and answers provide information for employers on reporting the cost of health insurance coverage, including information on transition relief for 2012, how to report, which coverage to include, and how to determine the cost of coverage.

1) Is the cost of an employers' health care benefit shown on the Form W-2 mean that the benefits are taxable to the employee?

No. There is nothing about the reporting requirement that causes or will cause excludable employer-provided health coverage to become taxable. The purpose of the reporting requirement is to provide employees with useful and comparable consumer information on the cost of their coverage.

2) When will employers have to start reporting the cost of health care coverage on the Form W-2?

Reporting for the 2011 calendar year was optional (employee would receive Form W-2 in early 2012). After 2011, employers are generally required to report the cost of health benefits on the Form W-2, with exception for those who qualify for transition relief (see question 4). Those employers who are eligible for transition relief are not required, until further guidance is provided, and in no event will reporting by these employers be required on any 2012 Forms W-2 (employee would receive W-2 Form in early 2013).
3) Which employers are required to report the cost of health care coverage?

All employers who are not eligible for 2012 transition relief that provide applicable employer-sponsored coverage (see question 5) under a group health plan must report the cost of health care coverage. This includes federal, state, and local government entities (except to plans maintained primarily for members of the military and their families), churches and other religious organizations, and employers that are not subject to the COBRA continuation coverage requirements. This does not include federally recognized Indian tribal governments or any tribally chartered corporation wholly owned by a federally recognized Indian tribal government.

4) To which types of employers and types of coverage does the transition relief apply to?

- Employers filing fewer than 250 Form W-2 the previous year
- Multi-employer plans
- Health reimbursement arrangements
- Dental & vision plans that either are not integrated into another group health plan or give participants the choice of declining coverage or electing it and paying an additional premium
- Self-insured plans of employers not subject to COBRA continuation coverage
- Employee assistance program, onsite medical clinics, or wellness programs for which the employer does not charge a premium under COBRA continuation coverage
- Employers furnishing Form W-2 to employees who terminate before the end of a calendar year and request a Form W-2 before the end of the year

5) What types of health care coverage must be included in the reported amount?

View the Form W-2 Reporting of Employee-Sponsored Health Coverage on the next page. This chart lists the types of health care coverage and explains whether reporting is required, prohibited, or optional.
<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Form W-2, Box 12, Code DD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report</strong></td>
<td><strong>Do Not Report</strong></td>
</tr>
<tr>
<td>Major medical</td>
<td>X</td>
</tr>
<tr>
<td>Dental or vision plan not integrated into another medical or health plan</td>
<td></td>
</tr>
<tr>
<td>Dental or vision plan which gives the choice of declining or electing and paying an additional premium</td>
<td></td>
</tr>
<tr>
<td>Health Flexible Spending Arrangement (FSA) funded solely by salary-reduction amounts</td>
<td></td>
</tr>
<tr>
<td>Health FSA value for the plan year in excess of employee’s cafeteria plan salary reductions for all qualified benefits</td>
<td>X</td>
</tr>
<tr>
<td>Health Reimbursement Arrangement (HRA) contributions</td>
<td></td>
</tr>
<tr>
<td>Health Savings Arrangement (HSA) contributions (employer or employee)</td>
<td>X</td>
</tr>
<tr>
<td>Archer Medical Savings Account (Archer MSA) contributions (employer or employee)</td>
<td></td>
</tr>
<tr>
<td>Hospital indemnity or specified illness (insured or self-funded), paid on after-tax basis</td>
<td></td>
</tr>
<tr>
<td>Hospital indemnity or specified illness (insured or self-funded), paid through salary reduction (pre-tax) or by employer</td>
<td>X</td>
</tr>
<tr>
<td>Employee Assistance Plan (EAP) providing applicable employer-sponsored healthcare coverage</td>
<td>Required if employer charges a COBRA premium</td>
</tr>
<tr>
<td>On-site medical clinics providing applicable employer-sponsored healthcare coverage</td>
<td>Required if employer charges a COBRA premium</td>
</tr>
<tr>
<td>Wellness programs providing applicable employer-sponsored healthcare coverage</td>
<td>Required if employer charges a COBRA premium</td>
</tr>
<tr>
<td>Multi-employer plans</td>
<td>X</td>
</tr>
<tr>
<td>Domestic partner coverage included in gross income</td>
<td>X</td>
</tr>
<tr>
<td>Governmental plans providing coverage primarily for members of the military and their families</td>
<td></td>
</tr>
<tr>
<td>Federally recognized Indian tribal government plans and plans of tribally charted corporations wholly owned by a federally recognized Indian</td>
<td></td>
</tr>
<tr>
<td>Tribal government</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Self-funded plans not subject to Federal COBRA</td>
<td>X</td>
</tr>
<tr>
<td>Accident or disability income</td>
<td>X</td>
</tr>
<tr>
<td>Long-term care</td>
<td>X</td>
</tr>
<tr>
<td>Liability insurance</td>
<td>X</td>
</tr>
<tr>
<td>Supplemental liability insurance</td>
<td>X</td>
</tr>
<tr>
<td>Workers' compensation</td>
<td>X</td>
</tr>
<tr>
<td>Automobile medical payment insurance</td>
<td>X</td>
</tr>
<tr>
<td>Credit-only insurance</td>
<td>X</td>
</tr>
<tr>
<td>Excess reimbursement to highly compensated individual, included in gross income</td>
<td>X</td>
</tr>
<tr>
<td>Payment/reimbursement of health insurance premiums for 2% shareholder-employee, included in gross income</td>
<td>X</td>
</tr>
</tbody>
</table>

### Other Situations

<table>
<thead>
<tr>
<th></th>
<th>Report</th>
<th>Do Not Report</th>
<th>Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employers required to file fewer than 250 Forms W-2 for the preceding calendar year (determined without application of any entity aggregation rules for related employers)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Forms W-2 furnished to employees who terminate before the end of a calendar year and request, in writing, a Form W-2 before the end of that year</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Forms W-2 provided by third-party sick-pay provider to employees of other employers</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
6) What amount should be reported by the employer on the Form W-2 for health coverage?

The amount reported should include both the employer and the employee paid portions. In the case of health FSA, the amount reported should not include the amount of any salary reduction contributions. Refer to Notice 2012-9 for more information.

7) In which section on the Form W-2 should the cost health benefits be reported?

This information is reported in box 12 of the Form W-2, with the code DD to identify the amount.

8) What amount should be reported for employees that terminated employment during the year and had employer-provided coverage before and after termination?

Under current rules, the employers may use any reasonable method for inclusion of the coverage provided after termination, as long as that method is applied consistently. For examples, refer to Notice 2012-9.

9) What amount should be reported for an employee that leaves during the year and requests a W-2 Form before the end of the year?

If an employee makes a request in writing, the employer must provide the Form W-2 within 30 days. However, under the current rules, the employer is not required to report any amount of health benefits in box 12, code DD.

Are employers required to issue Form W-2 to retirees or other former employees to whom the employer would not otherwise issue a W-2 Form?

No.

Source

Fees to Fund Patient Centered Outcomes  
*Policy & plan years ending on or after October 1, 2012 & before October 1, 2019*

The IRS has issued [Notice 2011-35](#) to implement Section 6301 of the PPACA to provide funding for a new patient-centered outcomes research institute. The goal of the institute is to help government, private insurers, employers, consumers and providers in making informed health decisions by advancing comparative clinical effectiveness research. The institute will not be an agency or establishment of the U.S government, and will be funded by the Patient-Centered Outcomes Research Trust Fund- to the Internal Revenue Code, IRC. The trust fund will be supported by fees to be paid by issuers of health insurance policies and sponsors of self-insured health plans.

Health insurance policy issuers would pay a fee of $2 per life covered, indexed for the national health care inflation rate.

**What this means for employers**

Similarly to insurance policy insurers, the sponsor of a self-insured plan would pay a fee equal to $2 multiplied by the average number of lives covered, adjusted for health care inflation. The IRC defines a sponsor to include the association, board or other entity that runs a multiple employment welfare arrangement (MEWA), a voluntary employees’ beneficiary association (VEBA), or some other type of plan run by two or more employers. The fees imposed are treated the same as if they were taxes.
Health FSA $2,500 Salary Cap

Plan years beginning on or after January 1, 2013

A health FSA allows an employee to pay for out-of-pocket medical expenses i.e.-prescription drug, office visit co-pays- on a pre-tax basis. Prior to the PPACA, the annual limit was set by the employer and typically ranged between $2,500-$5,000. As a result of the PPACA, the employer has less flexibility when it comes to setting a health FSA annual limit.

The IRS has issued Notice 2012-40, providing guidance on the effective date of the $2,500 limit on salary reduction contributions to health flexible spending accounts, FSAs, as enacted of the PPACA. This Notice also provides guidance on the deadline for amending plans to comply with the limit, and offers relief for certain contributions that mistakenly exceed the $2,500 limit and that are corrected in a timely manner. Finally, the Notice requests comments on whether to modify the long-standing “use or lose” rule that applies to health FSAs.

Notice 2012-40 Main Points

- The $2,500 limit on health FSAs salary reduction contributions applies on a plan year basis and is effective for plan years beginning on or after December 31, 2012. For those employers with non-calendar year plans will not be required to comply until plan year renewal in 2013.

- The option to amend the cafeteria plan to reflect the limit December 31, 2014 (after the limit actually takes effect)

- $2,500 contribution limit must be prorated if it is a short plan year (less than 12 months) based on the number of months in the plan year.

- The $2,500 limit will be indexed for cost-of-living adjustments for plan years beginning after December 31, 2013.

- Plans may adopt the required amendments to reflect the $2,500 limit at any time through the end of 2014. Notice 2012-40 requires plans that begin on or after January 1, 2013 to adopt the $2,500 annual limit.

- In the case of a grace period (which can be up to 2 months and 15 days), unused salary reduction contributions to FSAs for plan years beginning in 2012 or later that are carried over into the grace period will not count against the $2,500 limit for the following plan year.

- $2,500 limit applies to salary reduction contributions only. Non-elective contributions, flex credits, which are usually made available to employees in a cafeteria plan do not count against the $2,500 limit.

  - i.e. An employer contributes $500 flex credit to each employee’s health FSA for the 2013 plan year, each employee may still elect to make salary reduction contribution of $2,500. However, if an employer provides flex credits that employees may elect to receive as cash or as a taxable benefit, those flex credits are treated as salary reduction contributions.

- Relief is provided for certain salary reduction contributions exceeding the $2,500 limit that are due to a reasonable mistake and not willful neglect, and that are corrected by the employer.
What this means for employers

The guidance will be of interest to all employers that sponsor health FSAs and will impact all employees that participate in these accounts. The $2,500 contribution limit applies to health FSA plan years beginning on or after December 31, 2012. As a result, the limit does not apply until the plan year that begins prior to January 1, 2013 but that extends into 2013.

The $2,500 annual limit applies only to a health FSA, not to other employer-provided coverage, such as contributions to an FSA for dependent care assistance or adoption assistance, employee contributions to a HSA or HRA, or employee contributions to a cafeteria plan to pay for health care premiums under an employer-sponsored plan on a pre-tax basis. Other tax rules may impose annual contribution limits.

What this means for your employees

A health FSA is not treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.

The $2,500 annual contribution limit applies on an employee-by-employee basis. This means, if 2 spouses work for the same employer, each spouse can elect up to the limit set by the employer. i.e. $2,500 per employee or $5,000 per family limit.

The $2,500 limit applies on a controlled group basis. If an employee works for 2 or more corporations related by ownership (partnership, subsidiary) each of which has its own health FSA, the employee’s total contributions under all health FSAs within is limited to $2,500 (or such lower amount resulting from the total of the individual limits).
State Transitional Reinsurance Program  
*Beginning January 1, 2014 through December 31, 2016*

Under Section 1341 of the ACA, health insurance issuers (insurance company, insurance service, or insurance organization- including HMOs) self-insured group health plans, and third party administrators will pay an assessment to fund state non-profit reinsurance entities for the purpose of establishing a high-risk pool for the individual market. The assessment is imposed for a limited number of years, beginning in January 1, 2014 and ending December 31, 2016.

**FAQs Regarding State Transitional Reinsurance Program**

**What are the roles of non-profit reinsurance entities?**

Non-profit reinsurance entities are being created to stabilize premiums for coverage in the individual market in a state during the first 3 years of operating the insurance exchanges when the risk of adverse selection, as a result of new rating rules and market exchanges, is the greatest. The reinsurance entity collects payment and uses the amounts collected to make reinsurance payments to health insurance issuers that cover high-risk individuals for the 3 year period.

**What is the assessment?**

The assessment will total $25 billion that will be collected over the 3-year period in the amounts of $12 billion in 2014, $8 billion in 2015 and $5 billion in 2016. The government has not yet issued regulations determining how this total will be proportioned between health insurance issuers and third party administrators.

**Who is responsible for paying this assessment?**

Health insurance issuers, self-insured group plan sponsors, and third party administrators on the behalf of group health plans are responsible for paying the assessment. The Department of Health & Human Services will provide the method for determining the amount that each entity will be required to pay.

The PPACA does not specify how the payments will be collected or the timing for payments of the assessment, which will be addressed in further regulations. However, the ACA states that the assessment is to be allocated based on proportionate revenues or a specific amount per enrollee once claims costs reach a certain level (attachment point) and until the payment limit (cap) is reached.

**Are there estimates of what this assessment might mean for a self-funded plan?**

No.

**What this means for employers**

For employer sponsors of self-insured plans, these rules could mean increased costs in two forms. First, third party administrators, on behalf of self-insured group administrators, could pass these costs on to plan sponsors in the form of higher fees. Second, self-insured group health plans that are self-administrated (do not have a third part administrator) would be responsible for the reinsurance contributions. The exact amount of these costs will not be know until the contribution levels are set by the Department of Health & Human Services.
Source:


Shared Responsibility for Individuals  
*Beginning January 1, 2014*

Under the PPACA, individual mandate requires most Americans to carry health insurance or pay a penalty to the IRS beginning in 2014. Although the Supreme Court found that Congress did not have the power to impose the individual mandate under the Commerce Clause, it held that Congress could enact the individual mandate under its taxing power.

**What this means for employers and employees**

Individuals are responsible for ensuring that they, and any dependents, are covered under minimal essential coverage (see essential health benefits). Minimum essential coverage can be provided by:

- Government sponsored programs including: Medicare, Medicaid, Children’s Health Insurance Program (CHIP), TRICARE, or coverage through veteran affairs
- Employer-sponsored plans including governmental plans, grandfathered plans, and other plans offered in small or large group markets
- Individual market plans
- Other coverage designated as minimum essential coverage by U.S. Department of Health & Human Services or the Department of the Treasury

Those without coverage pay a tax penalty of the greater of $695 per year, up to a maximum of 3 times that amount ($2,085) per family or 2.5% of the family’s income. The penalty will be phased in according to the following schedule:

- $95 or 1% of taxable income in 2014
- $325 or 2% of taxable income in 2015
- $695 or 2.5% of taxable income in 2016

Exemptions will be granted for financial hardships, religious objections, American Indians, those without coverage for less than 3 months, undocumented immigrants, incarcerated individuals, those for whom the lowest plan option exceeds 8% of an individual’s income and those with incomes below the tax filing threshold ($9,350 for singles or $18,600 for couples).

Source:

Shared Responsibility for Employers (Play or Pay)

Beginning January 1, 2014

The PPACA amended the Fair Labor Standards Act, FLSA, by adding Section 18A, which requires employers who are subject to FLSA, have more than 200 employees and provide health care coverage to their employees to automatically enroll new full-time employees into the employer’s health benefit plan. The Department of Labor, DOL, stated that the automatic enrollment provisions are to be implemented in accordance to regulations issued by the Secretary of Labor. At that time, the DOL indicated that compliance was not required until such regulations were issued and that it intends to issue them prior to 2014.

The PPACA also includes the “employer shared responsibility” provisions effective in 2014 which impose penalties on certain employers that do not provide health coverage or that provide inadequate or unaffordable coverage for full time employees. Employers with 50 or more full time employees who do not offer health coverage to their full time employees and their dependents or provide unaffordable, inadequate coverage will be assessed a penalty if at least one full-time employee obtains a premium tax credit or cost-sharing reduction.

What this means for employers

Automatic Enrollment
The PPACA added the Section 18A to the FSLA requiring employers with more than 200 full-time employees to automatically enroll new full-time employees in one of the employer’s group health plans and to continue the enrollment of current employees. It also requires an employer to provide adequate notice and the opportunity for an employee to opt out of any coverage in which the employee was automatically enrolled. The DOL issued a FAQ in December of 2010, stating until final implementation regulations are issued, employers are not required to comply with automatic enrollment requirements. These final regulations are expected to be issued by 2014.

Employer Shared Responsibility
As added by the PPACA, this requires large employers (50 or more full-time employees) to provide adequate and affordable health coverage to full-time employees and their dependents. Adequate health coverage is defined by essential health benefits (see page 3). Affordable is defined has the cost of coverage not exceeding 9.5% of the employee’s household income or the employee’s Form W-2. The employer could be assessed a penalty is an employee qualifies for cost-sharing subsidies or premium credit.

Penalty

Play or Pay
Under the employer mandate, groups with 51+ employees who do not offer coverage will be assessed a $2,000 penalty per full-time employee, excluding the first 30 employees, if at least 1 employee receives a subsidy in the Exchange. A full-time employee is defined as 30 or more hours per week.

Free Rider
The coverage that employers provide must be deemed affordable and valuable. In order to be considered affordable, the cost of coverage must not exceed 9.5% of employee’s income. In order for the coverage be considered valuable, it must meet the essential health benefits requirement (see page 3). For each employee that seeks a subsidy through the Exchange, will be assessed a $3,000 penalty per employee.
What this means for employers
Employers must take a look at their employee population and decide if the employer and employees would be better suited going through the Exchange to receive health coverage, and receiving a penalty tax, or by offering an employer sponsored health plan. It is important to note that any penalties that may be incurred are an excise tax and will not be a tax deductible employer expense.

Determining Full-Time Employees

Current Employees
Notice 2011-36 outlines an approach for employers trying to determine whether a current employee is a full-time employees for purposes of the shared responsibility penalty; referred to as “look back” and “stability period”. The look back measurement is the approach in which the employer looks back at a period of 3 to 12 months to confirm that the employee averaged 30 hours of work per week or at least 120 hours of service per calendar month. If the employee met these requirements he/she would be considered a full-time employee during the stability period. The stability period must last at least 6 consecutive months after the look back period.

New Hires
Under the intended rules, if a new employee is expected to work full-time on an annual basis from date of hire and, in fact, works full-time during the first 3 months of employment, the employer will not be assessed a penalty as long as the employee is offered coverage no later than at the end of 3 months of employment.

If an employee works full-time during the first 3 months of employment but the hours are reasonably viewed as not representative of expected future hours (i.e. seasonal employment) the employer may use a second 3 month look back period (following the first 3 months of employment) to determine whether the employee is a full-time employee. If it is determined that the employee is full-time, no penalty will apply for the full 6 months.

90-Day Waiting Period Limits
The group health plan or issuer will be prohibited from imposing a waiting period that exceeds 90 days, effective with plan years beginning on or after 2014. The 90-day waiting period limit is applicable to both full-time and part-time employees who are otherwise eligible for the plan. The IRS intends to issue proposed regulations or other guidance addressing the coordination of the play-or-pay rules and the 90 day waiting period limits. The upcoming guidance is expected to provide that, at least for the first 3 months following an employee’s date of hire, an employer will not be subject to a penalty for failing to offer minimum essential health coverage to the employee during that 3 month period.
**Coverage of Classes of Employees**

PPACA does not require an employer to offer health coverage to any class of employees or to any employees at all (although penalties may apply for failure to offer). However, once an employer decides to offer coverage to a class of employees, it must satisfy PPACA 90 day waiting period requirement in respect to those employees.

i.e. An employer offers coverage to part-time employees once they have completed 750 hours of service. A part-time employee who works 20 hours a week will reach 750 hours in 37.5 weeks (just under 9 months). The waiting period begins the day when the employee completed 750 hours. It is important to note that there is no play or pay penalty in this situation because the employee is part-time but is still subject to the 90 day waiting period rules.

Sources:


Health Insurance Exchanges
*Beginning January 1, 2014*

A Health Insurance Exchange is a marketplace for individuals and businesses to compare, choose, and buy affordable health insurance for high quality care. The goal of an Exchange is to make health care easier to navigate for consumers and small businesses by allowing Minnesotans to compare health insurance options based on cost, quality, and consumer satisfaction.

An Exchange is an online marketplace where Minnesotans can purchase private health insurance or enroll in public programs like Medical Assistance and the Children’s Health Insurance Program (CHIP). Subsidies and tax credits will be available to eligible individuals and small businesses to help make coverage more affordable.

An Exchange strives to help small businesses provide coverage choices to their workers and allow employees to choose the plan that is best for them and their families. Employees will be able to use contributions from one or more employers to purchase coverage for them and their families and keep that coverage if they become self-employed, lose their job, or if they change jobs.

**Exchange Main Points**

**Effective Date**
- Unless otherwise noted, provisions relating to the Exchanges are effective January 1, 2014

**Creation & Structure**
- American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges for individuals and small employers up to 100 employees
- Large employers (over 100 employees) are eligible to participate in 2017

**Eligibility**
- U.S. citizens & legal immigrants who are not incarcerated

**Public Plan Option**
- Exchange must offer at least 2 multi-state plans
- At least one plan must be offered by a non-profit entity
- At least one plan must not offer coverage for abortions beyond those permitted by federal law

**Consumer Operated and Orientated Plan (Co-op)**
- Creates a non-profit, member- run health insurance company in all 50 states and the District of Columbia to offer qualified health plans

**Benefit Tiers**
- Creates 4 benefit categories of plans plus a separate catastrophic plan that will be offered through the Exchange
Insurance Market & Rating Rules

- Require guarantee issue and renewability
- Allow rating variation based on age only (3:1) premium rating area, family composition, and tobacco use (1.5:1)
- Require risk adjustment in the individual and small group markets and in the Exchange

Participating Health Plan Qualifications

- Meet marketing requirements
- Contracted with essential community providers
- Contracted with Navigators
- Accredited based on performance on quality measures
- Uniform enrollment form
- Standard presentation form
- Reports claim payment policy information, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, & enrollee rights

Exchange Requirements

- Maintains call center for customer service
- Establishes enrollment/disenrollment procedures
- Determines eligibility for tax credits
- Develops single form for applying to state subsidy program
- Contract with Medicaid agencies
- Exchanges must submit financial reports & comply with oversight investigations

Basic Health Plan

- Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange
- Plans must provide essential health benefits

FAQs Regarding Exchanges in Minnesota & Wisconsin

What functions will an exchange perform?

An Exchange would perform a number of functions including:

- Operating a toll-free hotline and website for providing information
- Ensuring that health insurance plans meet certain standards
- Providing information in a standard format to help consumers compare insurance companies and benefit plans
- Determining eligibility for individual premium tax credits, cost-sharing assistance, and coverage requirement exemptions
- Determining eligibility for Medical Assistance
- Determining eligibility for small business premium tax credits
- Communicating with employers regarding employee tax credit eligibility, cancellation of coverage etc.
- Establishing a navigator program that connects consumers with an individual or organization who assists consumers and businesses to navigate the Exchange
When would an exchange be effective?

Coverage through an Exchange would start effective January 1, 2014. State have until January 1, 2013 to create their own health insurance exchanges or the federal government will establish one for the state.

Who would be eligible to participate in an Exchange?

An Exchange would be available to be used by individual consumers and small businesses with up to 100 employees when it opens for enrollment. Minnesota may limit small business eligibility to those with less than 50 employees prior to 2016, but this decision has not yet be made. Large employees may be allowed to participate in 2017.

Where is Minnesota in the process to plan for a Health Insurance Exchange?

The state is working with all stakeholders to plan and develop a Minnesota exchange. Minnesota received over $5 million in grants to help design and develop an Exchange and form the Minnesota Health Insurance Exchange Advisory Task Force.

The task force will advise the Commissioner of Commerce on the design and development if a Minnesota Health Insurance Exchange.

What will the Minnesota Health Insurance Exchange Advisory Task Force do?

The task force will advise the Commissioner of Commerce on the design and development of a Minnesota Health Insurance Exchange.

What will the advisory task force do?

The task force will provide guidance and recommendations on a number of policy. Technical and operational issues, including but not limited to:

- Size of the small group market
- Merger of the individual and small group markets
- Provisions to avoid adverse selection
- Risk Adjustment
- Cost, quality and satisfaction rating for health insurers and health benefit plans
- Navigator/broker provisions
- Technical Infrastructure
- Exchange operations
- Long-term governance
- Ongoing funding mechanisms

Where is Wisconsin in the process to plan for a Health Insurance Exchange?

On January 27, 2011, Governor Scott Walker issued Executive Order 10 to create the Office of Free Market Health Care and tentatively develop a plan for Wisconsin insurance exchanges until the Supreme Court ruling. Nearly a year later, Governor Walker announced the state would discontinue any development on a health exchange and signed an Executive Order 56 closing the Office of Free Market Health Care and returned the Early Innovator grant funding, $37.7 million. Unless Wisconsin reverses its decision to suspend all state-based exchange implementation activity, the federal government will assume responsibility for running an exchange in the state.
Sources:


