Health Care Reform Update

What's coming and how does it affect you?

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2014 is upon us and it is the year the bulk of provisions in the Patient Protection and Affordable Care Act or PPACA will be implemented. This document provides summary information on programs that will impact you and your employees in the coming months. Please keep in mind many of the rules are still being reviewed and final guidance being written, statements here should not be regarded as absolute.

PCOR (Patient Centered Outcomes Research) Fees

What are Patient-Centered Outcomes Research Fees?

The fees will be used to fund the Research Institute, which was established under the Act to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings.

When – Applies to plan years ending after October 1, 2012. For self-funded plans the fee applies to the plan sponsor, for fully insured plans the fee is assessed against the insurer.

Impact – The fee is $1 times the average number of covered lives.

How – Reported and paid annually on IRS Form 720 (Quarterly Federal Excise Tax Return).

The PCOR fee applies to all accident or health plans and is the responsibility of the plan sponsor (employer) for self-funded plans. There are three options available for determining the average number of covered lives:

1. Actual Count. This method takes into account the number of covered lives on each day during the plan year.
2. Snap Shot Method. The snap shot allows for counting the number of employees with single coverage and the number with family coverage on one day of each quarter. The number of employees with family coverage is multiplied by 2.35. The total from each quarter is added for a grand total which is divided by 4.
3. 5500 Method. If your plan is required to file a Form 5500, payment would be based on the number of participants as of the beginning and as of the end of the plan year as reported on the 5500.

PCOR (Patient Centered Outcomes Research) Fees - Continued

Plans ending between October 1, 2012 and December 31, 2012 must file by July 31, 2013. Plan years that ended before October 1, will not have to pay until 2014 for the 2013 year. The fee increases to $2 in the second year and will be indexed in subsequent years.

Notification Requirements

When – March 1, 2013 effective date **delayed**.

Impact – Employers must notify all employees and new hires of their coverage options and the existence of Exchanges, minimum value coverage and consequences to the employee if they choose an Exchange plan.

How – Written notice must be provided. Further guidance will follow and model notices will be provided.

The notices under development are:

1. **Coverage option notices** must be provided by employers to all current employees and new hires as they join the company. The effective date has been delayed for additional time in preparing model notices and determining alternative notices that may be included such as information on the Children's Health Insurance Program, Essential Health Benefits and more.
2. **Exchanges** The notice will inform employees of the existence of the Exchange, of the services the Exchange provides and how to contact the Exchange.
3. **Minimum Value** If the employer plan's share of total allowed costs of benefits under the employer plan is less than 60% of such costs, the employee may be eligible for a premium tax credit when purchasing coverage through the Exchange.
4. **Consequences of Purchasing Through the Exchange** Employees must be notified that if they choose to purchase coverage through the Exchange, they may lose the employer contribution to any health benefits offered by the employer. Additionally, any contribution may be excludable from income for Federal income tax purposes.

MINIMUM VALUE COVERAGE AND PLAY OR PAY (SEE APPENDIX A FOR FLOW CHART)

When – Begins in 2014.

Impact – Penalties apply to employers when employees apply for coverage in the Exchange.

How – Penalties are payable to the Exchange if specific criteria is not met by the employer-offered benefits or if the employer does not offer a health plan.

To avoid minimum value coverage penalties, employer sponsored plans must be affordable and provide minimum value. Affordability is determined based on the employee's contribution for benefits. If the employee's cost for single coverage exceeds 9.5% of their income, the coverage is not affordable. Additionally, the employer's share of the cost of benefits must be at least 60%. Contributions to an HSA and amounts available through an HRA can be included in calculating the employer's share. The employers with at least 50 full-time equivalent (FTE) employees are subject to these provisions.

Things to consider when calculating full-time equivalents:

1. Full-time Employees. Any employee regularly scheduled to work at least 30 hours per week is considered full-time.
2. Part-time Employees. Part-time employees are those working less than 30 hours per week and are used to calculate FTE. The total number of hours worked by part-time employees, divided by 120 gives the full-time equivalent.
3. Seasonal Employees. Seasonal employees who work less than 120 days per year are not considered full-time employees.

Penalties:

1. Coverage Not Offered-The monthly penalty for employers who don't offer coverage is equal to the number of FTE, minus 30, times $2,000, divided by 12 months (# of FTE – 30 x $2,000 / 12).
2. For coverage that is not affordable and there are employees who qualify for the premium tax credit, the monthly penalty is the number of employees qualifying for the credit, times $3,000, divided by 12 (# with premium tax credit x $3,000 / 12).

PREMIUM TAX CREDIT

When – Begins in 2014.

Impact – May affect employer penalties as described above.

How – The credit applies to individuals whose employer doesn't offer coverage or who are not eligible for coverage through their employer or other government programs.

An individual who falls into one of the above categories of no coverage and has a modified adjusted gross income between 100% and 400% of the federal poverty level will qualify for premium tax credits to purchase coverage through the Exchange.

HOSPITAL INSURANCE TAX INCREASE

When – Beginning with the 2013 tax year.

Impact – Employers are responsible for withholding the additional tax on qualified wages.

How – Updating your payroll processes.

An additional 0.9% hospital insurance tax is imposed on wages in excess of $250,000 for married taxpayers filing jointly, $125,000 for married taxpayers filing separately and $200,000 for all others.

HEALTH REIMBURSEMENT ACCOUNTS (HRAS)

The primary concerns for an HRA in relation to PPACA and the Public Health Services Act (PHSA) are with regard to annual/lifetime maximums, minimum value, play or pay requirements and PCOR. Integrated or excepted HRA's are not subject to these provisions. See the summary descriptions below:

1. **Integrated HRA.** An integrated HRA is directly linked to a group health plan. Participation is predicated on enrollment in the health plan and the HRA reimburses specific expenses not paid by the health plan such as deductible, coinsurance, etc.
2. **Excepted HRA.** An HRA that reimburses only excepted benefits is an excepted HRA. Dental and vision that are separate from a group health plan are excepted benefits.
3. **Stand-alone HRA.** A stand-alone HRA is not linked to a health plan, will reimburse general healthcare expenses and may include premium reimbursement. See more information in the section on HRA as a Flexible Spending Plan.
4. **Grandfathered or Retiree HRA.** Grandfathered HRA's and HRA's that cover retirees only do have exceptions to some of the provisions of the law. A grandfathered HRA is one that was in existence on March 23, 2010 and has not implemented significant changes since that time. Determining grandfathered status may require further review.

With an integrated HRA, the health plan complies with the annual limit, minimum value, play or pay and PCOR requirements so as part of the health plan, the HRA has no further obligations. Excepted HRA's are not considered a health plan and therefore are also not subject to compliance. Stand-alone HRA's are classified as a health plan and as such would not meet the minimum value criteria, in addition an HRA is typically established with a maximum annual contribution thus that HRA would also not comply with the annual limit quotas. It has been proposed that HRA's designed to reimburse individual premium could be considered integrated with the individual plan but it doesn't appear this will be accepted.

HRA AS A FLEXIBLE SPENDING ARRANGEMENT

There is an option to make a stand-alone HRA exempt from the annual limits restrictions of PPACA. An HRA that meets the requirements of Section 106(c)(2) flexible spending arrangement will not be subject to prohibiting annual limits. A flexible spending arrangement is defined as a benefit program that provides employees with coverage under which:

1. A specified incurred expense may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and
2. The maximum amount of reimbursement which is reasonably available to a participant is less than 500% of the value of such coverage.

The stand-alone HRA that allows rollover will satisfy these requirements by setting a cap on the rollover so that the maximum available is always less than 5 times the annual value of the HRA. For example, if you contribute $500 annually to each participating employee, you would set a cap of less than $2,500.

Also note that the HRA cannot reimburse long-term care premiums under the flexible spending arrangement qualifications but can reimburse individual health premiums.

AFFORDABLE CARE ACT (ACA) REINSURANCE FEE

When – This fee which will be based on the number of covered lives in the plan, starting in 2014.

Impact – $63 per covered life per year or $5.25 per month. The requirement to pay the fee will be assessed on fully insured plans for major medical coverage and insurers are liable for paying the contributions. Self-funded plans are liable for the contributions, although a TPA can be used to remit the contributions on the plan's behalf.

How – By November 15 beginning in 2014, each group health plan must submit an annual enrollment count of the plan's average number of covered lives to HHS. Within 30 days of the enrollment count submission or by December 15, 2014 whichever is later, HHS will notify the plan of the reinsurance contribution amount due. The fees must be remitted within 30 days of the notification and failure to pay will subject the entity to federal penalties.

The fees are designed to stabilize premiums for coverage in the individual market from 2014 to 2016 and to assist in covering the Federally Facilitated Exchange's administrative costs. The contribution by plans, including self-funded plans, will be based on the requirement that the fund raise $12 billion for 2014 ($10 billion for the reinsurance program and $2 billion for the U.S. Treasury). Each year the fees will be reduced, so in 2015 it will be $8 billion and in 2016 $5 billion.

GOOD NEWS FOR SELF-FUNDED PLANS

Keep in mind that self-funded plans do not have to comply with the requirement to provide coverage for Essential Health Benefits as defined by PPACA. However, if any benefit is offered that is in the category of an EHB, it must **not** have an annual or life time limit.

Repeal of Deductible Limits

News on deductible caps on small plans: On April 1 2014 a bill passed that among other things eliminates the $2,000/$4,000 deductible on sponsored health plans. This means that the $2,000/$4,000 annual deductible limit placed upon fully insured small group health plans has been eliminated effective to the enactment of PPACA (March 23, 2010). Out of Pocket Maximum Limits still apply. The 2014 Out of Pocket Maximum Limits are $6,300 for self only coverage and $12,700 for Family Coverage.

Nothing in this document is intended to be legal advice.

PPACA Play or Pay Penalties Beginning in 2014