Health Care Reform: Top Employer Questions

INSIGHT™ risk management

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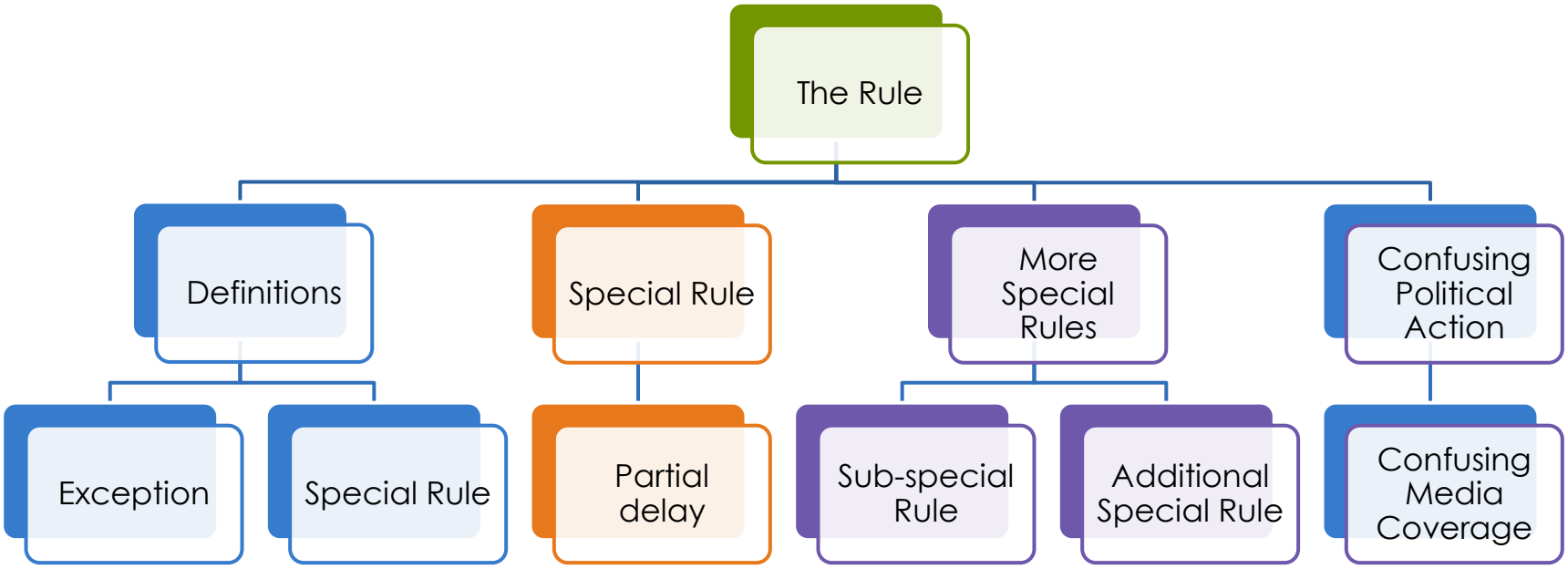
How Health Care Reform Works



Q: I heard they did away with the Employer Mandate. Is that true?

Final Regulations

- Issued on Feb. 10, published on Feb. 12
- Major provisions:
  - One-year compliance delay for medium-sized employers
  - Extension of 2014 transition relief
  - Some new transition relief
  - Clarification of a number of rules
- Overall structure and major rules maintained

Employer Shared Responsibility Rules (Pay or Play)

Medium Employers (between 50-99 employees)

- **Delayed until 2016**
- Employer may not reduce his workforce after Feb 9 in order to satisfy the limited workforce condition except for bona fide reasons

Large Employers (100+ FT/FTE employees)

- **Delayed until 2015**

Employers that change their plan year after Feb 9, 2014 are not eligible for the delay

Q: What is a grandfathered plan (and do I have one)?

Grandfathered Plans

Definition	• Health plan or health insurance coverage that covered individuals on **March 23, 2010** • Determination made separately for each benefit package
Requirements	• Do not significantly change costs or benefits • Provide notice to participants and beneficiaries in plan materials • Keep records of plan terms
Status	• Depends on each plan • New plans are not grandfathered • Check with your broker or carrier • Does not automatically expire

My Plan is Grandfathered. So What?

Grandfathered plans are exempt from *some* health care reform rules

- Coverage of preventive health services
- Expanded appeals process rules
- Guaranteed issue and renewal of coverage
- Essential health benefits package coverage
- Clinical trial coverage requirements
- Nondiscrimination rules for fully-insured plans
- Small group premium rating restrictions
- Health status nondiscrimination
- Cost-sharing limitations (OOP max and deductibles)
- Age 26 coverage limitations (temporary exemption)

Changes to Grandfathered Plans

Permitted Changes

- Routine coverage changes
- Premium changes*
- Adding new employees or family members
- Changing insurance carriers

Prohibited Changes

- Significantly reducing benefits
- Increasing coinsurance
- Significantly increasing copays or deductibles
- Adding annual limit
- Significantly reducing employer contribution (by more than 5%)

Q: What is an EHB Plan and who has to offer one?

What is an EHB Plan?

- EHB stands for Essential Health Benefits and an EHB Plan must include at a minimum the 10 EHB's outlined in PPACA.

Ambulatory Patient Services
Emergency Services
Prescription Drugs
Hospitalization
Laboratory Services
Maternity and Newborn Care
Mental Health and Substance Abuse Benefits
Preventative & Wellness
Pediatric Dental & Vision
Rehabilitative and Habilitative Services and Devices

- *All **Non-Grandfathered** Small Groups must offer an EHB Plan (50 or less employees)*

Other characteristics of an EHB Plan

Some other characteristics of an EHB plan are as follows:

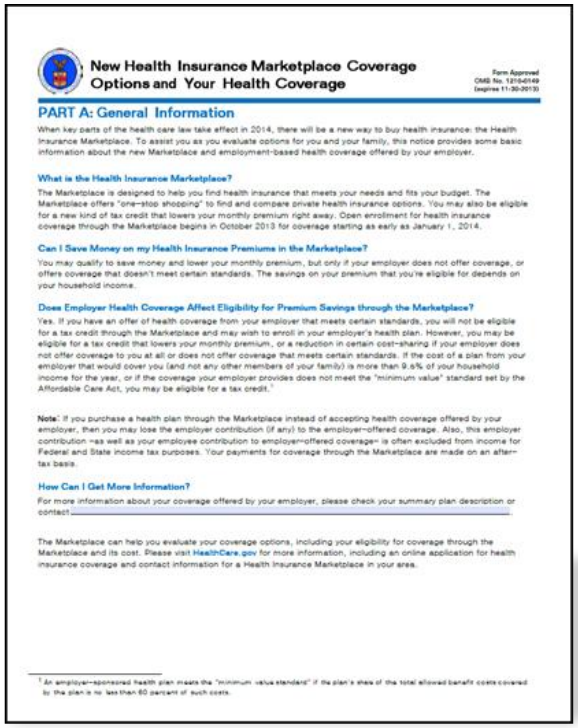
- Must meet one of the metal tiers (Bronze, Silver, Gold, Platinum)
- Must use Adjusted Community Rating
  - Male/female – same rate
  - No medical underwriting
  - Some carriers have interpreted this to mean no composite rates

Q: What information do I have to give my employees about the Exchange?

Notice to Employees of Coverage Options

Current employees:
by **Oct. 1, 2013**

New employees hired after Oct. 1:
within **2 weeks** of hire



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

- Employers subject to FLSA must inform **all employees** of Exchange information
- Include information on:
  - Exchange and services
  - Potential subsidy eligibility
  - Impact on employer contribution
- Model notices available

DOL: no legal penalties for failing to provide notice, but compliance encouraged

Other consequences may apply (?)

Delivering the Notice

Must be provided in writing

- In a manner calculated to be understood by the average employee

May be provided by first-class mail

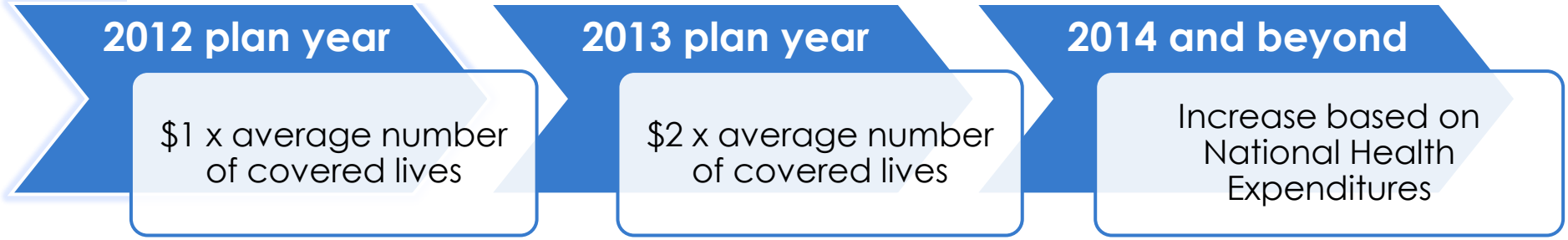
May be provided electronically

(if DOL requirements are met)

Q: What fees do we have to pay under health care reform?

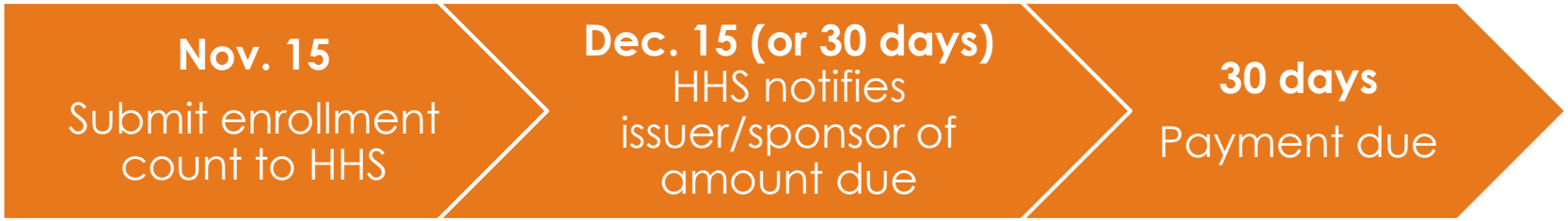
Patient-Centered Outcomes Research Institute (PCORI) Fees

- Fee to fund research on informed health decisions
- Paid by issuers and self-funded plan sponsors
  - Special rules for multiple self-funded plans (including HRAs)
- Paying the fee
  - Using Form 720 by July 31 each year
  - Beginning with plan years ending on or after Oct. 1, 2012
  - Ending with the 2018 plan year



Reinsurance Fees

- Fee to fund reinsurance program to stabilize individual insurance market
  - Program to operate 2014-2016
- Paid by health insurance issuers and self-funded plan sponsors (with some exceptions)
- Fees based on annual national contribution rate
  - 2014: **$5.25/month ($63/year)** x average number of covered lives



Health Insurance Providers Fee

- Annual fee on health insurance providers
  - Effective in 2014
  - Due Sept. 30 each year
  - Allocated according to market share: $8B in 2014 - $14.3B in 2018 (based on premium growth in later years)

Applies to:

- Covered Entities
- Including health insurance issuers and HMOs

Does not apply to:

- Companies with $25M or less in net premiums
- Self-insured employers
- Government and non-profit entities
- VEBAs

Q: Can my plan still have a waiting period?

Waiting Period Limits

- Waiting periods limited to **90 days** beginning with 2014 plan year

Strict 90 day limit	Other eligibility conditions permitted	Variable hour employees
• 1st of the month following 90 not permitted • Recommendation: use shorter period for 1st of the month enrollment	• Can't use to avoid 90-day limit • Orientation period allowed – max one month • Job related licensure requirements • Rehires can be treated as new hires	• Measure hours for up to 12 months to determine FT status • Offer coverage by end of 13th month

Q: Do I have to offer health coverage to my employees?

Employer Shared Responsibility Rules (Pay or Play)

Small Employers (fewer than 50 FT/FTE employees)

- No requirement to offer coverage
- Can get tax credits for providing coverage

Large Employers (50+ FT/FTE employees)

- Must offer coverage to FT employees and dependents to avoid penalties
- Coverage must be **affordable** and provide **minimum value**
- Penalties delayed until 2015; additional one-year delay may apply for ERs with 50-99 full-time EEs

Employer penalties triggered if any full-time employee receives subsidized coverage in an Exchange

Eligibility for Transition Relief

Employers that change plan years after Feb. 9, 2014 to begin on a later calendar date are not eligible for the delay

Maintenance of Workforce and Hours of Service	• May not reduce workforce size or hours of service Feb. 9-Dec. 31, 2014 to qualify based on size • Changes for bona fide business reasons permissible
Maintenance of Previously Offered Coverage	• May not eliminate or materially reduce coverage offered as of Feb. 9, 2014 during maintenance coverage period
Certification of Eligibility	• Must certify that it meets all eligibility requirements • Certification form expected to be part of final employer reporting requirements

Potential Penalties

Penalty A

- Employer **did not offer coverage** to substantially all FT employees and dependents (children)
- $2,000 x (all FT employees – 30)
- For 2015, ALEs with 100+ FT employees can reduce their FT employee count by 80 when calculating the penalty

Penalty B

- Employer offered coverage to substantially all FT employees/dependents
- But **not all employees**, OR coverage is **not affordable** or **does not provide minimum value**
- $3,000 x each employee who gets subsidized coverage (capped at Penalty A amount)

Avoiding Penalties

Offer coverage to FT employees and dependents that:

Is affordable

- Employee's contribution for self-only coverage does not exceed **9.5% of income**
- Safe harbors for what income and premium amount to use

Provides minimum value

- Plan covers at least **60% of costs** on average
- MV calculator or design-based checklists

"Substantially All" Full-Time Employee Percentage

Proposed rule:

- Employers must offer coverage to at least 95% of full-time employees to avoid largest penalties

Final rule:

- Percentage requirement **phased in over 2 years**
- **2015:** must offer coverage to **70%** of full-time employees
- **2016 and beyond:** offer coverage to **95%** of full-time employees

Employers still exposed to lesser penalties if coverage is not offered to all full-time employees

Q: Who is a full-time employee?

Full-time vs. Full-time Equivalent

Full-time employees

- Counted for large employer determination
- Must be offered coverage (along with dependents) to avoid penalties

Full-time equivalent employees

- Counted as a fraction for large employer determination
- Do not have to be offered coverage

Seasonal employees

- Special rules apply for large employer determination
- Special rules apply for offering coverage (along with variable hour employees)

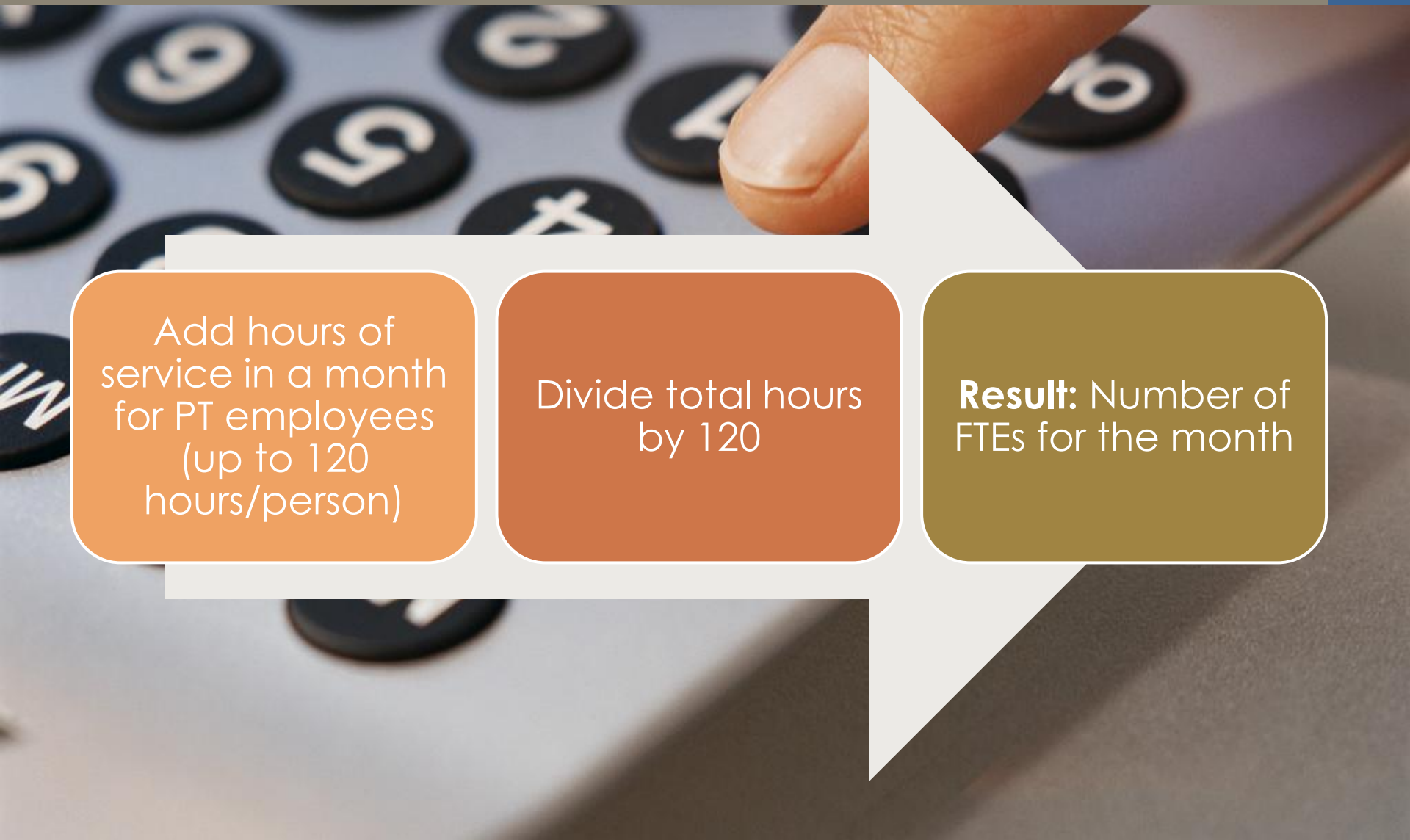
Full-Time Employee

With respect to a calendar month

An employee who is employed on average at least **30 hours of service per week**

130 hours of service in a calendar month = the monthly equivalent of 30 hours of service/week

Full-Time Equivalent Employees



Add hours of service in a month for PT employees (up to 120 hours/person)

Divide total hours by 120

Result: Number of FTEs for the month

Offering Coverage to FT Employees

New employees expected to work full-time

- Reasonably expected at start date to work full-time (not seasonal)
- Offer coverage by end of first 3 full calendar months of employment

Ongoing (current) employees

New variable hour employees

New seasonal employees

- Final regulations provide 2 methods for determining full-time status:
  - Monthly measurement method
  - Look-back measurement method

Monthly Measurement Method

- Used to **identify full-time employees** by employers who do not use the look-back measurement method
- Employees are identified based on the **hours of service for each calendar month**
- Employer must offer coverage to an employee by the end of **three full calendar months** beginning with the month the employee is otherwise eligible for coverage to avoid penalties
- Must be treated as returning employee unless there is a **13 week break in service** or 4 week break in service that is longer than the prior period of employment

Look-back Measurement Method

- May be used for new variable hour and seasonal employees if used for ongoing employees
- Employers **may not** use the look-back measurement method for variable hour/seasonal employees and use monthly measurement method for employees with predictable schedules
- Rules protect full-time status for employees transferring between positions using different methods
- Transition measurement periods allowed for 2014

Look-back Measurement Method

Measurement Period

Counting hours of service (3-12 months)

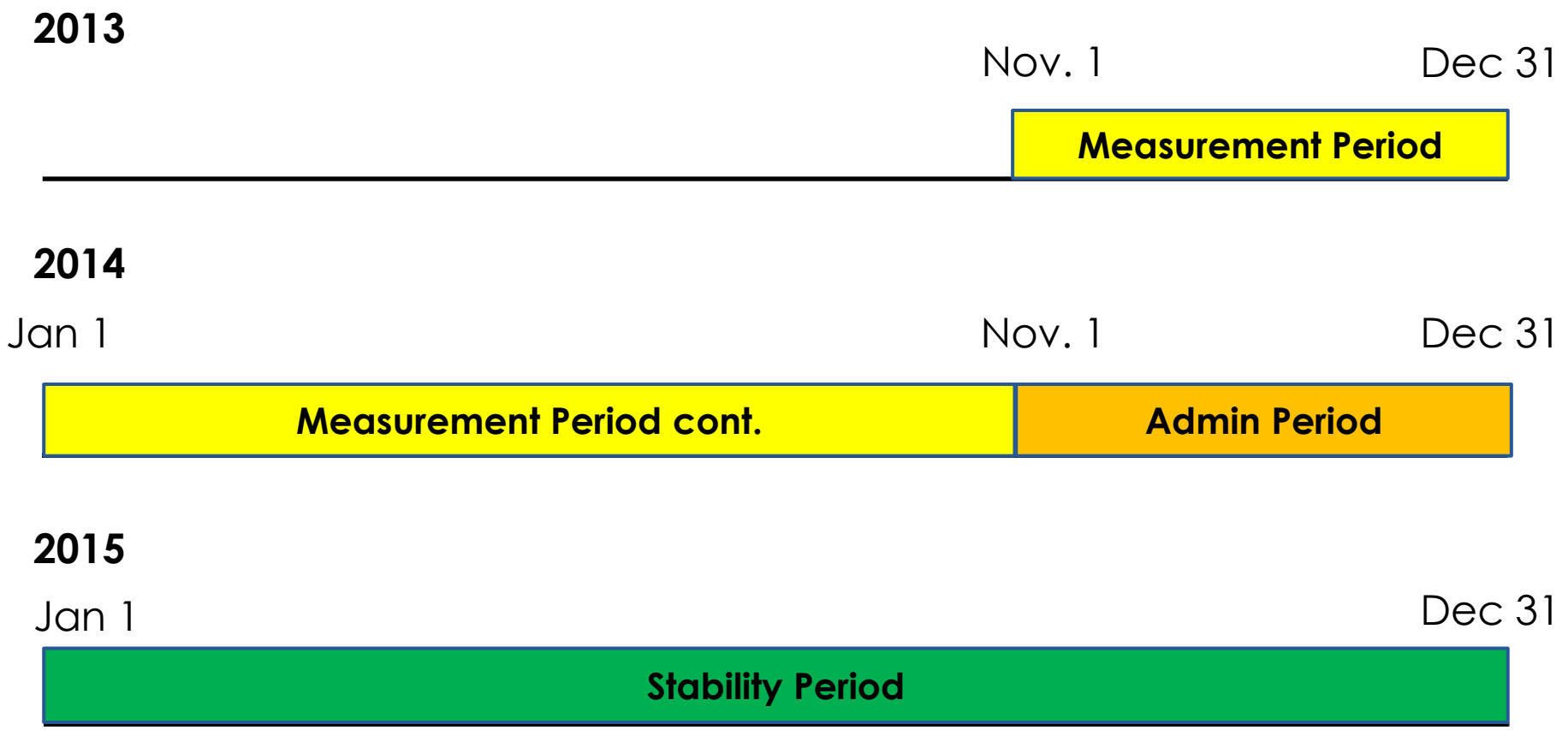
Administrative Period

Time for enrollment/disenrollment (Up to 90 days)

Stability Period

Coverage provided (or not) – length depends on type of employee and whether FT or not

Look-Back Measurement Method for Ongoing Employees



I'm a Large Employer. What are my reporting requirements?

Larger Employer Reporting

- The Section 6056 must be filed by all "applicable large employers" (ALEs) no later than Feb 28 each year (or March 31 if filed electronically).
  - An ALE is an employer that employed, on average, at least **50 full time employees** (including full time equivalents) during the prior calendar year.
  - ALEs without any full time employees are not subject to the section 6056 reporting requirements.
  - Employee statements must be provided by Jan 31 each year
  - Electronic filing is required for all ALEs filing at least 250 returns during the calendar year

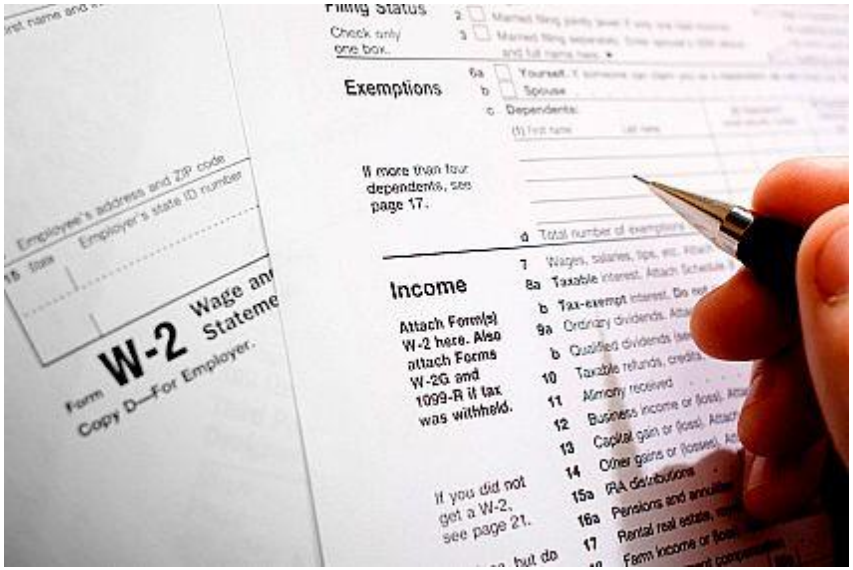
Required Information

- The ALE's name, address and employer identification number (EIN), and the calendar year for which the information is reported;
- The name and telephone number of the ALE's contact person;
- A certification as to whether the ALE offered to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, by calendar month;
- The number of full-time employees for each calendar month during the calendar year, by calendar month(however, full-time employees may also be identified on a weekly basis or a payroll period basis that approximates the calendar month);

Required Information

- For each full-time employee, the months during the calendar year for which minimum essential coverage under the plan was available;
- Each full-time employee's share of the lowest-cost monthly premium for self-only coverage providing minimum value offered to that full-time employee under an eligible employer-sponsored plan, by calendar month; and
- The name, address and taxpayer identification number (TIN) of each full-time employee during the calendar year and the months, if any, during which the employee was covered under an eligible employer-sponsored plan (however, reporting of social security numbers for an employee's spouse or dependents is not required).

W-2 Reporting



- Employers must report aggregate cost of group health plan coverage on each employee's Form W-2
- Does not change the tax rules for health coverage – coverage is still **not taxable**

For **small employers** (filed fewer than 250 W-2 Forms last year), reporting requirement is delayed until further guidance issued

Questions?

Thank you!