ACA Compliance Healthcare Reform Impact 2013-2014

Cliff Notes

Currently required for 2012-2013:

1. **PCORI Fees –** Employers offering HRA or MERP plans that had a renewal after 10-2-2012 must pay a $1 fee per insured employee on Form 720 by July 31, 2013 deadline for the 2012 plan year. Fee increases in 2013 to $2 per insured. Health Insurance companies for fully insured plans must also pay these fees, however employers are not required to participate in these filings. ***See additional detail below.***

2. **W-2 Reporting for Employer's with over 250 W-2's in 2012+ –** Employer's are required to include the premium paid to health insurance carriers on W-2 with code "DD" for each employee insured during any part of 2012. Any HRA, MERP and HSA funding are not required to be reported at this time only the medical premium paid to carriers.

3. **Summary of Benefits & Coverage SBC Requirement –** Required to be provided to employee's for all groups renewing on or after 9-23-12. Carrier required to provide to Employer's for distribution to all benefit eligible employees. If Employer offers HRA/MERP self funded plan integrated with medical plan, a separate SBC is required to be distributed to all benefit eligible employees. *BDS supplies Employer with the MERP SBC.* ***See additional detail below.***

4. **MSP Reporting –** Medicare Secondary Payor reporting is required whereby an HRA/MERP plan would provide $5,000 or more of funding to an individual. BDS collects this data from employer and provides reporting to CMS. Noncompliance Employer penalties up to $1,000 per day for each employee that should have been reported. ***See additional detail below.***

5. **FSA election limit of $2,500 -** Effective on renewal of plan year on or after 1-1-13.

Effective upon renewal on or after 1-1-14:

6. **LARGE EMPLOYERS Minimum Essential Coverage (MEC) –** Beginning on plan year renewals on or after 1-1-2014, deemed "Large" Employers (over 50 FTE's) must provide health insurance coverage (meeting minimum essential guidelines) to all employees working 30 or more hours per week at an affordable cost to employees. ***Cost for Single coverage is deemed affordable as long as it does not exceed 9.5% of the employee's W-2 wages.*** Penalties for Employers with 50 or more full-time "FTE" employees that do not offer MEC coverage are $2,000 per employee (exemption of 30 employees). Part time employees are taken into account in determining if employer has at least 50 employees. ***See additional detail below.***

7. **Small groups under 50 –** Deductibles cannot exceed $2,000 for single coverage and $4,000 for family coverage (as indexed). Still awaiting guidance on coinsurance limits and details regarding HRA supplements, etc. Fully insured plans in small group market must provide minimum essential benefits.

8. **EXCHANGES -** Beginning in 2017, states may allow all employers of any size to offer coverage through the exchange. Prior to 2017, only small employers – employers with 100 employees or less (except in states that limit small employers to employers with 50 or fewer employees) may participate.

PCORI Fees

Prepare to calculate and pay PCORI fee

New Code Section 4375 imposes a fee (referred to as the PCORI fee) on an issuer of a "specified health insurance policy" and Section 4376 imposes a fee on a *plan sponsor* of an "applicable self-insured plan" for each policy year ending on or after October 1, 2012.

The fee is $1 multiplied by the average number of lives covered under the policy or self-insured plan for policy years ending before October 1, 2013. Thereafter, the fee is $2 multiplied by the average number of lives covered. Thus, for calendar year plans, the CER Fee is $1 in 2012 and $2 in 2013. For policy years ending after October 1, 2014, the $2 fee is increased based on increases in the projected per capita amount of National Health Expenditures.

The health insurer is responsible for paying the fee with respect to the average number of lives (*i.e.*,employees and dependents) covered under a specified health insurance policy; ***the plan sponsor is responsible for paying the fee with respect to the average lives covered under an applicable self-insured plan.***

The PCORI Fee is calculated for each calendar year, even if the policy or plan operates under a fiscal year. The fee is paid by filing IRS Form 720 on an annual basis. The filing is due by the July 31 immediately following the end of the applicable policy/plan year. For example, the PCORI Fee for the 2013 calendar year would be due no later than July 31, 2014.

There is a special counting rule for HRAs and health FSAs that are not excepted benefits. Plan sponsors are only required to count the participants covered under an HRA or an FSA–not the dependents (to the extent not an excepted benefit).

LARGE EMPLOYERS Minimum Essential Coverage Rules

Beginning in 2014, "applicable large employers" are subject to penalties under new Code Section 4980H in certain situations where such employers fail to offer minimum essential coverage to their *full-time employees*, as defined by new Code Section 4980H, or fail to offer minimum essential coverage to full-time employees that is both affordable and provides minimum value. The requirements set forth in Section 4980H, which was added by the Patient Protection and Affordable Care Act ("ACA") are often referred to as the "employer shared responsibility" or "pay or play" requirements. The IRS recently prescribed a safe harbor in Notice 2012-58 ("Safe Harbor") for identifying full-time employees for purposes of compliance with the Code Section 4980H penalty assessment. Below is a brief overview of the rules set forth in Code Section 4980H and PHSA Section 2708 and the related guidance from the Notices.

Overview of Code Section 4980H

Beginning January 2014, new Code Section 4980H prescribes two different penalties related to coverage that an *applicable large employer* offers or fails to offer to its full-time employees and their dependents during a month.

Applicable Large Employer

An applicable large ***employer is any employer who employed on average at least 50 full-time "equivalents"*** on business days during the preceding calendar year. Full-time equivalents for a month equal the sum of full-time employees (as defined by Code Section 4980H) and an additional number equal to the total hours of service during a month of those who are not full-time employees divided by 120. This "full time equivalency" rule means that an employer with fewer than 50 full time employees may be an "applicable large employer" for purposes of the pay or play tax because part time employees are considered for this purpose. For purposes of determining whether an employer is an "applicable large employer" controlled group concepts apply. However, the separate line of business ("SLOB") provisions under Code Section 414(r) are apparently not applicable.

Keep in Mind: The 4980H Safe Harbor discussed herein does not apply to the determination of applicable large employer status. The IRS identified in Notice 2011-36 a potential method for making an *applicable large employer* determination and requested comments on that potential determination; however, IRS has not yet issued formal guidance on the *applicable large employer* determination.

Full-time Employee Defined in Code Section 4980H

A full-time employee for purposes of Code Section 4980H is any employee who, on average, is employed at least 30 hours of service per week during a month. Calculating full-time status each month and ensuring that the appropriate coverage is provided for each such month creates significant administrative burdens for many employers. Consequently, the IRS has created the 4980H Safe Harbor.

Keep in Mind: The 4980H Safe Harbor is just that–a safe harbor. Employers are not required to use the 4980H Safe Harbor to determine full-time status of its employees.

Beginning in 2015, insurers and self-funded plans will be required to report information about health coverage provided during the prior year to all participants, including Taxpayer Identification Numbers of all covered individuals and the specific dates that such individuals had such health coverage. This reporting must be provided to both the IRS and the individual participants. In addition, employers with 50 or more employees will be required to report information about health coverage provided during the prior year to full-time employees, including information about the lowest cost option offered and whether the minimum value requirements were satisfied. This reporting must also be provided to both the IRS and individual participants. At least one IRS spokesperson has already warned employers that this information reporting can be more complicated than it seems, and that employers must design their systems to capture the information needed to meet reporting requirements in advance in order to avoid "a lot of difficulty."*

However, to date, the IRS has issued only two requests for information (Notices 2012-32 and 2012-33) to address these requirements and no guidance. The comment period for both of these Notices expired on June 11, 2012, and the IRS is presumably in the process of reviewing comments, many of which likely contained numerous suggestions about how the reporting should be structured to minimize burdens for insurers, administrators and employers. There are limits as to how much the IRS can simplify the reporting, since it will be necessary for the IRS to gather enough information to determine whether the proper amount of tax is being paid by individuals under Code section 5000A and employers under Code section 4980H.

Employers with 50 or more full-time "applicable" employees are subject to the following penalties related to coverage that they offer or fail to offer to full-time employees:

- *Applicable employers who fail to offer full-time employees health coverage must pay a penalty with respect to each full-time employee in any month in which any full-time employee receives a federal subsidy for the exchange.*
- *The penalty is determined on a monthly basis and is the product of the total number of full-time employees of the employer (over 30) for that month and 1/12 of $2000 (nondeductible excise tax) (up from $750).*
- *For example, a business with 51 employees that does not offer coverage is subject to tax equal to 21 times the applicable payment amount.*

Even when coverage is extended, applicable employers who offer coverage for any month to a full-time employee who is certified as having enrolled in the exchange and received a tax subsidy is subject to a penalty equal to the product of the total number of such employees who have received a tax subsidy and 1/12 of $3,000 (capped at 1/12 of $2000 times the total number of fulltime employees during such month)

- *Note: employees offered employer coverage are not eligible for a credit unless their required premium exceeds 9.5% of household income or the plan's share of allowed costs is less than 60%.*

*Statement by Cathy Livingston, Deputy Division Counsel/Deputy Associate Chief Counsel in the Tax-Exempt and Government Entities Division of the IRS Chief Counsel's office on October 18, 2012 at a program cosponsored by the American Law Institute and the American Bar Association Section of Taxation.

IRC §6055 Notice 2012-32[2]		IRC §6056 Notice 2012-33
REPORTING TO IRS		
Self-Insured **Every sponsor of a self-insured health plan must report the following information to the IRS beginning in 2015 for coverage provided on or after January 1, 2014:**	Insured **Every health insurance Issuer that provides minimum essential coverage as defined in IRC §5000A(f) must report the following information to the IRS beginning in 2015 for coverage provided on or after January 1, 2014:**[3]	**Employers with 50 or more Employees must report the following information to the IRS beginning in 2015 for coverage provided on or after January 1, 2014:**
The name, address, and taxpayer identification number of the primary insured and each other individual covered under the policy or plan		For each full-time employee, the name, address, and taxpayer identification number (TIN) of the employee and the months (if any) during which the full-time employee (or any dependents) were covered under the eligible employer-sponsored plan
The dates each individual was covered under minimum essential coverage during the calendar year		Certify whether full-time employees (and their dependents) are offered the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in §5000A(f)(2)).
	Whether the coverage is a qualified health plan offered through an Exchange	If full-time employees (and their dependents) are offered the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, certify: (1) The duration of any waiting period (as defined in §6056(b)(2)(C)) with respect to such coverage; (2) The months during the calendar year when coverage under the plan was available; (3) The monthly premium for the lowest cost option in each enrollment category under the plan; and (4) The employer's share of the total allowed costs of benefits provided under the plan.
	If the coverage is a qualified health plan offered through an Exchange, the amount (if any) of any advance payment of the premium tax credit under § 1412 of the Affordable Care Act or of any cost-sharing reduction under § 1402 of the Affordable Care Act for each covered individual	
	The name, address, and employer identification number of the employer maintaining the plan	Name and Employer Identification Number (EIN) of the applicable large employer
	The portion of the premium to be paid by the employer	The number of full-time employees for each month of the calendar year

[2] In addition to employers and issuers, this reporting must be done by every government agency that administers government-sponsored health insurance programs and any other entity that provides minimum essential coverage.

[3] Notice 2012-32 states "If health insurance coverage is provided by a health insurance issuer and consists of coverage provided through a group health plan of an employer, it is anticipated that the regulations would make the health insurance issuer responsible for the reporting."

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<tr><td></td><td>Any other information that the Secretary may require for administering the tax credit under § 45R (credit for employee health insurance expenses of small employers)</td><td>The date the return is filed</td></tr>
<tr><td colspan="2">Other information that the Secretary requires</td><td>Other information that the Secretary requires</td></tr>
<tr><td colspan="3">REPORTING TO INDIVIDUALS</td></tr>
<tr><td rowspan="4">Every sponsor of a self-insured health plan must report to each individual listed on the return filed with the IRS the information above, no later than January 31, 2015, and each January 31 thereafter</td><td rowspan="4">Every health insurance Issuer that provides minimum essential coverage as defined in IRC §5000A(f) must report to each individual listed on the return filed with the IRS the information above, no later than January 31, 2015 and each January 31 thereafter</td><td>Employers with 50 or more Employees must report the following information to Full-Time Employees no later than January 31, 2015 and each January 31 thereafter:</td></tr>
<tr><td>The applicable large employer’s name and address</td></tr>
<tr><td>The applicable large employer’s contact information (including a contact phone number)</td></tr>
<tr><td>The information relating to coverage provided to that employee (and dependents) that is required to be reported on the § 6056 return</td></tr>
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Medicare Secondary Payer Reporting Requirements (MSP Reporting)

All Group Health Plans, including HRA and MERP plans, are required to report specific data for certain individuals to Centers for Medicare and Medicaid Services (CMS) so as to coordinate payments for individuals covered under both a Group Health Plan and Medicare. The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to their Medicare benefits. There are federal rules that determine whether Medicare or the other GHP insurance pays first.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage. Our responsibility to report, as a third-party administrator takes affect October 2010. This reporting is to assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly.

The health insurance carrier for a fully insured medical plan is responsible for providing the MSP reporting to CMS. ***The Employer/Plan Administrator is responsible for providing MSP reporting to CMS for any other coverage deemed "health insurance coverage" (ie. HRA's and MERP's).***

Currently MSP reporting is required by employer if an HRA would provide $5,000 or more of funding to an individual.

Summary of Benefits & Coverage (SBC's)

When must the SBC be provided?

Generally, the SBC must be provided to any employee that is eligible to enroll in the group health plan and must be provided to a participant or beneficiary at three different times:

- at any enrollment,
- upon request, and
- when there is a material modification in the information.

It must also be provided by a health insurer to a plan at certain times. The health insurance carrier for a fully insured medical plan is responsible for providing the SBC to the employer for distribution to eligible participants. ***The employer is responsible for providing an SBC to eligible participants for any other coverage deemed "health insurance coverage"(ie. HRA's, MERP's funded FSA's, etc.).***

Keep in Mind: The effective date of the SBC requirement is March 23, 2012. Thus, the SBC need only be provided at any enrollment, or upon request, that occurs on or after March 23, 2012.